# Walsall Healthcare NHS trust

## Use of Resources assessment report

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Date of publication: 25 July 2019

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

## *Ratings*

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

Our overall quality rating combines our five NHS 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 NHS trust and in the related evidence appendix. (See www.cqc.org.uk/provider/RBK/reports)

| **Are resources used productively?** | **Requires improvement** ● |
|---|---|

| Combined rating for quality and use of resources | Requires improvement |
|---|---|

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 NHS trust taking into account the quality of services as well as the NHS trust's productivity and sustainability. This rating combines our five NHS 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 NHS trusts for their Use of Resources assessments.

The aim of the assessment is to improve understanding of how productively NHS trusts are using their resources to provide high quality and sustainable care for patients. The assessment includes an analysis of NHS 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 NHS trust.

### Combined rating for Quality and Use of Resources

Our combined rating for Quality and Use of Resources is awarded by combining our five NHS 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 NHS trust. The combined rating for Quality and Use of Resources for this NHS trust was requires improvment, because:

- We rated safe, effective, responsive, and well-led as requires improvement; and caring as outstanding.
- We took into account the current ratings of the core services and community services not inspected at this time.
- The overall rating for the trust's acute locations remained the same.
- The trust was rated requires improvement for use of resources. Full details of the assessment can be found on the following pages.

# Walsall Healthcare NHS trust

## Use of Resources assessment report

Date of site visit:
8th February 2019

Tel: 01922 721172
www.walsallhealthcare.nhs.uk

Date of publication: 25 July 2019

This report describes NHS Improvement's assessment of how effectively this NHS trust uses its resources. It is based on a combination of data on the NHS 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 NHS trust's leadership team.

The Use of Resources rating for this NHS trust is published by CQC alongside its other NHS trust-level ratings. All six NHS trust-level ratings for the NHS trust's key questions (safe, effective, caring, responsive, well-led, use of resources) are aggregated to yield the NHS trust's combined rating. A summary of the Use of Resources report is also included in CQC's inspection report for this NHS trust.

| | |
|---|---|
| **How effectively is the NHS trust using its resources?** | **Requires improvement** |

## How we carried out this assessment

The aim of Use of Resources assessments is to understand how effectively providers are using their resources to provide high quality, efficient and sustainable care for patients. The assessment team has, according to the published framework, examined the NHS trust's performance against a set of initial metrics alongside local intelligence from NHS Improvement's day-to-day interactions with the NHS trust, and the NHS 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 NHS trust on 8th February 2019 and met the NHS trust's executive team (including the chief executive), the chair and relevant senior management responsible for the areas under this assessment's KLOEs.

## Findings

| Is the NHS trust using its resources productively to maximise patient benefit? | Requires improvement |
|---|---|

**We rated the use of resources at this NHS trust as Requires Improvement.** The NHS trust's performance is variable across the areas covered by this assessment and although it has demonstrated improvement in some it continues to have key workforce challenges, in particular high levels of sickness absences and high use of temporary staffing, which has contributed to a deterioration in its financial performance. Whilst the NHS trust has implemented productivity improvement initiatives, the impact is yet to be reflected in its financial position.

