North Bristol NHS Trust

Use of Resources assessment report

Southmead Hospital
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Date of publication:
25 September 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	**Good**
Are services safe?	**Good**
Are services effective?	**Good**
Are services caring?	**Outstanding**
Are services responsive?	**Requires improvement**
Are services well-led?	**Outstanding**

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

Are resources used productively?	**Requires improvement**

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

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

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

Use of Resources assessment and rating

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

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

Combined rating for Quality and Use of Resources

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

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

- The trust was rated good overall and rated requires improvement for use of resources. Full details of the assessment can be found on the following pages.

NHS Improvement

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Date of site visit:
17 May 2019

Date of NHS publication:
25 September 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?	**Requires improvement**

How we carried out this assessment

The aim of Use of Resources assessments is to understand how effectively providers are using their resources to provide high quality, efficient and sustainable care for patients. The assessment team has, according to the published framework, examined the trust's performance against a set of initial metrics alongside local intelligence from NHS Improvement's day-to-day interactions with the trust, and the trust's own commentary of its performance. The team conducted a dedicated site visit to engage with key staff using agreed key lines of enquiry (KLOEs) and prompts in the areas of clinical services; people; clinical support services; corporate services, procurement, estates and facilities; and finance. All KLOEs, initial metrics and prompts can be found in the Use of Resources assessment framework.

We visited the trust on 19 June 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?	Requires improvement

We rated Use of Resources as requires improvement. During 2018/19, the trust implemented 'Perform', its quality improvement methodology and delivered improvements in clinical productivity. In particular, the trust had reduced bed occupancy allowing it to absorb some of the pressure of significant non-elective growth. However, and despite these improvements, at the time of the assessment, the trust continued to have a poor performance on the 4-hour accident and emergency target and was not meeting a further two constitutional standards. The trust traded with a significant underlying deficit which, despite being stable, had not materially improved over the last two years.

- During the year, the trust had implemented its 'Perform' quality improvement methodology, rolling it out in every ward within the trust with 1,500 staff trained by the end of 2018/19. Together with the work undertaken under 'Perform' the trust had introduced schemes and service improvements to support its accident and emergency (A&E) 4-hour performance and preparedness for winter pressures and improve theatre productivity.
- The trust also had a better than median readmission rate which was the result of work done with a local ambulance trust to focus on a cohort of frequently admitted patients. The trust was also engaged with the national Getting Right First Time (GIRFT) programme with evidence that it had secured some improvements through this programme.
- The trust had a relatively low overall pay cost per weighted activity unit (WAU), benchmarking in the second best quartile nationally. The trust had developed innovative staffing models and used e-rostering and job planning to efficiently deploy its staff and had the seventh lowest agency staff cost per WAU nationally in 2017/18. The trust also had implemented a range of initiatives to support and retain staff.
- The trust's pharmacy services performed well with a low medicines cost per WAU, good clinical engagement resulting in reduced costs, wastage and switches to biosimilars drugs and a better than national average level of 7-day service on ward and use of innovative workforce model to deliver its service.
- The trust was part of a procurement consortium which the trust hosted and which was an exemplar of how efficiencies can be delivered from a collaborative arrangement in management and with economies of scale. The trust was ranked 23rd out of 133 on the latest procurement league table.
- The trust had consolidated several corporate services with local trusts. It ran a comparatively efficient finance function and had reduced the cost of delivering its human resources function since 2016/17. The trust operated from a recently built private finance initiative funded building. The trust had successfully leveraged the advantages of the building resulting in benefits in a reduced incidence of C.difficile cases, reduced length of stay, increased day case work. Consequently, the trust had less need to close wards because of infections during the winter. This also meant the trust had a lower maintenance backlog and critical infrastructure risks.

- The trust had over-achieved its control totals in 2017/18 and 2018/19 and its financial plan for 2019/20 anticipated to improve on its financial position in 2018/19. The trust had implemented service line reporting and had started to actively use it in particular to support its budget setting and to inform decision relating to services.

However, we also found that:

- At the time of the assessment, and despite the actions and improvements made by the trust on clinical productivity, the trust's performance against the A&E standard remained poor with the trust performing below the national and peer medians. The trust also did not meet the 18-week referral to treatment (RTT) and diagnostic 6-week wait standards.
- The trust's rate of delayed discharges and did not attend (DNA) rates were significantly above the national median.
- Despite the range of initiatives developed by the trust to retain staff, its retention rate for the year to December 2018, benchmarked in the lowest (worst) quartile nationally.
- On pathology, the trust benchmarked higher than the national median on cost per pathology test and although some of this was driven by the level of specialty work carried out by the trust, the trust could seek further productivity opportunities to reduce the cost of microbiology tests. The pathology network the trust was part of was less progressed than others across England. The trust was the second largest provider of interventional radiology nationally and this impacted its imaging cost per test which was comparatively high.
- Although the trust had leveraged its PFI building to improve its services, it had the 10th worst estates and facilities cost per square meter nationally and held £399 million debt on its balance sheet. The debt created an annual cost for the trust which was £34.3 million in 2018/19 and was contributing to the trust's underlying financial deficit.
- Despite the trust reporting a financial position better than its control total in 2017/18 and 2018/19 and planning to deliver an improved financial position for 2019/20, it had traded with a significant underlying deficit. This had stabilised over the last two years but is not expected to materially improve during 2019/20. The trust's delivery of cost improvement plans also showed room for improvements due to the trust's use of non-recurrent measures.

