Barking, Havering and Redbridge University Hospitals NHS Trust

Use of Resources assessment report

Rom Valley Way
Romford
Essex RM7 0AG
Tel: 0330 400 4333
www.bhrhospitals.nhs.uk

Date of publication: 26 June 2018

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

Ratings

Overall quality rating for this trust	**Requires improvement** 🟡
Are services safe?	**Requires improvement** 🟡
Are services effective?	**Requires improvement** 🟡
Are services caring?	**Good** 🟢
Are services responsive?	**Requires improvement** 🟡
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/RF4/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:

- we rated safe, effective, responsive, and well-led as requires improvement; and caring as good;
- we took into account the current ratings of the four core services across the two locations not inspected at this time. Hence, six services across the trust are rated overall as requires improvement, and the remaining two services are rated good;
- the overall ratings for each of the trusts acute locations remained the same; and
- the trust was rated inadequate for Use of Resources.

Barking, Havering and Redbridge University Hospitals NHS Trust

Use of Resources assessment report

Rom Valley Way, Romford, Essex, RM7 0AG
Tel: 0330 400 4333
www.bhrhospitals.nhs.uk

Date of site visit:
5th April 2018

Date of publication:
19 June 2018

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

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

How effectively is the trust using its resources?	**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 5 April 2018 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.

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 high quality, efficient and sustainable care for patients.

- The trust's reported deficit for 2016/17 of £10.9m was £1m better than the control total set by NHS Improvement, but included £21m Sustainability and Transformation Funding (STF) and some £12m of non-recurring benefits, implying an underlying deficit of £44m.
- The trust started to have issues of paying for essential clinical supplies in the first quarter of financial year 2017/18. The trust's cash position continued to deteriorate, and was unable to meet its financial obligations during the second half of the financial year, and had to resort to £39m of emergency Department of Health funding to meet its financial obligations and sustain its operations.
- The financial performance also declined during 2017/18. Excluding STF, the deficit at month 11 of the financial year (February 2018) is at £59.5m, and the full year forecast is a £55m deficit which is £38m worse than the plan and control total.
- In February 2018, NHS Improvement placed the trust into Special Measures for finance. The trust is currently receiving external support to strengthen its financial and operational resilience.
- During 2017/18, the trust continues to report a very high usage of bank and agency staff in excess of the agency spend ceiling set by NHS Improvement, driven by significant staff recruitment and retention issues.
- In addition, there was little evidence to demonstrate that the trust was using Get It Right First Time (GIRFT) and Model Hospital data to actively drive clinical and operational efficiency and improvement. The trust heavily relies on non-recurrent schemes to meet its cost improvement requirements.
- The trust has one of the worst A&E waiting time performances nationally; the performance in February 2018 was 74.1%, significantly below the 95% standard.

However, it should be noted that:

- The trust has consistently delivered the nationally mandated waiting time standard for diagnostic tests since June 2017, providing tests to over 99% patients within 6 weeks.
- The trust has also preformed consistently above the nationally mandated cancer waiting time standard for urgent referrals every month since July 2017, treating more than 85% patients within 62 days of referrals.
- The trust reports one of the lowest sickness and absence rates nationally when benchmarked against other trusts.

The trust acknowledges a need to tighten its budgetary control and engage with the divisions to develop its cost saving schemes, and there remain significant opportunities for the trust to make adequate use of its resources to increase its productivity and reduce its run rate.

