Medway NHS Foundation Trust

Use of Resources assessment report
Medway Maritime Hospital
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Kent
ME7 5NY
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Date of publication: 25 July 2018

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

Ratings

<table>
<thead>
<tr>
<th>Overall quality rating for this trust</th>
<th>Requires improvement ●</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are services safe?</td>
<td>Requires improvement ●</td>
</tr>
<tr>
<td>Are services effective?</td>
<td>Good ●</td>
</tr>
<tr>
<td>Are services caring?</td>
<td>Good ●</td>
</tr>
<tr>
<td>Are services responsive?</td>
<td>Requires improvement ●</td>
</tr>
<tr>
<td>Are services well-led?</td>
<td>Requires improvement ●</td>
</tr>
</tbody>
</table>

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/RPA/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:

The trust has implemented a number of changes since our last inspection to improve safety and it was noted, this had been sustained. However, there were still improvements to made in key areas such as retention of staff, mandatory training and ensuring safety checks were completed. There was recognition from the executive and senior management team that there was still work to be done to make sure a culture of safety existed across the whole of the organisation.

Our rating of the trust stayed the same. We rated it as requires improvement because:

- The trust was rated good for effective and caring. We rated safe, responsive and well-led as requires improvement.
- The trust was rated inadequate for Use of Resources.
- We did not inspect maternity, gynaecology, end of life care or services for children and young people.

We are monitoring the progress of improvements to these services and will re-inspect them as required.
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.

Proposed rating for this trust

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 30 April 2018 and met the trust’s executive team (including the chief executive), a non-executive director (in this case, the chair) and relevant senior management responsible for the areas under this assessment’s KLOEs.
Summary of findings

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

Inadequate

We rated use of resources as Inadequate because the trust is not making adequate use of its resources, putting at risk its ability to provide high quality, efficient and sustainable care for patients.

- In 2016/17, the trust reported a deficit of £43m against a control total of £47m deficit which included receipt of £10.8m of Sustainability and Transformation Funding (STF). In 2017/18, the trust reported a deficit of £62m against a planned deficit of £38m, a significant adverse variance of £24m against plan, including STF of £4m. The 2017/18 deficit represents over 20% of the trust’s annual expenditure and is one of the largest deficits in the non-specialist acute trust sector as a percentage of turnover.
- The trust’s underlying productivity compares poorly with other trusts. Its overall cost per weighted unit of activity (WAU) is higher than most other trusts nationally. For 2016/17 the trust’s overall cost per WAU was £3832, compared to a national average of £3481. This placed the trust in the least productive 10% nationally.
- The trust pay cost per WAU for 2016/17 was £2490. This compares with a national median of £2157, placing it in the highest (worst) cost quartile nationally. This means the trust spends more on staff per WAU than most trusts. The trust had an overall non-pay cost per WAU of £1342 for 2016/17 compared with a national median of £1300, placing it just in the second highest cost quartile nationally. This suggests that the trust may be able to reduce its spending on supplies and services.
- The trust is not able to consistently meet its financial obligations to pay its suppliers in the immediate term without support funding. The trust has extremely low cash reserves and is heavily reliant on short-term loans to meet its obligations and maintain positive cash balances. It received £88m of central funding in 2017/18 (£11m of this was for capital investment).
- The trust planned to deliver a cost improvement programme (CIP) of £12.6m in 2017/18 (or 3.7% of its expenditure). However, it has fallen short of achieving this target and delivered £7.0m of savings (2.0% of expenditure).
- At the time of the assessment in April 2018, the trust was not meeting constitutional operational performance standards for Referral to Treatment (RTT), Accident & Emergency (A&E) and Diagnostics. While trust performance across these metrics has improved between 2016/17 and 2017/18, performance is still considerably worse than national averages.