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 was not meeting three of the four constitutional standards. The trust met the cancer 62-day wait standard. The trust had a high rate of delayed transfers of care, did not attend rates although it benchmarked better or around the national median for pre-procedure bed days and readmission rates. The trust had rolled out in all wards its quality improvement methodology 'Perform' during 2018/19 which had allowed it to decrease its bed occupancy and absorb some of the non-elective growth. However, despite this, the trust's 4-hour accident and emergency performance remained poor.

- As at April 2019 (latest data available at the time of the assessment), the trust did not meet the 4-hour accident and emergency (A&E), diagnostic 6-week wait and 18-week referral to treatment (RTT) standards. The trust met the cancer-62 day wait standards although its past performance had been variable before this date.
- During 2018/19, the trust had not met the A&E standard and performed substantially below peers and the national median in seven out of the twelve months of that year. At April 2019, the trust's performance was 69.7%.

- Poor A&E performance was primarily driven by flow through the emergency department (ED) and long lengths of stay (LoS), as well as growth in attendances and admissions. The trust had absorbed 8.1% growth in non-elective activity, improving bed occupancy from 99.93% on average in 2017/18 to 95.11% in 2018/19 through its 'Perform' quality improvement methodology, along with speciality-led LoS improvement schemes such as Enhanced Supported Discharge for stroke patients. The trust had also installed touch screens in every ward showing real-time bed state and availability.
- The trust had also increased Same Day Emergency Care (SDEC) by 4% as a proportion of non-elective care in 2018/19 through the expansion of Ambulatory Emergency Care and the Surgical Assessment Unit and the Same Day Admissions Unit relocation. The trust had focused on frail patients, with increased medical staffing at the front door. This had resulted in a reduction in LoS for people aged over 85 in medical beds.
- In October 2018, the local health system had launched a Virtual Integrated Care Bureau and a Single Referral Form, which had streamlined the discharge process and contributed to a material reduction in long LoS by December 2018. The system also held a 'Diamond' escalation meeting three times a week led by Heads of Nursing which focused on stranded patients.
- The trust's 2018/19 winter plan had been informed by lessons learnt from the previous winter. Wards were allocated to medicine over the peak periods, which helped to significantly reduce outliers and improve overall LoS through more effective deployment of staff. The trust had maximised its capacity in quarter 3 and theatre productivity improvements had led to increased cases per day, list uptake and in-session utilisation.
- The trust had also introduced several innovative services as a way of managing increased demand for beds. Examples included Hospital at Home; extended use of hot clinic models in some specialties and 90% of emergency test results received within 60 minutes.
- However, despite these initiatives, at the time of the assessment, the trust's A&E performance did not demonstrate a consistent improvement.
- At the time of the assessment, the trust was meeting the cancer 62-day wait standard with a performance of 86% (March 2019) and had consistently performed above the national median since November 2018. However, the trust had only met the standard twice in the previous eight months although it planned to achieve it from September 2019. The trust had experienced issues within urology, due to workforce capacity issues and demand growth, and the impact of being a tertiary centre.
- Per the most recent available data at the time of the assessment (April 2019), the trust's RTT performance was 85.18% (92% standard) and it had 19 patients waiting longer than 52 weeks. However, at the time the trust was carrying out a data validation exercise for referrals prior to 26 February 2019, as electronic referrals from the national eRS system were not going onto the Lorenzo patient administration system with the correct clock start date if they had been on an appointment slot issue list or referred via the eRS referral assessment service. After 26 February 2019, a national fix had been applied to the Lorenzo system.. Scheduling was an issue and the trust was looking at artificial intelligence for smart scheduling to produce a theatre list with 100% utilisation. The trust had significantly reduced the number of patients waiting more than 52 weeks for treatment to 19 in April 2019.
- The trust had a Delayed Transfers of Care (DToC) rate of 7.07% (May 2019) compared to a national standard of 3.5% maximum. The main driver for the high percentage is the lack of availability of packages of care and reablement, delays are linked to slow flow through community facilities. Themes collated from stranded patient reviews indicated gaps in provision for stroke rehabilitation, younger people with complex care needs,

bariatric patients and people who require deep cleaning or decluttering to be able to return home.