- Performance against clinical services productivity metrics is variable. The NHS trust compares well in respect to Delayed Transfers of Care (DTOCs), 30-day emergency readmissions and elective pre-procedure bed days. This indicates better discharge processes and utilisation of elective bed capacity. Performance for non-elective pre-procedure bed days and Did Not Attend (DNAs) rates, though on an improving trend, remain worse than other NHS trusts, indicating that there is scope to improve utilisation of outpatient services and emergency bed capacity.
- The NHS trust also has variable performance against the constitutional operational standards. It is meeting the diagnostic and cancer standards and whilst it is not meeting the 18-week standard, performance is in line with its improvement trajectory. Further work is required to achieve sustained improvement against the 4-hr Accident and Emergency standard.
- The NHS trust has an overall cost per weighted activity unit (WAU) of £3,587 compared with a national median of £3,486 for 2017/18 (the most recent data), placing the trust in the second highest cost quartile nationally. This means the NHS trust spends more per unit of activity than most other trusts.
- Workforce productivity does not compare well in most areas. The NHS trust's cost per WAU is in the highest cost quartile nationally, which means that it spends more on pay to deliver activity when compared with other NHS trusts. The key contributors being nursing and temporary workforce costs. Sickness absence rates are also above the national median, and although the NHS trust achieved a reduction in agency costs in 2017/18, this has not been fully sustained, and the NHS trust expects to breach the 2018/19 agency ceiling by 23%. However, the NHS trust's overall retention rates compare well.
- A number of clinical service and workforce productivity improvement initiatives are being implemented by the NHS trust. They include nursing, medical and temporary workforce reviews to identify opportunities for better workforce deployment and cost reduction, and utilisation improvement programmes for theatre and outpatient services, which are supported by an external management consultancy. The NHS trust is also progressing some of the 'Getting It Right First Time' (GIRFT) improvement initiatives, in specialities such as orthopaedics. The full financial impact of these improvement programmes has not yet been modelled, however the NHS trust was able to demonstrate some in year financial benefits, such as reduced temporary agency nursing costs and improved income generation.
- The NHS trust's costs in pathology compare well and it has started working collaboratively with neighbouring NHS trusts in a pathology network, which is in line with the national strategy for sustainability of pathology services.

- Pharmacy costs also compare well, with the NHS trust benchmarking in the best quartile nationally. This is contributing to the NHS trust's low non-pay cost per WAU, which benchmarks lower than most NHS trusts. The NHS trust has pharmacy staff working on wards to support medicines optimisation and other various initiatives in place to reduce medicines wastage. The NHS trust has progressed well in delivering against the national top ten medicines programme, with savings performance that is better than target.
- There is more use of reporting radiographers for plain x-ray film reporting, which is the preferred operating model in imaging services as it releases consultant workforce capacity for more complex work. Other improvement initiatives in imaging services, include improving workforce capacity and improving utilisation of facilities through working with third parties. Outsourcing and agency costs, however, remain high.
- Estates and Facilities management costs are relatively lower than most NHS trusts, and the NHS trust is maintaining its estate well with a low maintenance backlog and critical infrastructure risk. This is partly due to the PFI arrangements in place for some of the estate, however the NHS trust also demonstrated a more proactive approach to maintenance of its retained estate. There is scope for further improvement in respect to waste management and PFI costs, which benchmark worse than most NHS trusts.
- Supplies and services costs compare well, however the NHS trust's performance against the NHS Improvement procurement metrics indicates that further cost reduction may be achieved through more effective procurement processes. Whilst the NHS trust is in a procurement collaboration, it is yet to optimise savings from this arrangement.
- The cost of running the finance function is lower than most NHS trusts and further improvements are planned for its sub-functions where the costs are outliers. The function has also recently taken over the programme management office to support productivity and financial improvements. Further work is required to ensure that financial modelling is embedded in early stages of developing productivity improvement initiatives, to allow for better understanding and delivery of financial benefits.
- The NHS trust did not agree its control total for 2017/18, and its performance was worse than plan. The NHS trust had a plan of £20.7 million against which it reported a deficit of £24.08 million. However, as a percentage of turnover (9.6%) this performance was in line with the previous year. The NHS trust agreed to its control total for 2018/19, but is not on track to deliver this, and the latest forecast position is £28.5 million deficit before PSF (11.48% of turnover) against a control total and plan of £15.5 million. The main contributors to the adverse position are a higher than expected pay bill driven by premium agency costs, and slippage against the cost improvement plan.
- For 2018/19, the NHS trust's cost improvement plan aimed to deliver a higher target of £15.5 million (5.61% of operating expenditure), which was the level of savings required to deliver the control total. Slippage against this plan was identified early in the year and the NHS trust strengthened its cost improvement delivery structures, however it has not achieved full recovery (against its plan) and is forecasting delivery of £13.7 million (4.71% of operating expenditure).

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

The NHS trust's performance for clinical services productivity is variable, however it has demonstrated improvements in areas where it does not compare well.

- At the time of the assessment in February 2019, and based on November 2018 data, the NHS trust was meeting the cancer and diagnostics constitutional operational standards.