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

- The trust has struggled to meet the national waiting time standard set for Accident & Emergency (A&E), and monthly performance has consistently fallen below the 95% target since April 2017. Between December 2017 and February 2018, the monthly A&E performance was below 80%.
- In recent years, the trust has seen a rise in demand for urgent and emergency care (UEC). As part of its clinical strategy, the trust has adopted the Urgent Care Centre (UCC) model to support its UEC delivery at both sites, providing alternative pathways to deal with the rising demand. However, the UCCs have not worked as planned, as a lack of GP support especially during the out of hours (OOH) period, which means that patients cannot be effectively streamed onto the most appropriate pathways during evenings. The delivery was further affected by a significant shortage in both medical and nursing staff in the A&E department. The current vacancy rate for medical staff is 50% and for nursing staff is 30% which has had a major impact on the overall delivery of the target.
- In addition, the trust has also seen a rise in emergency admissions, increasing demand for beds. As of 31st December 2017, the trust lost a total of 517 acute bed days due to delayed transfers of care. A lack of suitable neuro-rehabilitation beds within the local health economy has been a particular challenge for the trust, as a small number of patients have remained in acute beds for more than 200 days.
- When compared nationally to other trusts, patients treated at the trust are also more likely to require additional medical treatment for the same condition. Emergency readmission rates were at 8.8% in December 2017 which is above the national median. The trust recognises that its service provisions to prevent emergency readmission could be strengthened and has now started to work with its local health economy to develop pathways for end of life care, OOH support for frail elderly patients as well as support in community provider settings with an aim to reduce the readmission rate.
- In recent months, the trust has seen a deterioration in its delivery against the national Referral to Treatment (RTT) standard. The monthly performance since August 2017 had fallen below the required national target of 92%. Reviewing how well the trust is using its elective clinical resources shows that 10.6% of patients did not attend (DNA) their scheduled outpatient appointments for the first nine months of 2017/18, placing the trust in the worst performing quartile nationally. The trust has reviewed its performance and confirmed that most of the DNAs were associated with follow-up appointments. The trust has acknowledged the need to review its access policy to ensure that DNA recording is accurate, and measures are in place to ensure that any DNA slots can be offered to other patients at short notice to avoid clinical appointments being wasted. However, the trust has not yet assessed and quantified the efficiency opportunity in relation to DNA.
- Although the trust benchmarks well in terms of its operating theatre utilisation, the trust recognises there are further efficiency opportunities in this area to increase theatre throughput. The trust currently only uses its theatres for two sessions a day compared to some trusts undertaking three sessions a day, and acknowledges the need to review their usage to maximise utilisation.
- The trust have received visits from NHS Improvement's GIRFT team, and reviewed findings and recommendations related to a number of specialties. However, there is no substantive evidence to show that the trust has actively taken these recommendations forward.
- The trust is receiving external support to review efficiency opportunities highlighted by Model Hospital benchmarking. There is also no substantive evidence to show how effective the trust

has used Model Hospital benchmarking data to drive efficiencies within the trust.

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

- Recruitment and retention has been a major challenge for the trust. Staff retention at 82.8% in November 2017 was below the national median, placing the trust in the worst performing quartile nationally. The trust also reported a 15.8% vacancy rate in December 2017, and has relied on bank and agency staff to cover vacancies to deliver its serviceswhich has driven up the total pay costs. Overall, the trust's pay cost per Weighted Activity Unit (WAU) of £2,255 is within the second highest (worst) cost quartile nationally, compared to a national median of £2,157, indicating that it spends more on staff per unit of activity than most trusts.
- The trust has particularly high vacancy rates among registered nurses and medical staff, at 18.6% and 16.7% respectively. Bank and agency usages of these two staff groups accounts for 74% of total spend on bank and agency for the first 11 months of 2017/18. The trust has undertaken some actions to address vacancies and agency spend. For example:
    - The trust has held a series of recruitment events. They were particularly successful among nursing staff, and between March 2017 and February 2018, the trust has offered roles to 420 registered nurses and midwives.
    - All doctors are now on Pan London agency rates from February 2018.
    - The trust has also stepped up its monitoring and oversight on workforce and agency control during the second half of 2017/18.
- Despite strengthened controls and an increase in number of substantive staff in post from 5,905 to 6,041 in 2017/18, there has not been a material reduction in bank and agency spend. By month 11 (February 2018) of the financial year, the year-to-date agency spend of £31.3m was 50.2% above the agency ceiling set by NHS Improvement. Furthermore, the full year total agency spend is unlikely to show any material improvement on the 2016/17 total agency spend of £33.7m. The trust continues to be one of the highest agency spenders of all hospital trusts in England, and the trust's position as of Month 10 (January 2018) of the financial year was the fourth highest nationally.
- The trust uses an electronic rostering system to manage nursing rosters. However, the interface between the electronic rostering system and the temporary staffing provider is not currently available. Evidence from other providers demonstrates that an interface could increases the bank staff usage as opposed to agency staff. There are also compliance issues regarding divisional staff not using central systems to book bank and agency staff. In February 2018, the trust reported a shift fill rate of 82%, indicating that 18% of staffing requirements were unmet.
- All consultant job plans are required to be reviewed annually. The trust has implemented and signed off 70% of consultant job plans in 2017/18 which is below the national requirement. The review was temporarily on hold at the time of the assessment, whilst the trust explored team-based consultant job planning. During the review and sign-off process, the trust had to seek external mediation to resolve a number of specific issues. The trust is also considering rolling out medical staff E-rostering. Currently, the trust does not have job plans for Clinical Nurse Specialists in all specialities, indicating further improvement opportunity in this area.
- The trust's sickness rate was at 3.28% in October 2017 which is within the lowest quartile compared to national median.