However:
- In addition to the improvements made to referral to treatment (RTT), Accident & Emergency (A&E) and diagnostics performance, there has also been an improving trend in performance against the 62 day cancer treatment standard, where the trust has met this standard since January 2018 and is expecting to sustain compliance in 2018/19.
- As part of the review, the trust demonstrated it has taken measures to improve clinical productivity (for elective and non-elective activity). The trust provided evidence to show improvements in length of stay with reductions in excess bed days for elective and non-elective admissions and a sustained rebalancing of activity towards increased use of day cases which indicates improving use of resources.
- Through improved operational processes, at the beginning of April 2018, the trust had delayed transfers of care (DTOC) 6 week average rate of 2.3%, which is lower than the national target of 3.5% average.
• While in 2017/18, the trust’s agency costs remained above the national average (highest quartile) when taking agency as a proportion of overall pay costs, through improved controls, the trust has significantly reduced agency expenditure from £40.5m in 2016/17 to £17.4m in 2017/18 and is now managing costs within its ceiling (£21.3m).
• The trust is actively engaging with the Getting it Right First Time (GiRFT) and Model Hospital programmes indicating a culture of improvement.

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 not routinely achieved the constitutional performance standards, with the exception of the cancer standard, and the trust has high emergency readmission rates. However, the trust is putting in place measures to improve clinical productivity and its performance for DTOCs, minimising pre-procedure stays and patients not attending appointments compares well.
• At the time of the assessment in April 2018, the trust was not meeting constitutional operational performance standards for RTT, A&E and Diagnostics. While trust performance across these metrics has improved between 2016/17 and 2017/18 performance is still considerably worse than national averages and NHS Improvement South regional averages.
• There has been an improving trend in cancer performance, where the trust has met this standard since January 2018 and is expecting to sustain compliance in 2018/19.
• Patients are more likely to require additional medical treatment for the same condition at this trust compared to other trusts. At 8.6% as at December 2017, emergency readmission rates are materially above the national median of 7.4%. The trust has undertaken a deep dive on non-elective activity through its Local Accident and Emergency Delivery Board. This process has tested key pathways and the trust has identified frequent readmissions associated with Urinary Tract Infections (UTIs) and cellulitis which it is taking steps to address. Quarterly performance reports show a recent reduction in emergency readmissions, but at this point it is unclear whether the measures put in place will sustain the improvement.
• Fewer patients are coming into hospital unnecessarily early prior to treatment compared to most other hospitals in England.
• On pre-procedure elective bed days, at 0.04, the trust is performing in the lowest (best) quartile, 0.09 days below the median when compared nationally – the national median is 0.13 bed days.
• On pre-procedure non-elective bed days, at 0.67, the trust is performing in the second lowest (best) quartile, 0.11 days below the median when compared nationally – the national median is 0.78 bed days.
• The trust has taken measures to improve clinical productivity (for elective and non-elective activity). There has been a reduction in excess bed days for elective and non-elective admissions and a sustained rebalancing of activity towards increased use of day cases that indicates improving use of resources.
• The Did Not Attend (DNA) rate for the trust is relatively low at 7% for December 2017. To improve DNA rates, the trust reported that outpatient appointments are now managed by a new IT system. The trust has also introduced an improved text reminder service and has targeted actions with individual clinical services to address variation.
• As at the beginning of April 2018, the trust reports DTOC 6 week average rate of 2.3%, which is lower than national target of 3.5% and it reports an improving trend. The improvement has been made and is being sustained through daily system calls which provide pre-emptive review of potential patient discharges and ensures plans are in place to facilitate the discharges.
• The Trust has changed from manual to automated reporting of Length of Stay (LOS) monitoring and has reports covering all wards that identify stranded and super-stranded patients supported by Dr Foster Model analysis. The improvements in LOS monitoring and DTOC processes in conjunction with other management activities has allowed the trust to close two winter escalation wards resulting in a net 68 beds reduction.

• Further improvement initiatives include theatre cost optimisation (through monitoring of start and end times and drugs and consumables use). The trust expects improvements to deliver positive results over 2018-19. However, there is no evidence to demonstrate the beneficial impact on productivity at this point.

• The trust has engaged with the Getting it Right First Time (GIRFT) programme. There have been six GIRFT deep dive visits to the trust and one revisit to date, engaging with Ear, Nose and Throat (ENT), Urology and Orthopaedics services. The trust reported that these visits have been helpful and that the introduction of GIRFT methodology has reduced length of stay in its Urology Service. During the site visit, the trust reported following an ENT service review that there has been a consolidation of pathways which has helped to improve referral rates.

