Yeovil District Hospital NHS Foundation Trust

Use of Resources assessment report

Higher Kingston
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Date of publication:
8 May 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	**Requires improvement**
Are services safe?	**Requires improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Requires improvement**

Our overall quality rating combines our five trust-level quality ratings of safe, effective, caring, responsive and well-led. These ratings are based on what we found when we inspected, and other information available to us. You can find information about these ratings in our inspection report for this trust and in the related evidence appendix. (See www.cqc.org.uk/provider/RA4/reports)

Are resources used productively?	**Inadequate**

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 trust taking into account the quality of services as well as the trust's productivity and sustainability. This rating combines our

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

Use of Resources assessment and rating

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

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

Combined rating for Quality and Use of Resources

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

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

- At trust-wide level, we rated safe and well-led as Requires improvement, and effective, caring and responsive as Good.
- The trust was rated Inadequate for use of resources. Full details of the assessment can be found on the following pages.

However:

- the overall ratings for the trust’s acute location improved to good overall for all key questions.

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Date of site visit:
11 January 2019

Date of NHS publication:
8 May 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?	**Inadequate** ●

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 January 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?	Inadequate

We rated Use of Resources as inadequate because the trust is not making adequate use of its resources putting at risk its ability to provide efficient and sustainable care for patients.

The trust had the twelfth highest overall cost per Weighted Activity Unit (WAU) nationally and had a deteriorating deficit position representing 15.1% of its turnover, the fourteenth highest nationally and during our assessment, we did not find the trust had a compelling plan on how it was going to materially improve its financial position.

- The trust had a total cost per weighted activity unit (WAU) of £3,842 for 2017/18 which placed the trust in the top worst 10% nationally and above the peer median of similar size trusts. The trust had incurred deficits in three consecutive years despite delivering an average of 4% costs improvement and missed its control total in 2017/18 with a deficit of £21.3 million (excluding Sustainability & Transformation Fund) and was forecasting to miss it in 2018/19 with a forecast deficit of £22.2 million excluding Provider Sustainability Fund (15.1% of its turnover) after delivering a 3.8% cost improvement plan.
- The trust had a deteriorating underlying deficit of £25.7 million in 2018/19 from £23.6 million in 2017/18. A drivers of deficit analysis carried out in the summer 2018, had highlighted that 60% of the trust's deficit could be significantly reduced through internal measures or through collaboration with the Sustainability & Transformation Partnership (STP). However, at the time of the assessment, the trust could not articulate its plan to materially reduce the part of the deficit which is within its control or could be materially reduced through pro-active engagement with the STP.
- As a result of its ongoing deficit position, the trust was in receipt of cash revenue funding from the Department of Health & Social Care (£21.3 million in 2018/19).
- There were opportunities for the trust to improve on clinical productivity. The trust benchmarked in the worst national quartile for pre-procedure non-elective bed days and data showed a 9% productivity opportunity in theatres. The trust also had a lower than national and peer median proportion of day cases and despite evidence of good day case rate in urology and ophthalmology, the data was distorted by coding issues which are being addressed. Also, the trust did not articulate a clear plan on how it was working pro-actively and collaboratively with its STP to improve clinical and non-clinical productivity.
- During our assessment, the trust did not demonstrate it was reconsidering its business model to ensure services for which demand is insufficient are delivered on a sustainable basis. Options had been identified which the trust had not materially progressed on.
- The trust had engaged with the Getting It Right First Time (GIRFT) programme and provided examples where improvements in productivity had been made following GIRFT reviews.
- The trust had a total pay cost per WAU in the worst cost quartile nationally and above the peer median driven by a high cost per WAU for medical, corporate and non-substantive staffs. The trust also had a high agency staff cost per WAU and had been operating over its agency ceiling for two years. The trust had taken some actions to control these costs,

but further work was required to drive costs down in particular working with local trusts and learning from similar organisations nationally.

- The trust did not have Service Line Reporting, the reference costs it submitted for 2016/17 which form the basis of several metrics in the Model Hospital were inaccurate and, although it was developing patient level costing information ('PLICS') at the time of the assessment, the system was not yet fully operational. During our assessment, the trust did not demonstrate a systematic approach to using benchmarking or financial information to identify and deliver productivity improvements and savings.
- The issue with the 2016/17 reference cost data also meant that during our assessment we were unable to compare the trust's performance against prior year.