It was not meeting the 18 -week Referral to Treatment (RTT) standard but was delivering above its recovery trajectory for this standard. The NHS trust was also not delivering the 4-hour Accident and Emergency standard. An improvement plan had been developed for the NHS trust (and wider Walsall system), however this is not being delivered. The Emergency Care Intensive Support Team has been working with the NHS trust to make sustained improvements in performance against this standard, and as part of the 2019/20 operational planning round, a revised trajectory is being developed by the NHS trust.

- Patients being treated at the NHS trust are less likely to require additional medical treatment for the same condition when compared with other NHS trusts. For the period October 2018 to December 2018, the emergency readmission rate at 7.14% is below the national median of 7.86%, an improvement on the previous year (8.79%). Improvements have been achieved through initiatives which ensure that there is appropriate monitoring of patients after discharge. For instance, virtual surgery and fracture clinics are held for patients who have been discharged and may require further surgery. Further work is also planned in conjunction with health commissioners (as part of a Walsall Together Programme) to support patients manage long-term conditions better at home, with an initial focus on respiratory and cardiology conditions.
- Delayed Transfers of Care (DToC) at 3.5% (October 2018) are in line with the national median. Opportunities exist for further improvement as the NHS trust identified that there are delays in the discharge process, which result from inefficiencies in the current approach to utilising therapy interventions. There is a heavy reliance on therapy interventions to mobilise patients, and this drives unnecessary referrals for therapy services, generating longer waiting times. Work has commenced to review current practice against best practice models.
- The NHS trust's average Length of stay for elective admissions benchmarks better than the national median and the NHS trust has achieved a reduction in the average Length of stay for non-elective admissions over the last 12 months, though this remains above (worse than) the national median. There has also been a reduction in the percentage of beds occupied with long stay patients, from an average of 22.6% in 2017/18 to 21.4% as at November 2018.
- The NHS trust has integrated teams for discharge planning which include therapists and social workers, who work with wards to support prompt discharge of patients. There is an intermediate care service (a joint venture through Walsall Together) which further supports elective patient flow through provision of a facilitated discharge service. The NHS trust has also engaged with the national programmes which aim to improve patient flow, such as SAFER, Red 2 Green and MADE events.
- Fewer patients are coming into hospital prior to the day of their surgery compared to other hospitals in England, as indicated by the pre-procedure bed days for elective care which benchmarks well nationally. Performance for the period October to December 2018 is 0.03 days compared to the national median of 0.13. This is an improving position and puts the NHS trust in the best quartile nationally, with only six other NHS trusts reporting a better position. The NHS trust attributes this performance to changes in practice (driven by clinicians) which led to more patients being admitted on the day of surgery. The aim was to ensure continuity of elective work by reducing the planned surgery cancellations as a result of bed capacity constraints.
- The NHS trust is above the national median and in the worst quartile for the pre-procedure non-elective bed days, which for period October to December 2018 were 0.83 days compared to a national median of 0.65 days. This indicates that patients are waiting longer in hospital for emergency procedures, when compared to other NHS trusts. The

NHS trust has identified that this performance is largely driven by delays to hip fracture pathway and has appointed a dedicated consultant lead to implement the improvements.

- The NHS trust has undertaken work to make improvements in theatre utilisation, which was one of the workstreams established as part of the Financial Improvement Programme. This is a programme of support, introduced by NHS Improvement, through which NHS trusts are supported in materially reducing their costs to improve their financial positions. The programme ended in March 2018, but the NHS trust has maintained this workstream and for the period April 2018 to December 2018, its income performance is reported to be £1 million better than plan, with £0.6 million of this attributed to improved theatre utilisation. Further significant improvements however remain to be made as the NHS trust continues to experience inconsistent theatre performance and high cancellations rates.
- The Did Not Attend (DNA) rate for the NHS trust, though improved, remains in the worst quartile nationally. For October 2018 to December 2018, the DNA rate was 9.09%, compared to a national median of 7.32%. This is however an improvement on the previous year, when the NHS trust's performance was 11.76% for the same quarter. The reduction has been delivered through an Outpatients Service Improvement Plan. Further improvements are being made with patient text and voice call reminders. The NHS trust is also considering triage of Trauma and Orthopaedics and Colorectal patients, prior to offering a first outpatient appointment.
- There is strong clinical engagement with the national 'Getting It Right First Time' programme, and the NHS trust has commenced work eight specialties to identify areas for productivity improvements. For instance, in orthopaedics, an action plan has been developed with the aim of delivering improved utilisation through increasing the number of joint replacement operations on a standard all-day theatre list during February 2019. The NHS trust has not yet quantified any benefits expected from these initiatives.