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

• The trust’s overall pay cost is very high reflecting very high medical staff costs offset to a small degree by lower nursing and other staff costs. The trust does not have well embedded consultant job planning and there is scope to improve e-rostering. However, the trust has done well in reducing its agency spend in 2017/18.

• For 2016/17 the trust had an overall pay cost per WAU of £2490, compared with a national median of £2157, placing it in the highest (least cost effective) quartile nationally. This means that it spends more on staff per unit of activity than most trusts. The trust is in the highest quartile for doctors’ cost per WAU and second highest quartile for corporate staffing. However, it benchmarks below national averages for nursing, Allied Health Professionals (AHP) and Scientific, Therapeutic and Technical (STT) staff.

• The trust’s AHP costs are very low and benchmark in Quartile 1. The trust believes this to be an explainable variation and due to purchasing AHP resource for various services (including speech.

• The trust’s overall pay costs for 2017/18 are comparable to 2016/17 at around £214m, so there is no evidence of excessive pay cost growth across this period. In this period there has been a shift in staffing mix, with a reduction in agency expenditure replaced with bank and substantive staff, which is generally expected to provide better value and quality of care.

• The trust did not meet its agency ceiling as set by NHS Improvement for 2016/17. However it has significantly reduced agency expenditure from £40.5m in 2016/17 to £17.4m in 2017/18. The ceiling for both years was £21.3m. In 2016/17 agency cost per WAU was £474 compared to £137 national average, so the trust was significantly worse than average and in the bottom quartile for this metric. The trust figures will have improved in 2017/18 in light of the overall reduction in agency spend. However, the trust is still spending more than the national average on agency as a proportion of total pay spend indicating there is an opportunity for further productivity gains.

• The reductions in the agency and locum usage have been delivered through improved control processes, restrictions on use of interim staffing, through local, national and international recruitment campaigns, changing terms and conditions of new starters and enhancing the trust bank for temporary staff needs.

• The trust uses an e-rostering tool for nursing and clinical support team and aims to achieve sign off of rotas 6 weeks in advance but acknowledged during the visit that this is not always achieved.
• The trust has a job planning system in place for consultants but acknowledged during the review that it has not have a fully up to date set of job plans. Work is currently underway to standardise job plans and review clinical and support sessions. The level of authorised consultant plans has taken two years to improve from 28% in 2015/16 to 50% in 2017/18. The trust has an ambition to reach 95% in 2018/19. However this will require a step change in the rate of authorisations.

• Staff retention at the trust shows room for improvement, with a retention rate of 82.9% in December 2017 against a national median of 85.7%. The trust indicated that due to its vacancy and high agency usage it has been focused on recruitment as a primary consideration rather than retention.

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

• While the trust’s pharmacy service performed well against the ‘Top 10’ medicines target, it has challenges to address in its radiology service and has a slightly higher than average pathology cost.

• The trust’s pharmacy services performed well against the ‘Top 10 Medicine switch’ at 129% of target. However, the trust’s overarching Hospital Pharmacy Transformation Plan is under-developed as reflected in a range of operational metrics. The management team has recognised this weakness and has recently appointed a new Chief Pharmacist. However the change is too recent for significant progress to be identifiable at this point.

• The trust acknowledges there are challenges in terms of recruitment and retention of staff in its radiology services as well as the age of the imaging equipment. The trust has recently appointed a new head of radiology to address weaknesses in imaging performance.

• In terms of pathology services, the trust is in a Joint Venture (JV) with another NHS trust, which will form part of the wider pathology network development. Review of Model Hospital.

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

• The trust compares well in terms of procurement and is making some investments in its physical and IT infrastructure. However, overall non-pay costs are slightly above average and the trust has very high HR costs and one of the highest backlog maintenance requirements in the country.

• NHS Improvement ranks all trusts’ performance in procurement based on a weighted combination of metrics. At Quarter 4 2016/17, the trust was ranked 60th (out of 136) but is improving. The trust’s current position is estimated to be 44th. The trust has been submitting procurement metrics regularly to NHS Improvement, which demonstrates better engagement with the initiative than the majority of trusts.