However, during our assessment we also found areas where the trust benchmarked well nationally:

- At the time of the assessment, the trust met the 4-hour accident and emergency (A&E), diagnostics 6-week wait and the cancer 62-days constitutional standards. The trust benchmarked well on did not attend rates (DNA) and delayed transfers of care (DTOC).
- The trust had achieved successes in overseas recruitment of nurses and was providing support in this area to other trusts in the south west of England. The trust also had a better than national median sickness rate.
- The trust benchmarked well on clinical support services with evidence of collaborative working with other local trusts and actions taken to address productivity opportunities in pathology, imaging and medicine management.
- The trust's procurement function was performing very well, being 11 out of 136 trusts on the procurement league table and it was expected that although non-pay cost per WAU was still high in 2017/18 savings would be reflected in next year's Model Hospital data.
- The Human Resources function benchmarked well against the national median providing a good service for a low cost.

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 did not benchmark well on a number of clinical services metrics. In some cases, the trust was taking actions and had achieved some improvements, such as in DTOC and DNA rates. However further work was required to reduce variation with peer and national medians, with regards to day cases and there were opportunities within theatres. The trust had engaged with the GIRFT programme and had started to make tangible improvements.

- At the time of the assessment, based on the most recently published data (November 2018), the trust was not meeting the constitutional operational performance standards around 18-weeks referral to treatment (RTT) wait (91.1%) although its performance compared favourably to the national and peer median. However, the trust was meeting all other constitutional standards: cancer 62-day wait (85.2%), 4-hour accident & emergency (A&E) (97.6%) and diagnostics 6-week wait (0.4%). The trust's performance against the RTT target had declined during 2018 mainly as a result of high referrals in some specialties (e.g. urology, upper and lower gastrointestinal tract) and skin cancers.
- Patients were more likely to require additional medical treatment for the same condition at this trust compared to other trusts. At 10.9%, emergency readmission rates were

above the national median of 9.1% and peer median of 9.4% and in the highest (worst) quartile nationally. The trust cited coding issues in ambulatory emergency care, open access and planned reviews as explanations for the high rate of readmissions.

- On pre-procedure elective bed days, at 0.05, the trust is performing better than the national median of 0.11 (June 2018) and benchmarked in the lowest (best) quartile nationally. However, on pre-procedure non-elective bed days, at 0.82 (June 2018), the trust is performing worse than the national median of 0.69 and peer median of 0.7. The trust stated this was due to using theatres at the weekend and bank holidays for orthopaedic and obstetric procedures and the trust was looking to address this issue under its theatre utilisation project.
- However, at the time of the assessment, the trust did not articulate a clear plan on how it was materially and pro-actively improving its clinical productivity (elective and non-elective) by working across the local health and care economy to co-ordinate services. Data collected by the consultancy firm Foureyes Insight Ltd (June 2018) also identified productivity opportunities of 9% in theatres. However, despite the trust having a theatre productivity plan in place, they cited the lack of volume as a reason for the full productivity being unachievable.
- The number of procedures undertaken by day case surgery was lower than both the peer and national medians for quarter 2 2018/19. The trust's day case rate during this period was 71.5% against a peer median of 78.4% and a national median of 77.4%. The trust provided evidence of good day case rates in urology and ophthalmology. However, the trust has also identified that coding issues distort the day case rate. Further work is required to resolve this issue to ensure its day case rate is accurate and can be compared at national and peer level to assess where improvements can be made. Furthermore, the conversion of patients from day case to inpatient stay for the same period was high at 8% against a peer median of 6% and a national median of 7.1%.
- The trust had reduced its DNA rate to 6.04% (June 2018) which is better than the national median of 7% and benchmarked in the lowest (best) quartile nationally. The trust explained the improvement was driven by the introduction of text messaging and online check-in kiosks.
- The trust reports a DTOC rate that is lower than national average with a six weekly average of 1.1% at the time of the assessment. The trust has achieved this low rate through initiatives such as Home First, and a weekly system wide stranded patients multi-disciplinary team meeting, which allows full engagement of social care colleagues.
- The trust has engaged with the GIRFT programme under the leadership of the trust's medical director and clinical leads. The trust could demonstrate improvements with orthopaedics (e.g. reduced length of stay, implementation of all-day lists) and ophthalmology (e.g. reduction of the follow up backlog through the optimisation of the cataract surgery patient pathway).
- During our assessment, the trust did not demonstrate it was actively reconsidering its business model to ensure services for which demand is insufficient are delivered on a sustainable basis. The trust commissioned an options appraisal which concluded in December 2017 to reconfigure some of its services. The review concluded that several options were possible but required further discussion with local providers who would be impacted by the change. This has however not significantly progressed. The trust has provided examples where services/waiting lists were transferred although the decision could have been made earlier therefore reducing costs sooner or their scope was too limited to make a significant impact.