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

The NHS trust has a high pay bill with nursing and temporary workforce costs as the main contributors. To address this, the NHS trust has embarked on a review of its workforce skill mix, costs and deployment processes. It is also working to reduce the high sickness absence rates.

- For 2017/18 the NHS trust had an overall pay cost per WAU of £2,392 compared with a national median of £2,180, placing it in the highest cost quartile nationally. This means that it spends more on staff per unit of activity than most NHS trusts. However, the NHS trust is in the lowest cost quartile for medical cost per WAU.
- Nursing and midwifery staff cost per WAU for 2017/18 is £852 compared to a national median of £710. A nurse staffing review of all in-patient areas identified a relatively high number of higher graded nursing posts within the NHS trust, which was contributing to this high cost per WAU. These posts were previously created to enhance recruitment and retention of nursing staff. The NHS trust is addressing this high cost through its nursing transformation program, which will deliver changes in the nursing skill mix, with expected savings of £0.5 million.
- The NHS trust has identified that there is insufficient capability in its current e-rostering software to attain optimisation of substantive staff in workforce deployment processes. A business case for procuring a more effective e-rostering software solution has been developed. The NHS trust has a process in place to monitor patient acuity and dependency, however this is largely manual. Electronic collation of patient acuity and

dependency data would provide more accurate monitoring information and further improve effectiveness of staff deployment.

- Medical staffing cost per WAU at £478 is lower than the national median of £533 and in the lowest cost quartile nationally. The NHS trust is working to improve deployment of medical workforce through achieving consistency in job planning approach across specialities, and electronic capture of job plans (with the NHS trust reporting 78% compliance). Further work is required to ensure alignment with the NHS trust demand and capacity plans. The NHS trust has commissioned external consultancy support to address this and to also identify other productivity improvement opportunities, through the review of medical agency spend.
- The NHS trust achieved a reduction in overall agency spend for 2017/18 compared to the previous year, with the spend reported to be marginally above the agency ceiling set by NHS Improvement. However, the improvement has not been fully sustained in 2018/19, and agency spend is expected to rise above 2017/18 levels and exceed the agency ceiling (2018/19) by 23%. Drivers of agency spend remain, cover for vacancies and sickness absences, as well temporary capacity during periods of high emergency demand.
- The NHS trust has strengthened its controls for agency booking and is working to proportionately increase the bank staff fill rates. Evidence provided by the NHS trust demonstrated that since October 2018, there has been a reduction in monthly spend on overall temporary nurse staffing, mainly driven by a reduction in use of agency staff. The NHS trust has also been successful in eliminating use of care support agency workers in December 2018. The NHS trust is part of the Black Country collaboration where NHS trusts are working together to drive down the medical agency prices and is in early stages of developing a bank collaborative with a neighbouring NHS trust.
- The NHS trust is progressing the use of alternative roles in its workforce model. Examples of the new roles established include advanced clinical practitioners in the emergency department to support assessment and streaming of patients to the right care settings, advanced physiotherapy practitioners working in the community to support GP's as well as improvements in the Musculoskeletal pathway, and advanced practitioners in imaging services who have improved reporting times and patient flow.
- The overall staff retention rate is 86.9% for November 2018, placing the NHS trust above the national median of 85.9%, and in the second-best quartile nationally. However, there are staff groups with high turnover rates, for instance AHPs, which is driving high agency use. Improvement actions implemented include, better performance reporting (on staff retention and turnover) to support management address areas with lower retention rates and working with the National NHS Leadership Academy to identify ways to enhance talent management and succession planning.
- At 5.43% in September 2018, overall sickness absences rate is worse than the national median of 4.00% and places the NHS trust in the worst quartile nationally. Sickness absence cover is one of the drivers of agency use and the NHS trust is taking a range of actions to address this. For instance, improved reporting to support monitoring and management of absences and use of Health and Wellbeing initiatives, focused on improving attendance. A new attendance policy has been developed which focuses on the health and well-being of staff and is linked to delivery of a revised sickness absence target of 3.75%.