- The trust's readmission rate of 5.38% benchmarked in the lowest (best) quartile compared to a national median of 7.5% (quarter 3, 2018/19). The trust had focused, in partnership with a local ambulance trust, on more than 100 people who were frequent attenders, 10% of whom, at the time of the assessment, had care plans to prevent admission.
- The trust had focused on improving daily discharge volumes and timing although the trust continued to experience challenges around long length of stay patients, with high volumes of patients staying within the trust. This indicated a lack of clinical risk sharing across the system to support the organisation reducing these volumes. The trust used a hot clinic model in certain specialties which enabled them to bring patients back to the hot clinic on the next day. They were looking to allow GPs to refer directly to the hot clinics in the future.
- Fewer people were coming into the hospital unnecessarily prior to elective treatment compared to most other hospitals by spend. The trust's pre-procedure elective bed days at 0.10 days benchmarked well against the national median of 0.12 days at quarter 4, 2018/19. And for non-elective, the trust at 0.69 days was broadly in line with the national median of 0.66 days. The trust saw patients from a geographically dispersed area, in relation to its tertiary services, which sometimes means bringing them in earlier than would otherwise be the case, in particular for renal patients who require pre-operative dialysis. The trust was exploring patient hotel models to further reduce the time patients were spending in hospital before elective procedures.
- The trust's did not attend (DNA) rate was 7.62% (quarter 4, 2018/19) which was higher than the national median of 6.96%. The trust had focused on improving patient communications using, for instance text reminders and proactively contacting patients to ensure attendance. Pilot projects to offer Skype appointments had dramatically reduced DNAs in the pilot areas.
- The trust's performance against the diagnostic 6-week wait standard was 4.27% at April 2019 (1% standard). Performance was most challenged in endoscopy and urology. The trust had seen a growth in referrals for endoscopy and cancer 2-week wait patients. At the time of the assessment, teams were working six (rather than five) days, with ad hoc seventh day working. The trust had a recovery plan in place and plans were being developed to increase capacity and work with commissioners to better manage demand and capacity across the health system. The trust was, however, not expecting to recover its performance until after March 2020.
- The trust was actively engaged with the Getting It Right First Time (GIRFT) programme and had appointed the Deputy Medical Director as the GIRFT lead. Examples of implementation included a new surgical care 'bundle', reducing surgical site infections by 50%. Six of the nine GIRFT recommendations in urology were already completed or are actively progressing at the time of the assessment. The trust had good clinical engagement, including with Clinical Directors, and were keen to develop a quality approach to clinical improvement.

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

The trust had a relatively low overall pay cost per WAU, benchmarking in the second lowest quartile nationally. The trust had developed innovative staffing models and was using e-rostering and job-planning to plan and deploy staff efficiently. Although the trust benchmarked

less well on retention and sickness, it had measures in place to continue to improve in these areas.

- For 2017/18, the trust had an overall pay cost per WAU of £2,131 compared with a national median of £2,180, placing it in the second best cost quartile nationally. This means that it spent less on staff per unit of activity than most trusts. The trust is in the lower (best) quartile for allied health professionals (AHP) and nursing cost per WAU (respectively £115 and £659), although it benchmarked in the second highest (worst) quartile for medical cost per WAU (£539).
- The trust is using an acuity-based approach to rostering and applied a SAFE care model twice a day to review acuity and deploy staff. The trust was making effective use of e-rostering, through 'Allocate', with 80% of nursing staff, including bank staff, being rostered and paid electronically with rosters available on average 6 weeks in advance. The trust was using a two-step approval process for nursing and midwifery rotas, where the supervisory ward sister was the first level of approval and the clinical matron the final level of approval.
- Future improvements plans were in place during 2019/20 to introduce electronic job planning and e-rostering for medical staff. There was an established annual review of job plans, with 95% of job plans being completed at the time of the assessment. The job planning cycle was clinically led by specialties with final job plans being reviewed at a divisional level. At the time of the assessment, team job planning was in its infancy with respiratory and trauma & orthopaedics about to start the process.
- The trust's sickness rate (4.36% at end of November 2018) was in line with the national median of 4.35%. The trust continued to strengthen its return to work interview and occupation well-being campaigns, although these had not yet had an impact on staff sickness levels. The trust had improved its staff health and well-being programme in 2018/19 focussing on the main reasons for sickness absences.
- The trust had spent less than its agency spend ceiling set by NHS Improvement in 2017/18 and in 2018/19 when the trust spent £11 million compared to a ceiling of £14.5 million. Despite the increase in spend in 2018/19 compared to 2017/18 when the trust spent £6.3 million on agency costs, the trust's spend on agency staff was 3.08% of its total staff spend compared to a national median of 5.01%, placing the trust in the lowest (best) quartile nationally.
- The trust had achieved significant reduction in agency spend up to 2017/18 using a collaborative staff bank and working collaboratively with a system neutral vending agency to reduce the usage of Tier 4 (high cost) agencies which had continued to operate in 2018/19. The trust had introduced a 'passport' for all staff, including bank staff, with two other acute providers. The trust was also looking at ways to increase the frequency at which bank staff were paid and have recently introduced an additional payment point of substantive staff working bank. The trust had however continued to experience pressures in the intensive support unit and with some consultant posts where the trust resorted to agency staff. At the time of the assessment, the trust, however, had a clear recruitment plan and had revised its bank staff rates to make it more attractive.
- Staff retention at the trust showed room for improvement, with a retention rate of 83.1% in the year to November 2018, placing the trust in the lowest (worst) quartile nationally. The trust had established a trust-wide retention steering group in 2018/19, focussing on supporting new members of staff, particularly in their first twelve months, through pilots schemes such as 'shifty buddy' offering support to nursing staff during their shifts and 'stay conversations' to understand why options could be available to encourage staff to stay working for the trust. The trust had consequently seen a reduction in the number of staffs leaving voluntary and with less than one year of service compared to 2017/18. The