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

The trust had an overall pay cost per WAU in the highest (worst) cost quartile nationally. The trust had demonstrated improvements and best practice in a number of areas including staff retention, job planning and with the recruitment of overseas nursing where it provided support to other trusts in the south west region. However, further work was required to reduce its medical cost per WAU and agency staff spend.

- In 2017/18, the trust had an overall pay cost per WAU of £2,396, compared with a national median of £2,180 and a peer median of £2,360, placing it in the highest (worst) cost quartile nationally. This meant that it spent more on staff per unit of activity than most trusts. This was mainly driven by high medical costs per WAU (£580) which benchmarked in the highest (worst) quartile and above the peer median (£532). The trust also had high costs per WAU for corporate, administrative staffs (£448 compared to a national median of £359) and non-substantive staffs (£427 compared to a national median of £274). The trust benchmarked in the second lowest (best) quartile and below peer median for both Allied Health Professionals (AHPs) and nursing costs per WAU.
- The trust attributed the high medical cost to the small rural nature of the trust which attracted experienced consultants with Clinical Excellence Awards (CEAs). Additionally, the trust explained that, in some specialties, it had to offer high levels - on average of 2 to 2.5 Supporting Professional Activities (non-patient focused activities, such as continuous professional development) to attract consultants to the trust and compete effectively with other nearby trusts.
- The trust had been successful in recruiting overseas (particularly in the Philippines & Dubai) and ten trusts across the south west region had commissioned the trust to recruit overseas nurses for them. The trust had recruited 60 nurses under the programme benefitting the trust and those in the south west. This had also allowed the trust to generate additional income and at the time of the assessment, the trust told us they had no nursing vacancies.
- In 2017/18, the trust's agency costs (£5.6 million) were slightly above the agency spend ceiling set by NHS Improvement (£5.5 million). At the time of the assessment, the trust was also forecasting to miss its agency spend ceiling for 2018/19 with a spend of £6.0 million compared to a ceiling of £5.6 million. The trust also spent comparatively more than other trusts in 2017/18 with agency staff cost per WAU (£160) benchmarking in the highest (worst) quartile nationally and above the national median (£107) and peer median (£129).
- The trust was forecasting to reduce its agency spend in 2018/19 compared to 2017/18 (£6.0 million compared to £6.6 million in 2017/18). However, the trust' spend on agency staff continued to be above the agency spend ceiling given by NHS Improvement and at 5.66% of pay costs in February 2019, was higher than the national median (4.94%). The high cost of agency staff was driven by the need to use high cost locums in a number of specialities due to the small nature and geographical location of the trust. Additionally, the trust had to use short term high cost nursing agency staff to fill the gaps in rotas while the newly recruited overseas nurses passed the registration requirements of the Nursing & Midwifery Council. There was also no collaborative bank with other local trusts as the trust believed staff would not travel to and from alternative trusts due to the geographical distances although the trust was in discussion with the STP and at the local Workforce Action Board to consider centralising bank staffing across Somerset. The authorisation to use high cost nursing agency staff was also delegated to matrons and not referred to executives for sign off. The trust had applied the NHSI guidance on agency avoidance during 2018 with the introduction of hot shifts with incentive rates. The trust also regularly

reviewed its high cost medical locums and had had some successes in transferring them to substantive contracts.