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

The NHS trust has started working collaboratively with partners to deliver sustainable services in pathology, which is in line with the national strategy for this area. The cost of pharmacy services is relatively lower than most NHS trusts, and it is progressing well in delivering against the nationally identified savings in the top ten medicines programme. The NHS trust is utilising reporting radiographers in its imaging services, however further work is required to reduce high outsourcing and agency costs.

- The overall cost per test in pathology benchmarks in the second lowest quartile nationally mainly due to a very low cost per test in microbiology. Cost per test in cellular pathology is high and in the highest cost quartile nationally.
- The NHS trust has recently transferred its pathology services to the Black Country Pathology Service Network. This development is in line with the national strategy for delivering sustainable Pathology services, however it's too early to assess delivery of benefits.
- The imaging department has a high rate of radiographer reporting for plain x-ray films, when compared with other NHS trusts. Radiographer reporting for plain x-ray films releases consultant capacity to undertake more complex work. The NHS trust also has dedicated radiographer support for the emergency department. There is real time information on diagnostics requests from ED, which is available to staff, allowing for better monitoring and management of patient waiting times and patient flow.
- There is collaboration in providing some of the imaging services, to support better utilisation of workforce and improvements in pathways and patient experience. The NHS trust works with a neighbouring NHS trust to provide breast screening services, with whom they also share consultant resource in Neurophysiology and Clinical Measurement. This has resulted in standardised practice across two organisations. The NHS trust has contracted an external service provider to undertake MRI examinations, which allows it access to new equipment, improved utilisation and better turnaround times.
- The NHS trust has a number of vacancies in the imaging department (which is driving agency and outsourcing costs), with their current vacancy rate being 7.34%. The high vacancy rate is partly due to increased number of posts, which have not yet been filled. The NHS trust undertook a demand and capacity review which identified a requirement for additional capacity in radiology. There has been some recent success in recruiting to senior roles such as sonographers and senior radiographers, but recruitment to lower graded roles remains a challenge.
- DNA rates in radiology are high, in particular for plain x-ray films, non-obstetric ultrasound and nuclear medicine. The NHS trust has identified delays is communicating appointment slots to patients as the key driver and is addressing this through prompter communication of appointments and confirming patient attendance via telephone.
- The NHS trust's medicines cost per WAU is relatively low when compared nationally and places the NHS trust in the best performing quartile. As part of the Top Ten Medicines programme, the NHS trust is progressing well in delivering against the nationally identified saving opportunities, achieving 122% of the savings target to date. The NHS trust has progressed switching to most of the biosimilars, but there are further opportunities to pursue in respect to Trastuzumab and Adalimumab.
- The NHS trust has other cost improvement initiatives in place, most of which aim to reduce drug wastage. For instance, pharmacists ensure patients are transferred with their medicines between wards which reduces the need for re-dispensing. The NHS trust

also has a pharmacy robot to support stock control and tracking of medicines. Evidence of savings delivered to date through these initiatives was however not provided.

- The NHS trust compares well in respect to prescribing pharmacists providing support on wards. Prescribing pharmacist support medicines optimisation practice, which drives safety efficiency and cost reductions.
- The NHS trust provides IT services to other NHS organisations in its locality, through hosting IT network and support service provision. Its clients include clinical commissioning groups and GP practices.
- There is some progress in implementing electronic prescribing for chemotherapy, however all other prescribing is paper based. The NHS trust is developing a business case for an electronic prescribing system.

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

The NHS trust's non-pay costs compare well. However, there is opportunity for further improvement through more effective procurement processes, and reduction in the estates PFI and waste disposal costs. The NHS trust also needs to investigate and address the high Human Resources (HR) function costs.