How effectively is the trust using its clinical support services to deliver high quality,

sustainable services for patients?

- The trust's pharmacy and medicine cost per WAU is in the lowest (best) cost quartile nationally. However, the trust has only achieved 82% of its top 10 medicine saving target in January 2018, placing them the third worst performing trust in the country. This indicates significant scope for improvement in this area.
- The trust is currently working on its Pharmacy Transformation Plan which includes implementation of digital prescribing. However, the trust requires capital investment to fulfil its implementation, and has not assessed the return on investment or efficiencies in relation to the investment. The trust has not yet undertaken review of its skill mix within the pharmacy team in 2017/18. The Transformation Plan includes scope to use more technicians and provide pharmacy support on wards in 2018/19.
- The trust is currently receiving external hands on support to devleop a culture of continuous improvement. The support team has helped the trust pharmacy services to reduce its turnaround time for to-take-out (TTO) prescriptions in recent months. The trust has reported a reduction in TTO turnaround time from an average of 2.5 hours to less than one hour for patients awaiting discharge, and is currently tracking the progress.
- As one of the trusts within East London pathology network, the trust is still in the process of agreeing with its neighbouring trusts on how to organise and consolidate their pathology services for the future to make it more effective and efficient. Although the trust's average cost per pathology test is lower than national average, there remains significant efficiency opportunity for the trust through collaborative work.
- The trust has not submitted any radiology returns to NHS Improvement; therefore, we were unable to assess the effectiveness of how the trust has been using its radiology resources.

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

- The trust's overall non-pay cost per WAU at £1,307 is slightly above national average; however, its Human Resources (HR) and finance costs per £100m turnover are in the highest (worst) cost quartile nationally.
- The HR cost per £100m turnover at £1.6m is ranked the second most expensive nationally. This is partly due to the fact that the trust medical and non-medical education department and organisational development functions are part of its HR services, which contributed to the overall costs. The trust recognises that there is an opportunity to consolidate its functions within its HR services to reduce the cost. However, at the time of the assessment, there is no substantial evidence to show any material cost reductions.
- The trust also acknowledged that its finance function cost per £100m turnover at £967,663 is within the top 15 most expensive trusts in England. The trust is currently undertaking reviews to assess vacancies within its Finance Department in order to consolidate roles and reduce the use of bank and agency.
- The trust's procurement function cost per £100m turnover is also within the most costly (worst) quartile nationally, and it has one of the lowest (worst) Procurement Process and Price Performance score in the country. The score is developed by NHS Improvement to measure whether a trust is efficient in securing best prices for both clinical and general supplies. However, the trust has used NHS Improvement's Purchase Price Index and Benchmark (PPIB) tool for most part of 2017/18, and is paying 2.5% above median prices and 10.8% above the minimum prices. During the second half the year, the trust has recruited new staff into the procurement team to strengthen its capability, and bought an additional PPIB toolkit licences to identify where potential savings could be made. The procurement team continues to work with

clinicians to review the use of clinical products.

- Estates and facilities costs per square metre at the trust are in the most expensive (worst) cost quartile when compared to the national benchmark. The trust has recognised that a lack of processes and expertise within its estates and facilities team has made the supporting service inflexible and inefficient and impacting on the trust's overall operations.
- During 2017/18, the trust restructured its estates and facilities team and expanded the number of subject matter experts. The new team has focused on a reduction of wastage to maximise the current use of its estates. One of the key challenges faced by the trust is how to effectively manage its two main hospital sites, especially Queen's Hospital which was developed under a Private Finance Initiative (PFI) agreement in 2006. At the time of this assessment, the trust has completed 20 moves in six months at the PFI site. This has resulted in some corporate support functions being moved out of more expensive PFI facilities into much cheaper accommodations, to make spaces for clinical services. The trust have a further 40 moves planned for 2018/19. The trust has also reduced the number of off-site locations it operates at from 22 down to 11 which is a significant achievement. The trust is currently working with NHS Improvement PFI experts to review its PFI contracts.