- The trust had improved its retention rate in the 12 months to July 2018 from 81.9% to 83.2% although the retention level was still below the national median of 85.8% and peer median of 85.5% and benchmarked in the lowest (worst) quartile nationally. The trust however explained that the rate was impacted by the transfer of staff to its new subsidiaries, Simply Serve Ltd, which had started to operate in February 2018.
- The trust had a good retention of overseas nursing staff as a result of steps taken to make them feel welcomed into the trust and to provide ongoing pastoral support. However, the trust had recognised that it found it difficult to retain other staff due to its size and the incentives the trust can offer compared to larger, more attractive local trusts.
- At 3.3% in June 2018, staff sickness rates were better than the national and peer median of 3.8%.
- The percentage of staff appraised in the prior 12 months was lower than the benchmark group average in the 2017 staff survey. However, the trust cited the change to electronic records during this period as the reason for the reduction.
- The trust had a 90% compliance of job plans and job planning was currently under-going an exercise to ensure that job plans were accurate, and SPAs were aligned to the trust's strategy and objectives.

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

The trust was using its clinical support services in an effective way to deliver a good service for its patients. Its pathology costs benchmarked as relatively expensive and the trust benchmarked well for imaging costs. The trust had relatively high medicines costs due to wholesaling activity and was working collaboratively across the STP in pharmacy and pathology.

- The trust's pathology services were part of a joint venture (South West Pathology Services (SPS)) with Taunton & Somerset NHS Foundation Trust formed in 2012. The trust had successfully leveraged the economies of scale and consolidation opportunities available from this service model. However, the trust acknowledged that it was running under capacity and could have further benefited from wider integration of services with other providers but this was currently not within the scope of the pathology network proposal from NHS Improvement.
- The trust's overall pathology cost per test (£1.94) benchmarked in the second highest (worst) quartile nationally, although its overall cost per capita (£30.74) and total tests per capita (14.6) were low and benchmarked in the lowest (best) quartile. SPS were, at the time of the assessment, reviewing the high cost per test and there were contract mechanisms in place with SPS to ensure turnaround time targets were met.
- The trust's imaging cost per test (£37.50) benchmarked well against other services and was in the lowest (best) quartile. However, some of the data on the Model Hospital which the trust had reported regarding the reporting backlog and the age of the estate was incorrect. The trust needs to ensure that the data reported to Model Hospital is updated and accurate. Revised figures which had been received from the trust showed that the backlog was at a low level and some of the equipment was coming to the end of its useful life. The trust was considering an equipment replacement plan with a managed equipment service proposed across the STP.

- The trust was now fully established for both radiology consultants and radiographers and the trust benchmarked unfavourably against other trusts in the volume of plain x-rays reported by Radiographers (2017/18). The trust was actively training radiographers to report plain X-rays and expected this metric to improve for 2018/19.
- The trust's medicines cost per WAU at £343 was relatively high compared to a national median of £320. This was due to the trust's wholesaling activity for Somerset Partnership NHS Trust. The trust was achieving above the target for the top ten medicines savings delivering 140% for 2017/18.
- The trust had done a considerable amount of work to reduce its medicines stockholding from 31 days in 2015/16 to 14 days in 2017/18 and to improve pharmacists on ward 7 day services with investment made during 2017/18. Further improvements in pharmacy were planned with an Electronic Prescribing and Medicines Administration (EPMA) system due to go live during 2019/20. The trust Chief Pharmacist has a joint role with Dorset County Hospital allowing the trust to tender jointly and collaborate for further efficiencies and is increasingly working collaboratively across the Somerset STP.
- The trust was using technology in several innovative ways to improve operational productivity across the organisation. The trust reported that it had started to use a number of alternatives to face to face hospital appointments including running a number of virtual clinics and would be piloting a system in 2019/20 to allow patients to self-manage their condition from home. The trust had implemented Trakcare that had enabled it to track all patient activity including stock and consumables allowing it to make more informed decisions.

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

The trust had a high non pay cost per WAU and slightly higher than median costs for its estates and facilities. The trust's procurement function performed highly, although the cost of its procurement service was higher than average.