• For corporate services, based on NHS Improvement’s data collection in Quarter 3 (Q3) 2017/18, the trust ranked at the upper limit of the third cost quartile (second worst) for both human resources (HR) and governance and risk functions. In HR, the trust benchmarks in the upper quartile (worst) for both cost and whole time equivalents (WTEs) in temporary staffing despite the significant progress that it has made on agency expenditure in the year.

• In the recruitment and education sub-functions the trust is in the upper (worst) quartile for cost and the third (second worst) quartile for WTEs, suggesting that it has a higher graded skill mix than other trusts. In terms of performance at Q3 in 2017/18, the trust has a relatively high average time to recruit (exclusive of notice period) for substantive and non-clinical staff. The trust is at the median time for clinical staff (59 days).
• For governance and risk functions, the trust receives a relatively high volume of complaints and benchmarks in Quartile 3, (the second highest). The trust is in the upper (worst) quartile for both cost and WTEs in clinical audit and corporate governance.
• In estates and facilities services the trust had a cost of £351 per square metre in March 2017, which places it slightly above the national average of £338. Benchmarking indicates catering and laundry costs are higher than average while cleaning costs are lower than average. This annual cost is in the context of the trust reporting a requirement to complete £50m of backlog maintenance. The trust's backlog cost per square metre is £583/m2 which is one of the highest rates in the country. The trust is investing significant capital in 2018/19 to address fire safety concerns and in updating its Emergency Department, which are expected to reduce overall backlog.
• The trust is also analysed as having relatively high levels of non–clinical space; 48% against a target of 35%. The trust believes that this could be due to an incorrect data submission and is reviewing this.
• The trust is prioritising the upgrading of its technology infrastructure. The trust evidenced it has been testing options and is planning the implementation of new systems for electronic documents management; e-Prescribing and Electronic Patient Records. The ability of the trust to improve the management of its operations including the recording of activity data is heavily predicated on this implementation. The trust reported lack of capital investment capacity is causing productivity constraints in operations including the outdated imaging equipment. The trust is planning to procure new equipment using a managed service solution as a result.

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

• The trust's financial sustainability continued to decline in 2017/18. It trust incurred a deficit of £62m against a planned deficit of £38m, a significant adverse variance of £24m against plan, including Sustainability and Transformation Funding (STF) of £4m. The deficit represents over 20% of the trust’s annual expenditure and is one of the largest deficits in the non-specialist acute trust sector.
• The primary cause of the variance was lower operating income than expected (with a £16m adverse variance to plan on clinical income). This has been due to the trust being unable to generate additional income included in its plan, which is in part due to contract management expertise and capacity. Contract disputes with local commissioners which ultimately required parties to enter an Expert Determination resolution process has also adversely impacted upon income. Other factors that contributed to the trust failing to deliver its overall financial plan were prior year contract issues and bad debts, operational cost pressures and non-delivery of cost improvement plans (CIP).
• The trust planned to deliver £12.6m of CIP in 2017/18 representing 3.7% of its expenditure, a value broadly in line with that delivered in 2016/17. However, it has fallen short of achieving this target and delivered £7.0m of savings (2.0% of expenditure). This was reported to be due to a focus on managing operational pressures and improving performance standards in the first half of the financial year combined with limited capacity within the trust’s divisions to implement the efficiency plans.
• The trust is not able to consistently meet its financial obligations to pay its suppliers in the immediate term without support funding, as reflected by its capital service and liquidity ratings which are assessed as level 4, being the worst category. The trust has extremely low cash reserves and is heavily reliant on short-term loans to maintain positive cash balances. It received £87.7m of Department of Health funding in 2017/18.
• A Service Level Reporting (SLR) system has been re-introduced in 2017/18 with some refinements required. The trust is focusing on the contribution made by services and has used SLR as a tool to engage with clinicians on productivity and efficiency and to help to
drive understanding of the opportunities. There is limited evidence that SLR has led to improved use of resources in 2017/18. However the trust expects it to support delivery of CIP opportunities in 2018/19.

- Historically, the trust has relied heavily on external consultancy support. However at the end of 2016/17 it took steps to release the majority of interim consultancy staff. In 2017/18, the trust has used external consultants to support improvements in operational performance, particularly aimed towards the 4 hour A&E standard, CIP delivery and the implementation of its Better, Best, Brilliant (BBB) improvement programme.