trust also had a wider retention campaigns, such as 'joy at work', 'stones in their shoes' and 'itchy feet' where staff can telephone a help line and discuss career options. The trust was also developing flexible working and individual career route maps to help with retention. The trust had also run free breakfasts with staff during the winter and at Easter to reward staff during difficult periods. A further example of best practice was the new exit interview, which was a 16-point questionnaire, that provided instant feedback.

- The trust had a newly developed programme to support overseas nurses and build a community by living together through supporting a housing contract.
- As the national picture for workforce remained challenging, the trust had developed innovative roles and workforce models. Examples included blended workforce with an occupational therapist as a ward manager in a spilt role with a registered nurse for a rehabilitation therapy ward. In addition to this example, the trust had also introduced ward-based therapists at band 3 and 5, along with nursing associates who had an option to progress onto becoming trained nurses. The trust also had plans to implement advanced care practitioner and surgical care practitioner roles.
- The medical workforce presented challenges for the trust. The trust had supported clinical fellows, who were a vulnerable group, with their exams and focused on the well-being of junior medical staff with the establishment of junior well-being lead for junior doctors. The trust also had a physician associates training programme with a local university. At the time of the assessment, the trust was working further on its medical workforce strategy to include all medical associate professional roles.

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

The trust's costs on clinical support services did not benchmark well against other trusts for imaging and pathology. The trust's pharmacy services in contrast benchmarked well nationally which meant the trust was spending less on this service than other trusts and demonstrated several examples of outstanding practice particularly in the use of digital tools and pharmacy services to support patient care and efficient service delivery.

- The overall cost per test for pathology for 2017/18 was considerably higher than the national median at £4.46 against a national median of £1.86 being in the highest (worst) quartile and against a peer median of £2.49. Flowing from this the trust benchmarked high for overall cost per capita (£96.72 against a national median of £40.27 and a peer median of £52.02) but benchmarked well for total tests per capita (21.7 against a national median of 22.5).
- The trust hosted the regional cellular pathology service for three acute providers and hosts other more resource heavy pathology services which gave rise to higher costs per test and costs per capita. The cost per test for microbiology for 2017/18 was £9.96 compared to the peer median of £3.62 and national median of £4.36. The trust did not carry out any low cost virology testing and hosted the regional Antimicrobial Reference Laboratory Service which would give rise to higher costs per tests but we would not have expected it to be as high as it was and there may have been further productivity opportunities including automation in this area.
- A national priority for pathology as per the NHS Long Term Plan and further NHS operational guidance for 2019/20, was the establishment of regional networks to improve efficiency as well as quality and resilience in pathology services. At the time of the assessment, the proposed pathology network the trust was part of had agreed a £340 million managed equipment service (MES) contract over 15 years starting in 2021 that was expected to deliver up to 9% efficiencies for all trusts in the network. This was a

significant step in delivering the pathology network. At the time of the assessment, centralisation of services across Bristol for histopathology, microbiology and genetics had already been implemented. Progress by the West of England Pathology Network of which the trust formed a part of pathology transformation more widely was, however, less progressed than others across England and this needed to be a priority for the trust and its partners in the network. A strategic outline business case was planned to be delivered to NHSI in August 2019.