- For 2017/18 the trust had an overall non-pay cost per WAU of £1,446 compared with a national median of £1,307 and peer median of £1,209, placing it in the highest (worst) cost quartile nationally.
- The trust's procurement service was run by a wholly owned subsidiary, Simply Serve Ltd that commenced in February 2018. Efficiencies from the transition had been made and the subsidiary was making a contribution to the trust's financial position but was yet to see these benefits reflected in the Model Hospital. The procurement function's processes were relatively efficient and tended to successfully drive down costs on the things it buys. This was reflected in the trust's procurement league table position of 11 out of 136 trusts. The performance on the percentage variance for the top 100 products at 3.5% variance from median price also suggested that the trust was getting the best prices from its procurement operations. The trust had a low supplies and services cost per WAU of £270 in placing it in the lowest (best) quartile nationally compared to the national median of £364. The procurement team worked collaboratively across the STP as part of the Peninsula Purchasing and Supply Alliance and work was underway to achieve level 2 of the procurement standards.
- For 2017/18, the cost of running its finance function was high at £0.971 million per £100 million turnover compared to the national median of £0.715 million per £100 million turnover and peer median of £0.746 million per £100 million. The cost included the cost of a high cost Programme Management Office service that had now been addressed via a restructure resulting in the reduction of agency costs previously incurred. The finance

function also had the additional requirement of accounting for three wholly owned subsidiaries.

- The cost of running the trust's Human Resources (HR) function benchmarked well against other trusts at £1.056 million per £100 million turnover compared to a national median of £1.094 million per £100 million turnover. The recruitment team had had success with overseas recruitment and now ran an efficient overseas recruitment service for other trusts. The trust ran a high quality HR service and benefited from reduced sickness and good staff survey results across the organisation. The trust was looking at collaborating further across the STP in its back office functions and was aiming to go live with shared payroll, mandatory training and occupational health systems during 2019/20.
- At £365 per square metre in 2017/18, the trust's estates and facilities costs benchmarked slightly above the national median (£325). The trust benchmarked slightly higher than the national median for hard facilities management costs (£86 per square metre against £80 per square metre) and for soft facilities management costs (£135 per square metre against £127 per square metre).
- The trust had an aging estate that required ongoing investment to keep the hospital running. The reported value of the trust's backlog maintenance was low at £136 per square metre compared to £182 nationally. The trust was conducting a review of the backlog and expected this to rise. The trust had a high critical infrastructure risk of £113 per square metre compared to the national median of £81. The trust described robust processes in place to mitigate against any risk arising from the backlog or the critical infrastructure risk.
- The trust benchmarked high for inpatient food at £4.63 a meal against the national median of £3.59 for 2017/18. The trust had changed suppliers from May 2018 and would see this cost reduce. The trust's cleaning costs for 2017/18 benchmarked high against other trusts at £41 per square metre against the national median of £39. The trust had invested in additional cleaning capacity to ensure it met high quality standards. As of February 2018 the trust's estates and facilities staff transferred into the subsidiary company and the trust expected the costs to reduce.

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

The trust had a total cost per WAU in the top worst 10% nationally and above peer median, had delivered deficits since 2015/16 and was planning to under-achieve its deficit position in 2018/19. The trust had planned to deliver significant savings in 2018/19. The trust had a significant underlying deficit, £10.1m of which could be addressed internally or within the STP although the trust lacked a clear view of the next steps to address this deficit. The trust relied on cash support from the Department of Health and Social Care (DHSC).

- In 2017/18, the trust had reported a £19.5 million deficit including Provider Sustainability Fund (PSF) (£21.3 million excluding PSF) against a control total and plan of £13.1 million deficit (£17.4 million excluding PSF). The deficit represented 13.6% of turnover (15.1% excluding PSF). The deterioration against plan which had not been fully communicated and reflected into the trust's forecast position until the year end, was driven by a number of issues including severance payments, and the trust's share of the deterioration of one of its subsidiary companies.
- For 2018/19, the trust had a control total and plan of £16.7 million deficit (including Sustainability & Transformation Fund (STF); £19.9 million deficit excluding STF). The deficit represented 11% of its turnover (13.3% excluding STF). As at December 2018, the trust was on plan but forecasted to miss its control total with a full year deficit of £20.2 million including STF (13.5% of turnover) (£22.2 million excluding STF or 15.1% of

turnover), £3.4 million worse than plan. At the time of the assessment, the trust told us that the year-end position was driven by the non-achievement of £0.75 million savings which had not been agreed with and delivered across the STP, lower than plan STF due to under-achievement of its control total and staff cost pressures.