- For 2017/18 the NHS trust had an overall non-pay cost per WAU of £1,194 compared to a national median of £1,307, placing it in the second lowest cost quartile nationally. A breakdown of the cost categories shows that supplies and services costs per WAU also benchmarks better than the national median, however there is scope to further improvement this non-pay cost through more effective procurement processes.
- The NHS trust is 68 out of 136 on the procurement league table for period July to September 2018, and its Procurement Process and Price Performance at 61, benchmarks slightly better than the national median. This indicates that there is scope to improve the effectiveness of the NHS trust procurement processes in driving down the cost of purchases.
- This NHS trust is part of the Black Country procurement Collaborative but is yet to optimise the procurement benefits from this arrangement. Evidence provided by the NHS trust demonstrated improvement in the value of savings delivered through this arrangement, but with scope for further savings.
- For 2017/18, the cost of running the Finance function is in line with most NHS trusts, whereas the Human Resources benchmarks in the highest cost quartile. The Finance function cost is £0.68 million per £100 million of turnover compared to the national median of £0.7 million. The HR function cost is £1.24 million per £100 million of turnover compared to a national median of £1.09 million. The NHS trust has undertaken actions to reduce its finance function costs in future years, for instance, it has retendered its audit services, where costs benchmark higher than most NHS trusts. The NHS trust needs to further investigate and address the drivers of the high running costs for the HR function.
- The NHS trust's estates and facilities cost per square metre is £338, which places it below its peer benchmark value of £345. The NHS trust's maintenance backlog and critical infrastructure risk metrics also compare well against the peer benchmarks. The NHS trust has a PFI arrangement in place for part of its estate, however it also

demonstrated a more proactive approach to maintenance of its retained estate, with 62% of the maintenance work being planned.

- The NHS trust has undertaken developments of estates to improve clinical services productivity, for instance expansion of an emergency ward to create more additional bed capacity for seasons of high demand, expansion of Emergency department to reduce congestion in peak times and relocation of ITU and HDU, into one area. The NHS trust has not provided the quantified benefits realised or expected from these improvements.
- There is scope to further reduce the cost of running the estate in respect to waste management and PFI costs, which are above peer benchmarks and in the highest cost quartile when compared with peers. The NHS trust has appointed a sustainability and waste manager to support improvements in waste management, which include re-tendering of contracts and enhanced NHS trust wide training in waste segregation. To date the NHS trust has not secured savings against its PFI contact costs but intends work with papers to identify potential savings opportunities.

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

The NHS trust did not achieve its financial plan in 2017/18 mainly due to underperformance against its income plan. Whilst it has improved the income performance in 2018/19, it will not achieve the control total due to under performance against its CIP target and cost pressures associated with additional emergency capacity and temporary staffing.

- For 2017/18, the NHS trust did not agree its control total of £10.9 million deficit (excluding STF). The NHS trust had a plan of £20.7 million against which it reported a deficit of £24.08 million (9.6% of turnover). This was in line with the reported position in the previous year, as a percentage of turnover.

- A combination of factors contributed to the adverse outturn including under achievement against income plan, cost pressures arising mainly from use of medical agency staffing, and costs of additional capacity, created in response to the rise in emergency demand. The NHS trust also attributes the loss of income to displacement of elective activity as a result of emergency demand pressures and the national request to cancel inpatient elective activity during the winter of 2017/18.
- For 2018/19, the NHS trust agreed its control totals of £15.5 million deficit before PSF and £10.5 million with PSF. The NHS trust is not on track to achieve its control total for 2018/19, and at the time of the assessment, was forecasting a deficit of £24.5 million deficit before PSF (9.6% of turnover) and £20.0 million with PSF. The main contributors to the adverse position being a higher than expected pay bill driven by premium agency costs and slippage against the cost improvement plan. The NHS trust put in place a financial recovery plan aimed at strengthening expenditure controls and driving improved productivity and income generation, however since the assessment, the position has further worsened with the forecast deficit increased to £28.5 million before PSF (11.48% of turnover) in February 2019.
- The NHS trust delivered marginally below its cost improvement plan for 2017/18. It reported delivery of £10.9 million (3.9% of operating expenditure) against a plan of £11 million. 70% of delivered CIP was reported as recurrent and 20% as delivered through improved income generation.
- For 2018/19, the NHS trust's cost improvement plan aimed to deliver a higher target of £15.5 million (5.61% of operating expenditure), which was the level of saving required to

deliver the control total. Slippage against this plan was identified early in the year and the NHS trust strengthened its cost improvement delivery structures. This included realignment of the programme management office to the finance directorate and appointment of an interim Chief Operating Officer to drive reductions in capacity costs and productivity improvements in theatres and out patients. In addition, the NHS trust has undertaken workforce reviews to identify opportunities for reduction in the pay bill. The NHS trust has not achieved full recovery (against its plan) and as at December 2018 was reporting delivery of £7.2 million against a plan of £8.9 million, with 44% of this reported as recurrent. The NHS trust is forecasting delivery of £13.7 million (4.71% of operating expenditure).