- The trust's imaging cost per test (£69.04) benchmarked high against other trusts and was in the highest (worst) quartile for 2017/18. The trust was the second largest provider of interventional radiology service across the country and had included the cost of providing portering services in the cost per test that are usually excluded from the comparators. The trust also had the second largest thrombectomy service in the country that is associated with high cost devices.
- In an area that was struggling for staffing nationally, the trust had managed to reduce its reliance on bank and agency to 2.7% of its total staffing spend in its imaging service which was in the lowest (best) quartile for 2017/18. The trust had successfully managed to grow its own radiographers and had a partnership with the local university.
- The trust's medicines cost per WAU at £281 benchmarked well against the national median of £309 for 2017/18 (second lowest (best) quartile). The trust's pharmacy department regularly shared reports on drugs expenditure to clinical divisions and this had helped to reduce costs and wastage overall. The trust was also engaged with the STP's medicines workstream which had progressed opportunities for collaborative procurement and home care. The trust engaged well with clinicians and this was reflected in the trust's adoption of biosimilars with the trust performing at 142% delivery of the top ten medicines target for 2017/18 and delivering a further £1.87m in 2018/19.
- The trust's metrics on Model Hospital for pharmacy time on clinical activity for 2017/18 was high at 78% compared to the national median of 76%. The pharmacy team had used their workforce skill mix to its advantage and had further developed the pharmacy technicians post to free up pharmacists' time to prescribe. The trust had also introduced a joint pharmacist post with its commissioners that was improving patient care through joint working and was also helping to retain staff. The trust had also worked hard to implement 7-day services on its wards with above national benchmarks for Sunday on-ward clinical pharmacy.
- The trust's performance on electronic prescribing was limited and Electronic Prescribing and Medicines Administration (EPMA) implementation was seen as a priority. The trust had submitted a business case for EPMA to NHS Improvement.
- The trust was using technology in several innovative ways to improve access, reduce demand and improve flow through the hospital. The trust had implemented a real time live bed management system and implemented Hospital at Home – a remote monitoring and telecoms service to patients. The trust had also successfully reduced paper throughout the hospital to 10% of what it was previously.

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 non-pay cost per WAU above the national median and performed well on the procurement league table while running as part of a successful procurement consortium. The trust benchmarked well for corporate services costs and benchmarked high for estates and facilities cost per square metre due to its large Private Finance Initiative (PFI) contract.

- For 2017/18 the trust had an overall non-pay cost per WAU of £1,355 slightly above the national median of £1,307 and in the second highest (worst) quartile.
- The trust's supplies and services costs per WAU was £476 (second highest (worst) quartile) significantly higher than the national median of £364 and slightly higher than the peer median of £446. However, the higher cost per WAU would be expected from a trust delivering a higher proportion of specialised activity than the national median and its peers.
- The trust was part of a procurement consortium with two local NHS trusts that had been in place for the past 17 years and which the trust hosted. This had allowed the trusts involved to leverage scale in their procurement and reach a more efficient management of procurement.
- At quarter 3, 2018/19, the trust ranked 23 out of 136 trusts in the procurement league table published by NHS Improvement to assess the relative performance of non-specialist NHS acute providers' procurement departments which meant the trust was performing relatively well in this area. The trust had a relatively low cost at £0.129 million per £100 million turnover compared to the national median of £0.206 million per £100 million turnover. The collaborative function is an exemplar in how efficiencies can be achieved from a collaborative arrangement in management and with economies of scale. The consortium engaged well with wider system to further support efficiencies across the NHS.
- The purchase price index and benchmarking tool (PPIB) data for 2017/18 indicated a good the performed well against national and peer medians on the percentage variance from median price (1.54%) and percentage variance from minimum price (10.7%) against both national (2.2% and 10.6% respectively) and peer medians (2.1% and 11.6% respectively).
- The trust had collaborated with other trusts to run a joint occupational health, internal audit and fraud service and was working on bank and payroll services.
- For 2017/18, the cost of running the trust's finance function was low at £0.461 million per £100 million turnover compared to the national median of £0.715 million per £100 million turnover. The trust had managed to reduce its transactional costs of finance (accounts payable down from £0.111 million per £100 million turnover to £0.039 million per £100 million turnover) while investing in its business partnering team.
- The cost of running the trust's Human Resources (HR) function benchmarked high against other trusts at £1.196 million per £100 million turnover compared to a national median of £1.093 million per £100 million turnover. The cost of the overall HR function had reduced since 2016/17 from £1.625 million per £100 million turnover with the trust investing in digitisation as part of its new people strategy. Education costs were a significant outlier (£0.591 million per £100 million turnover compared to a national median of £0.290 million per £100 million turnover), this was predominantly because the trust included the cost associated with the apprenticeship levy within its data return (in accordance with national guidance) although this had not been consistently included by other trusts nationally, therefore distorting the national median. The trust had reduced education costs since 2016/17 and was in further discussions with a local NHS trust with regards to a joint education hub to enable further efficiencies.
- The trust had improved its time to hire clinical and non-clinical staff which stood at 43 days in 2017/18, in the lowest (best) quartile nationally. The trust also had a proportionally low number of employee relations cases and a better than national median time taken to close cases of 12 weeks. The trust had invested time and resource in training and supporting line managers to deal with these types of cases.