- The trust had an underlying deficit estimated at £25.7 million in 2018/19, a deterioration on 2016/17 (£19.9 million) and 2017/18 (£23.6 million). During 2018/19, NHS Improvement carried out a drivers of deficit review across the Somerset STP. The analysis showed that although a large part of the trust's deficit was "structural" in nature (£7.7 million) and was outside of the trust's control, at least £10.1 million were "strategic" or "operational" which the trust could address by itself or within the STP. At the time of the assessment, the trust was unable to articulate the next steps to progress in reducing the size of its deficit including work with the STP.
- In 2017/18, the trust had delivered an £8.1 million cost improvement plan (CIP) (4.7% of expenditure) with £6.2 million delivered recurrently. In 2018/19, the trust had a £7.1 million CIP (4% of expenditure) and at the time of the assessment, it was forecasting to deliver slightly less with £6.8 million (3.8% of expenditure), £4.8 million delivered recurrently.
- The trust's total cost per WAU (£3,842) which was in the highest (worst) 10% of trusts nationally and above peer median (£3,496) would indicate that there were further opportunities to deliver savings, including some highlighted by the Model Hospital. During our assessment, the trust did not demonstrate a systematic use of available benchmarking information or engagement with similar trusts nationally to identify improvements and assess the value for money of its services.
- The trust did however commission the consulting firm PwC in November 2017 to review its CIP, identify opportunities and improve on key processes to derive efficiencies such as programme management office, cost control and cash flow forecasting.
- The trust had a number of commercial ventures, including three active subsidiaries. The trust expected to deliver a small surplus across the subsidiaries (£0.1 million) in 2018/19 although this masked expected deficits for two of them totalling £1 million. One of its subsidiaries (Symphony Health Services Ltd) was also trading with an underlying deficit position of £1.5 million. At the time of the assessment, the trust was unable to articulate a plan to recover the position for the two deficit making subsidiaries; was considering further investment to increase capacity although the region already has excess capacity; or clearly evidence the benefit, as loss making entities, to patient services or the trust's strategy.
- The trust relies on revenue support from the Department of Health & Social Care (DHSC) to keep sufficient cash reserves to meet its financial obligations and pay its staff and suppliers. The trust reforecasted its cash requirement upward mid-year and again at quarter 3. At the end of 2018/19, the trust anticipated to have accumulated £73 million of debt from the DHSC, an increase of £21.3 million on 2017/18. This was set to increase until the trust is able to reduce its deficit position. Since 2017/18, the trust had a balance sheet in a net liabilities position which meant it owed more than it owned.
- The trust was not making use of Service Line Reporting and the trust had experienced system issues in 2016/17 which meant its reference cost information used in the Model Hospital was inaccurate and could not be used for effective benchmarking. The trust was investing in developing a Patient Level Information Costing System (PLICS) with a view to pilot the system during 2019/20 and the trust reported good clinical engagement during the development phase.

Outstanding practice

During our assessment we identified several outstanding practice areas. Below are some of the key or most innovative ones:

- The trust had a very low rate of DTOC achieved through Home First initiative and weekly multi-disciplinary team meetings including social care to address the cases of stranded patients.
- The trust had been very successful at recruiting overseas nursing and had a low rate of turnover of these nurses. The trust provided support to another ten trusts across the south west of England in this area.
- The trust also had no nursing vacancies at the time of the assessment.
- The trust provides quality HR services at a low cost.
- The trust's procurement function is 11 out of 136 on the procurement league table.

Areas for improvement

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

- There are opportunities for the trust to improve on clinical productivity: pre-procedure non-elective bed days, proportion of day cases and with theatres.
- The trust should progress with delivering the improvement opportunities identified through the GIRFT programme.
- The trust medical cost per WAU is very high and the trust should consider (including learning from and working with other trusts) on how to make progress to reduce this cost.
- The trust should continue to progress in reducing its spend on agency staff.
- The trust should work with the SPS network to ensure there is a joint understanding of the drivers of the high cost per pathology test.
- The trust should explore further opportunities to consolidate back office functions with other nearby trusts.
- The trust should have a clear plan to address the operational part of its deficit and work pro-actively with the STP to progress at pace on addressing the common strategic issues.
- The trust should continue to progress with rapid implementation of PLICS and improve the range of financial information and benchmarking data shared within the trust to inform on service line performance and productivity opportunities.
- The trust should ensure there is a clear plan or clear narrative around subsidiaries so that benefits of the less profitable entities are well understood and justified.