- The NHS trust assessed its underlying deficit position as £19 million. A breakdown of this deficit was not provided by the NHS trust. We were not able to assess whether the drivers are within the NHS trust's control.
- Due to the historical deficit position, the NHS trust is reliant on additional cash support in the interim to consistently meet its financial obligations and maintain its positive cash balance. The NHS trust's cash position has been further adversely impacted by delays in commissioners' payments, as a result of disputes. This together with the NHS trust's decision to prioritise its PFI contractual and pharmaceutical suppliers' payments, has contributed to the increase in average creditor days, meaning the NHS trust's performance against the better payment practice code remains poor at 21% by number of invoices.
- The NHS trust uses service line reporting to support the identification of efficiencies at speciality level. Reports are published on quarterly basis and show the contribution levels for each speciality. The NHS trust is using its workforce cost information to assess opportunities for cost reduction. The NHS trust has not yet developed patient level costing systems.
- The NHS trust does not have any material commercial income streams, however it is actively exploring opportunities to maximise its NHS clinical income through; improving utilisation of facilities and workforce in theatres and outpatients, repatriation of activity such as births and improving quality of activity coding to support income billing.
- The NHS trust is not routinely reliant on management consultants. However, it has commissioned external management consultants to provide support in areas where the NHS trust has had insufficient capabilities, for instance development of financial sustainability programmes and high value business cases. The NHS trust is working to ensure transfer of these skills to its substantive staff. Total spend on management consultants in 2017/18 was £2.3 million (0.8% of operating expenditure), and this is expected to reduce to £1.6 million (0.6% of operating expenditure).

## Areas for improvement

We have identified scope for improvement in the following areas:

- The NHS trust should continue working towards improving its outpatients and theatres services utilisation, including reduction in DNAs and cancelled operations.
- The NHS trust's Finance team should support the quantification of GIRFT initiatives and ensure appropriate cost/benefit monitoring of these programmes

- The NHS trust should work at pace to implement the more effective software for deployment of the nursing workforce.
- The NHS trust should continue working to reduce temporary staffing costs.
- The NHS trust should investigate and address the high costs of the Human Resources department.
- The NHS trust should work towards improving its creditor payment performance.
- The NHS trust should continue working to reduce waste management and PFI costs.
- The NHS trust should identify the drivers of its underlying deficit and develop a plan to return to financial balance.