- The cost of the information management and technology function at the trust benchmarked well against other trusts although the trust had invested heavily in this area in 2017/18 (£2.202 million per £100 million turnover compared to a national median of £2.474 million per £100 million turnover). The trust had a refreshed digital strategy that is underpinned with good clinical engagement.
- At £562 per square metre in 2017/18, the trust's estates and facilities costs benchmarked in the highest (worst) quartile above the national median (£342). The trust benchmarked slightly higher than the national median for hard facilities management costs (£89 per square metre against £97 per square metre) and for soft facilities management costs (£139 per square metre against £112 per square metre).
- The trust had a large PFI which it moved into in 2014. It had many single site rooms that added to the costs, however, the building had been built to be operationally efficient and while these efficiencies were not being achieved in the first few years of the move the trust was now benefitting from these operational efficiencies. The trust had seen reductions in C.difficile, length of stay and seen improvements in day case rates with most work now consolidated all on to the Southmead PFI site. The new building allowed the trust to isolate patients reducing the need for ward closures for infection concerns in the winter. As expected with a modern building, the trust had relatively low critical infrastructure risk (£33 per square meter) and low backlog maintenance (£37 per square meter) compared to the national medians.
- At the end of 2017/18 the trust's cleaning costs were relatively high at £55 per square meter compared to the national median of £43 per square meter with the high number of individual rooms providing an added complication. The trust is reviewing its cleaning methodologies to see whether it can be made more productive and this should be done as a priority.

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

Since the trust entered special measure for financial reasons in 2016/17, it had made significant progress to reduce its deficit, exiting special measures the following year in 2017/18. The trust had overachieved its control total in both 2017/18 and 2018/19. However, the trust was still in a deficit position and relied on cash revenue support from the Department of Health and Social Care (DHSC) to meet its financial obligations. The trust continued to have a significant underlying deficit which was not improving, and the trust had accumulated a significant debt of £588.6 million due to its Private Financing Initiative (PFI) building and accumulated debt with the DHSC.

- In 2018/19, the trust had delivered a deficit of £34.4 million (excluding Provider Sustainability Funding (PSF); £11.2 million deficit including PSF) which represented 5.9% of turnover and was £0.2 million better than its control total set by NHS Improvement. This was however £2.4 million worse than prior year where the trust overachieved its control total with a deficit of £32.0 million. Although the trust achieved its control total in 2018/19, this was supported by non-recurrent measures.
- For 2019/20, the trust had a plan to deliver £29.9 million deficit (excluding central funding; £4.9 million deficit including central funding) representing 4.9% of turnover. The plan was however supported by a £29.5 million cost improvement plan (CIP).
- In 2018/19, the trust had delivered £29.8 million CIPs (4.6% of expenditure). However, the trust was off plan by quarter 2 in 2018/19 and despite the identification of additional

schemes, the trust materially under-delivered its plan resulting in £18.8 million cost improvement delivered recurrently, the lowest level in the previous three years.

- For 2019/20, the trust had a plan to deliver £29.5 million CIPs (4.7% of expenditure) with a target of £25 million delivered recurrently. The trust was managing schemes against an in-year and a full-year target to control the impact of under-delivery and deliver its current year control total and improve its underlying financial position. As at May 2019, the trust reported it had achieved £1.4 million recurrent CIPs, 47% of its recurrent CIP for the first two months of the year. Information provided by the trust during the assessment, showed that the trust had material gaps and risks to its recurrent target of £25 million. 16% of the schemes expected to start implementation by end of June 2018/19 were high risk or not developed and the full year value of the recurrent CIP was estimated at £20.1 million with a lower risk assessed value.
- The trust had an underlying deficit of £48.8 million (8.1% of turnover) for 2018/19 which had stabilised on 2017/18 (£48.6 million). Despite the trust's target to deliver £25 million recurrent CIPs in 2019/20, the trust forecast its underlying deficit to only slightly reduce to £47.4 million (7.4% of turnover). At the time of the assessment the trust was finalising a drivers of deficit analysis and provided the assessment team with an early draft. This argued that the trust's two key drivers were the trust's PFI building and commissioner income under-recovery with £9.8 million identified as further operational productivity opportunities. The analysis carried out internally needed to be completed and externally challenged to ensure it provided a robust picture of the trust's drivers of deficit. The trust had plans to develop a financial recovery plan building on this analysis and its transformation strategy. The trust also needed to ensure their recovery was in the context of the Sustainability & Transformation Plan (STP) strategy.
- The trust had a Project Management Office as well as quality improvement teams to support the identification, support and delivery of efficiency schemes. The trust was however looking in 2019/20 to review how it organised this functions to ensure it had the optimum structure to deliver its financial recovery plan and its efficiency schemes.
- The trust had a capital services rating of 4 (worst) for 2018/19. The trust had accumulated £588.6 million debt as at the end of 2018/19, mainly due to the trust's PFI but also because of the accumulated debt with the Department of Health and Social Care from prior year deficits (£111 million). As a result, the trust had spent £39.5 million in finance costs in 2018/19 with a similar level expected in 2019/20, most (£34.3 million) to finance the trust's PFI (although the trust received £4 million of annual PFI support from its commissioners). The trust explained that its level of debt impacted the options available to fund future significant capital schemes, such as its plan to redevelop its women's and children's facilities.
- The trust had liquidity days rating of 4 (worse) for 2018/19 and the trust relied on DHSC's revenue cash support to meet its financial obligations and pay its staff. The trust expected to require further cash support during 2019/20 although to a lesser extent, provided it delivered its plan.
- During 2018/19, the trust had developed its service line reporting (SLR) alongside the model hospital data to identify opportunities for improvement and as part of the business case process. In particular, SLR data had been used in setting the trust's budget for 2019/20. The trust gave the example of neurosurgery where SLR and model hospital data indicated a loss-making service with potential for productivity improvement and where the trust was using the SLR data to further understand the drivers of this position. The trust however acknowledged that it needed to refine SLR data quality.
- The trust had identified in its drivers of deficit potential for income improvement in particular from contract disagreements. In particular, the trust estimated it could derive