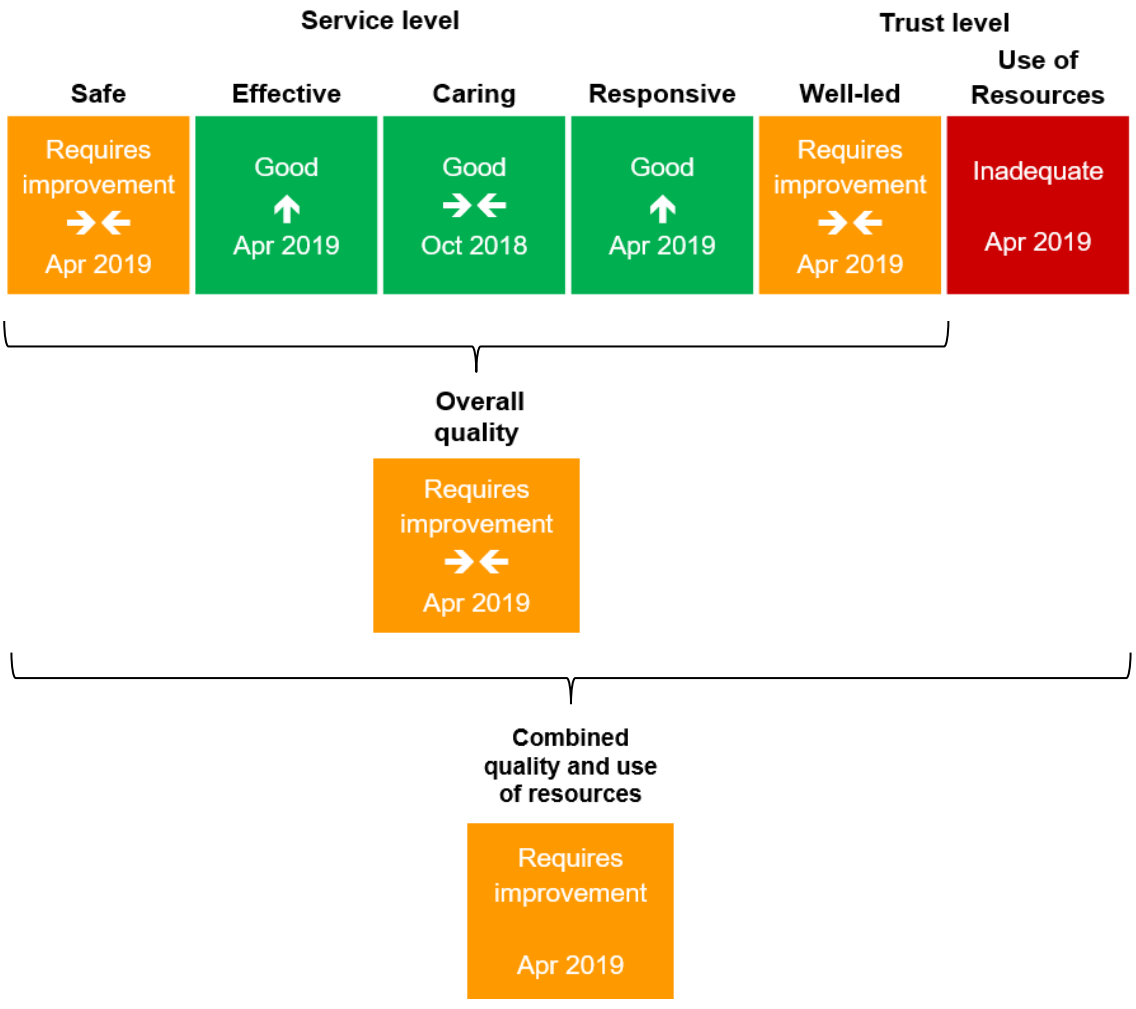
Ratings tables

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

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

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

Ratings for the whole trust



Use of Resources report glossary

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

Did not attend (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)	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.

cost per £100 million turnover	
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.