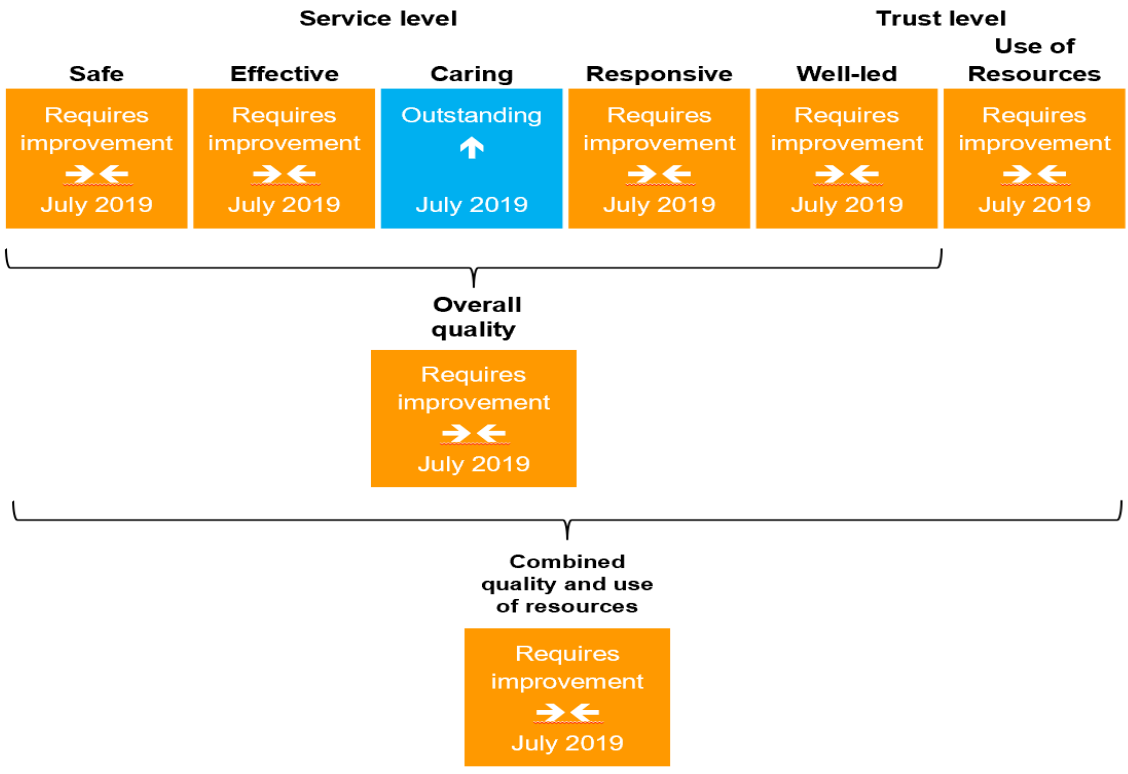
## *Ratings tables*

| Key to tables | | | | | |
|---|---|---|---|---|---|
| Ratings | Inadequate | Requires improvement | Good | Outstanding | |
| Rating change since last inspection | Same | Up one rating | Up two ratings | Down one rating | Down two ratings |
| Symbol * | ➔➔ | ↑ | ↑↑ | ↓ | ↓↓ |
| Month Year = date key question inspected | | | | | |

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

### Ratings for the whole trust



# Use of Resources report glossary

| Term | Definition |
|---|---|
| 18-week referral to treatment target | According to this national target, over 92% of patients should wait no longer than 18 weeks from GP referral to treatment. |
| 4-hour A&E target | According to this national target, over 95% of patients should spend four hours or less in A&E from arrival to transfer, admission or discharge. |
| Agency spend | Over reliance on agency staff can significantly increase costs without increasing productivity. Organisations should aim to reduce the proportion of their pay bill spent on agency staff. |
| Allied health professional (AHP) | The term 'allied health professional' encompasses practitioners from 12 diverse groups, including podiatrists, dietitians, osteopaths, physiotherapists, diagnostic radiographers, and speech and language therapists. |
| AHP cost per WAU | This is an AHP specific version of the pay cost per WAU metric. This allows NHS 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 NHS 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 NHS trust boards, governing bodies and chief executives of NHS 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. |

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| 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 NHS trust save costs on unconfirmed appointments and increase system efficiency. |
| Distance from financial plan | This metric measures the variance between the NHS trust's annual financial plan and its actual performance. NHS 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 NHS 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 NHS 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 NHS 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) | This metric shows the annual cost of the NHS trust's HR department for each £100 million of NHS trust turnover. A low value is preferable to a high value but |

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| cost per £100 million turnover | 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 NHS 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 NHS 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 NHS trust cost to produce one WAU across all areas of clinical activity. A lower than average figure is preferable as it suggests the NHS trust spends less per standardised unit of activity than other NHS trusts. This allows NHS 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 NHS 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 NHS trust cost to produce one WAU across all areas of clinical activity. A lower than average figure is preferable as it suggests the NHS trust spends less on staff per standardised unit of activity than other NHS trusts. This allows NHS trusts to investigate why their pay is higher or lower than national peers. |
| Peer group | Peer group is defined by the NHS 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 |

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| 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 NHS 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 NHS trusts (the performance element). A high score indicates that the procurement function of the NHS 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 NHS trusts, using a consistent approach. It helps NHS Improvement to determine the type and level of support that NHS 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 NHS 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 NHS 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 NHS 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 NHS trusts' % |

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| | achievement against these targets. NHS 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. |