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

- In 2016/17 the trust reported a deficit of £10.9m, which was £1m better than plan. However, the actual underlying financial position going into 2017/18 was a deficit of £44m. This was because the deficit included a one-off income of £21m for the financial year and also £12m savings achieved on a non-recurrent basis. This put the trust in a challenging financial position at the start of 2017/18.
- During the first half of 2017/18, risks related to paying its creditors started to emerge. These risks were direct results of payment disputes with commissioners, retrospective bank and agency claims and issues associated with prior-year accounting adjustments. Due to poor financial control, the trust rapidly ran out of cash to pay its suppliers and maintain its essential services in October 2017. The trust had to request £20.7m emergency cash loan between October and December 2017, and then a further £18.3m in January 2018. The trust's latest performance against Better Practice Payment Code (BPPC) showed that only 12.8% of its non-NHS trade creditors were paid within 30 days of receipt of goods or a valid invoice at February 2018 against a National target of 95%, highlighting further cash management issues.
- The trust's reported financial performance deteriorated sharply in Months 7 (October 2017) and 8 (Noveber 2017) of 2017/18, when significant accounting issues (some of which related to 2016/17) were identified. The deficit at the end of month 11 2017/18 (February 2018) was £59.5m (excluding STF) and is expected to be £55m for the full year, which is £38m off the plan and control total. The underlying deficit for the full year is estimated at £45m, a deterioration from the prior year's underlying result.
- Disputes with its commissioners have had an adverse impact on the trust's income position. The trust is currently seeking expert arbitration to resolve its £26m incomes disputes related to over performing above the contracted level of activity.
- The trust has failed to control its expenditure within its divisional budgets during the year. The trust has not used Service Line Reporting (SLR) data to understand or manage the performance of individual services. The accumulative overspend against plan was at £41.6m at the end of February 2018.
- The trust has also fallen significantly short of its annual Cost Improvement Programme (CIP) target of £26m in 2017/18. At Month 11 (February 2018) of 2017/18, the trust had delivered £17m of its £26m CIP, £11m of savings secured is recurrent. The trust acknowledges its failing

at monitoring its CIP delivery during the year as well as a lack of clear divisional accountability to own the saving schemes and targets, which led to the material CIP shortfall.

- Following the sharp deterioration in financial performance in Quarter 3 of the 2017/18 financial year, NHS Improvement placed the trust into special measures for finance in February 2018. The trust recognises that it needs to strengthen its financial controls in the coming year to improve its finances. The trust is also receiving external support to aid its financial recovery.

Outstanding practice

- The trust's Estate Department undertook a property and service review in collaboration with clinical services in 2017/18. The review focused on off-site properties which were used sporadically. This has led to a rationalisation of these properties from 22 to 11, reducing the total space costs.

Areas for improvement

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- The trust needs to address its cash flow management and underlying financial deficit, and ensure that it has a full understanding of the drivers behind the deficit, and has a credible recovery plan in place to strengthen its financial and operational resilience through improved productivity and run rate.
- There is a need for the trust to improve its use of the electronic rostering system, to improve the interface between the electronic rostering system and its use of bank and agency staff, to meet its agency ceiling. The trust also needs to roll out medical staff electronic rostering.
- The trust needs to rapidly increase the number of consultant job plan sign-offs and ensure that all doctors' job planning requirements are fulfilled.
- The trust needs to consider how it will take forward the GIRFT findings and recommendations, and use the evidence to drive its clinical improvement.
- The trust needs to engage with its local health and care economy to develop service provisions which can help them deliver their Clinical Strategy successfully.
- The trust needs to demonstrate how its quality improvement initiative (such as reduction in DNA rates, improving theatre utilisation) can translate into efficiency and cost savings.
- The trust also needs to strengthen its understanding and evidence regarding the return on investment and financial impact in relation to its business cases.
- The trust needs to ensure that all consultant job plans are up-to-date and there are job plans for Clinical Nurse Specialists.
- There is significant scope for improvement in areas of clinical support services including Pharmacy, Pathology and Imaging services, and there is a need for the trust to engage with the national programmes in these areas.
- There is significant scope for improvement in areas of procurement and corporate services including HR and Finance.