an additional £2 million income from private patients. The trust was also reviewing with the STP opportunities to repatriate activity from the independent sector.

- The trust had spent £1.7 million on consultancy fees during 2018/19. The trust commissioned an external firm for £1.2 million to support the development and roll out of its Perform quality improvement programme. The trust had carried a post implementation review and had estimated that the return on investment was 1.74.

Outstanding practice

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

- The trust had worked with an external firm to introduce the 'Perform' quality improvement methodology within the trust with each ward having a dedicated coach and monitoring the benefits of the approach. There were tangible examples of improvements in particular the trust had reduced its bed occupancy.

- The trust's PFI building has a set of Medirooms attached to theatres which could be used flexibly and allowed the trust to protect its elective activity over winter and enable the trust to operate emergency surgical service independent of the bed base.

Areas for improvement

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

- The trust had a poor performance against the 4-hour A&E standard and must continue to progress at pace to improve its performance.

- At the time of the assessment, the trust was finalising an analysis to understand the drivers of its deficit. The trust must ensure that the analysis, carried internally, is externally challenged to ensure it is robust.

- The trust must progress at pace with developing its financial recovery plan to improve materially its underlying deficit position, working with its health system partners where necessary and within the context of the STP strategy.

- The trust must progress at pace with the identification, planning and implementation of its cost improvement plan to ensure that it is able to deliver its CIP target for 2019/20.

- The trust has a high level of delayed transfers of care. The trust should continue to focus on reducing the delays included through continued work with the local health and social system.
- The trust did not meet the 6-week diagnostic wait standard at the time of the assessment and had a recovery plan in place. The trust should ensure that it delivers its recovery plan at pace and work across the health system to improve its performance.
- The trust has rolled out its 'Perform' quality improvement methodology across the trust. However, the trust should consider how to maintain the focus and ensure the methodology is consistently embedded across the trust to derive the anticipated benefits.
- The trust should continue to engage in the West of England Pathology Network to support progress on a strategic outline case for Pathology transformation across this geography as early as practicable.
- The trust should continue to explore productivity opportunities, including automation, with a view to reduce the cost per test for microbiology which was significantly higher than the national median.
- Considering its significant debt position, the trust should continue to explore, including with local partners, options for the funding and provision of necessary and significant capital expenditure.

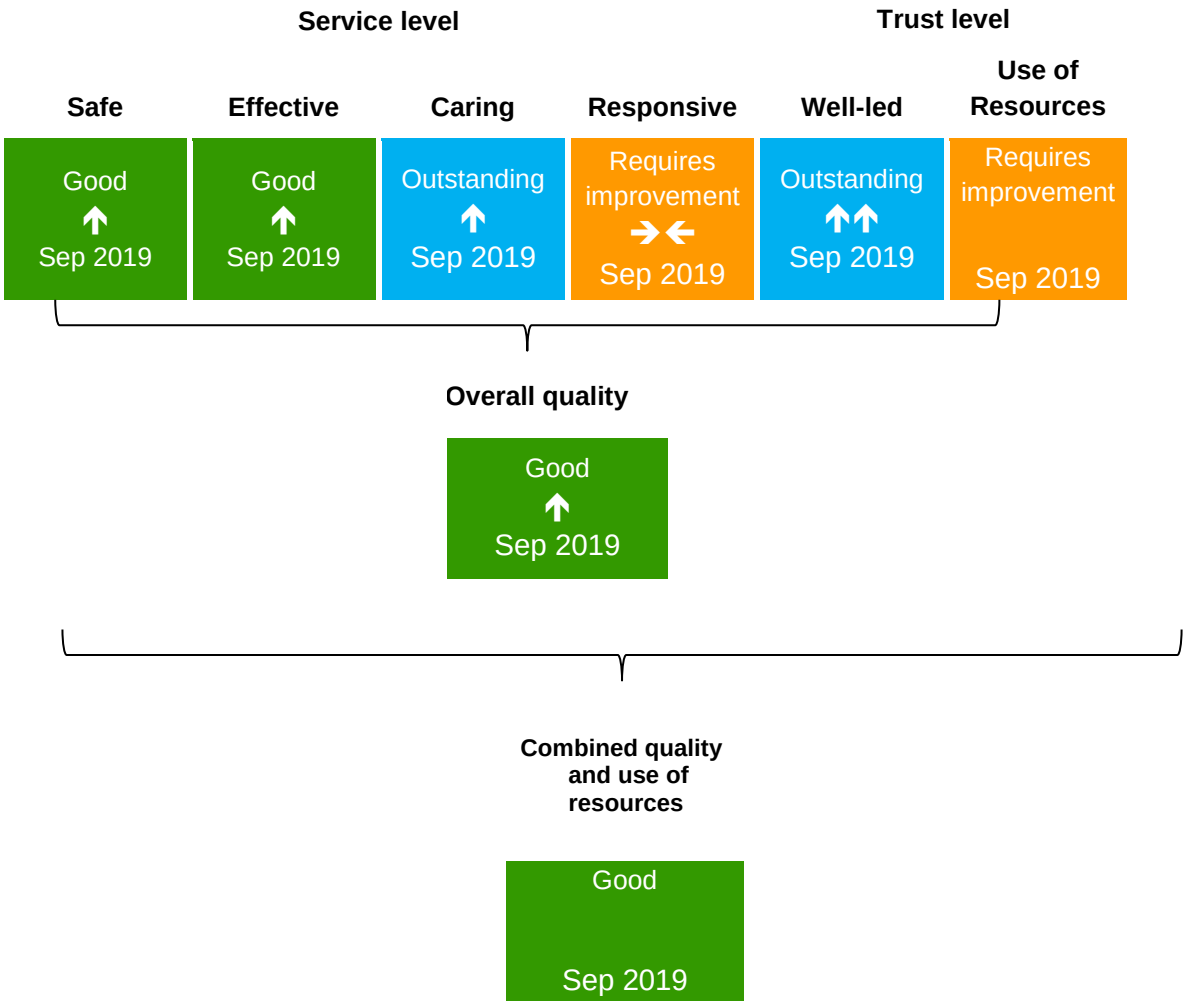
Ratings tables

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) cost per £100 million turnover	This metric shows the annual cost of the trust's HR department for each £100 million of trust turnover. A low value is preferable to a high value but the quality and efficiency of the department's services should also be considered.
Income and expenditure (I&E) margin	This metric measures the degree to which an organisation is operating at a surplus or deficit. Operating at a sustained deficit indicates that a provider may not be financially viable or sustainable.
Key line of enquiry (KLOE)	KLOEs are high-level questions around which the Use of Resources assessment framework is based and the lens through which trust performance on Use of Resources should be seen.
Liquidity (days)	This metric measures the days of operating costs held in cash or cash equivalent forms. This reflects the provider's ability to pay staff and suppliers in the immediate term. Providers should maintain a positive number of days of liquidity.
Model Hospital	The Model Hospital is a digital tool designed to help NHS providers improve their productivity and efficiency. It gives trusts information on key performance metrics, from board to ward, advises them on the most efficient allocation of resources and allows them to measure performance against one another using data, benchmarks and good practice to identify what good looks like.
Non-pay cost per WAU	This metric shows the non-staff element of trust cost to produce one WAU across all areas of clinical activity. A lower than average figure is preferable as it suggests the trust spends less per standardised unit of activity than other trusts. This allows trusts to investigate why their non-pay spend is higher or lower than national peers.
Nurses cost per WAU	This is a nurse specific version of the pay cost per WAU metric. This allows trusts to query why their nurse pay is higher or lower than national peers. Consideration should be given to clinical staff mix and clinical staff skill mix when using this metric.
Overall cost per test	The cost per test is the average cost of undertaking one pathology test across all disciplines, taking into account all pay and non-pay cost items. Low value is preferable to a high value but the mix of tests across disciplines and the specialist nature of work undertaken should be considered. This should be done by selecting the appropriate peer group ('Pathology') on the Model Hospital. Other metrics to consider are discipline level cost per test.
Pay cost per WAU	This metric shows the staff element of trust cost to produce one WAU across all areas of clinical activity. A lower than average figure is preferable as it suggests the trust spends less on staff per standardised unit of activity than other trusts. This allows trusts to investigate why their pay is higher or lower than national peers.
Peer group	Peer group is defined by the trust's size according to spend for benchmarking purposes.

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