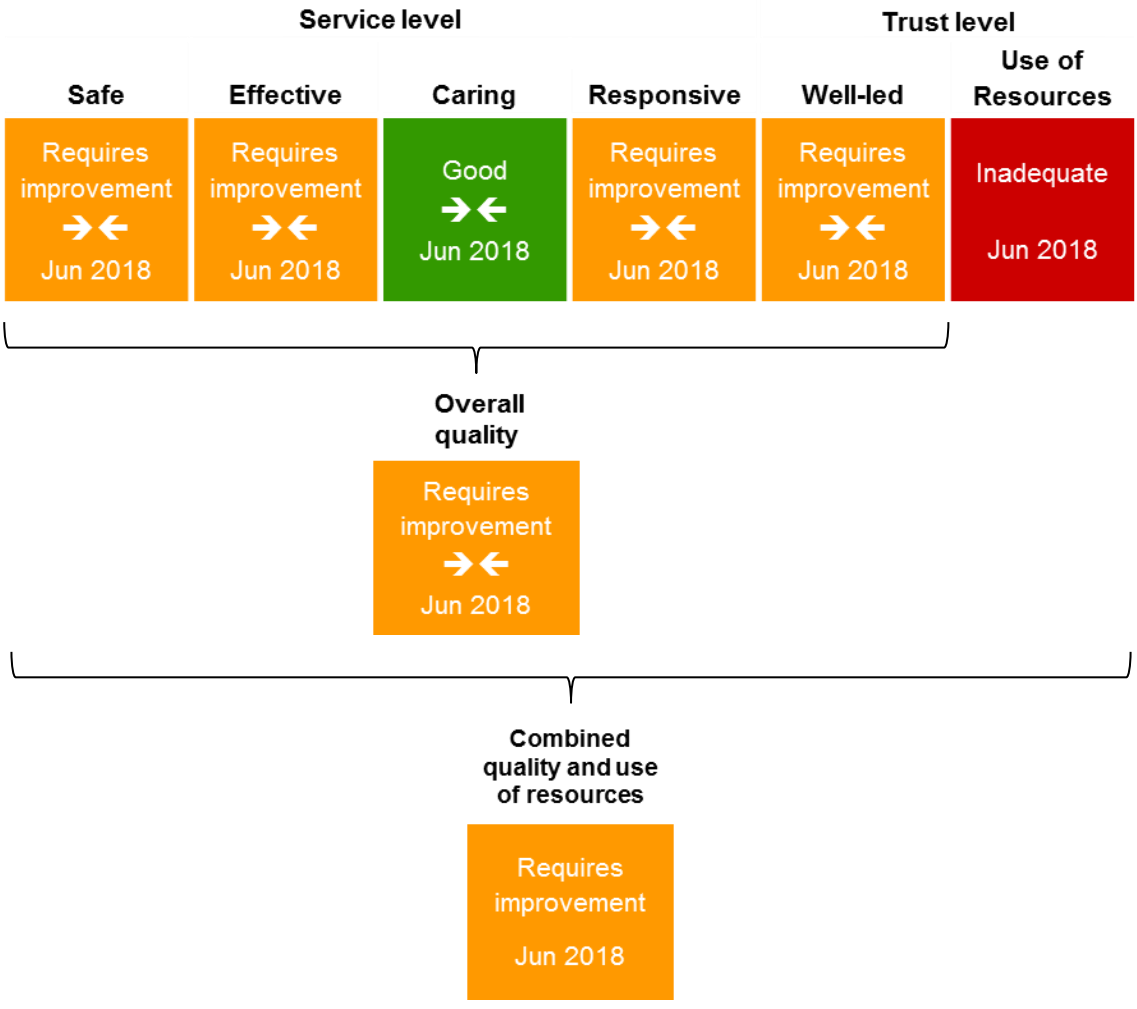
Ratings tables

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	A high level of DNAs indicates a system that might be making unnecessary

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

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

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