### Outstanding practice

While in 2017/18, the trust's agency costs remain above the national average when taking agency as a proportion of overall pay costs, through improved controls, the trust has significantly reduced agency expenditure from £40.5m in 2016/17 to £17.4m in 2017/18 and is now managing costs within its ceiling (£21.3m). This positive change has been delivered through improved control processes, restrictions on use interim staffing, through local, national and international recruitment campaigns, changing terms and conditions of new starters and enhancing the trust bank.

The trust's pre-emptive and targeted approach to DTOCs has resulted in performance that is significantly better than national expectations.

### Areas for improvement

The most recent full refresh of the Model Hospital was based on the 2016/17 reference cost data. However, a number of key metrics are updated on a more frequent basis within the Model based on other data sources. When using the 2016/17 Model Hospital as a point of reference, potential changes to the metrics in 2017/18 through changes in the operating costs and activity delivered by the trust are considered. The trust has provided evidence to indicate that it has made a range of operational and clinical improvements between 2016/17 and 2017/18 through its Better, Best, Brilliant Improvement programme. However there are several key areas for improvement to be addressed:

The trust needs to address its 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 with system partners to strengthen its financial and operational resilience through improved productivity and run rate.

The trust failed to deliver planned CIPs in 2017/18; and will need to ensure its plans for new programme management office resource and expertise are expedited to support divisional delivery of schemes moving forwards.

The trust has opportunity to improve pay cost per WAU, particularly in regards to medical and corporate staffing. It will be important that going forward the trust demonstrates an improvement path towards at least a median cost per WAU. In response to its medical staffing position; the trust needs to maintain its focus efforts on standardisation of job plans and achieving its ambition to ensure authorised consultant plans are in place for all consultants.

Emergency readmission rates are above the national median the trust should continue to work on this with system partners through its Local Accident and Emergency Delivery Board.
Ratings tables
Use of Resources report glossary
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>18-week referral to treatment target</td>
<td>According to this national target, over 92% of patients should wait no longer than 18 weeks from GP referral to treatment.</td>
</tr>
<tr>
<td>4-hour A&amp;E target</td>
<td>According to this national target, over 95% of patients should spend four hours or less in A&amp;E from arrival to transfer, admission or discharge.</td>
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<tr>
<td>Agency spend</td>
<td>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.</td>
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<tr>
<td>Allied health professional (AHP)</td>
<td>The term ‘allied health professional’ encompasses practitioners from 12 diverse groups, including podiatrists, dietitians, osteopaths, physiotherapists, diagnostic radiographers, and speech and language therapists.</td>
</tr>
<tr>
<td>AHP cost per WAU</td>
<td>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.</td>
</tr>
<tr>
<td>Biosimilar medicine</td>
<td>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.</td>
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<tr>
<td>Cancer 62-day wait target</td>
<td>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.</td>
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<tr>
<td>Capital service capacity</td>
<td>This metric assesses the degree to which the organisation’s generated income covers its financing obligations.</td>
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<tr>
<td>Care hours per patient day (CHPPD)</td>
<td>CHPPPD 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.</td>
</tr>
<tr>
<td>Cost improvement programme (CIP)</td>
<td>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.</td>
</tr>
<tr>
<td>Control total</td>
<td>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.</td>
</tr>
<tr>
<td>Diagnostic 6-week wait target</td>
<td>According to this national target, at least 99% of patients should wait no longer than 6 weeks for a diagnostic procedure.</td>
</tr>
<tr>
<td>Did not attend (DNA) rate</td>
<td>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</td>
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</tbody>
</table>
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.
<table>
<thead>
<tr>
<th><strong>Income and expenditure (I&amp;E) margin</strong></th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Key line of enquiry (KLOE)</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Liquidity (days)</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Model Hospital</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Non-pay cost per WAU</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Nurses cost per WAU</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Overall cost per test</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Pay cost per WAU</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Peer group</strong></td>
<td>Peer group is defined by the trust’s size according to spend for benchmarking purposes.</td>
</tr>
<tr>
<td><strong>Private Finance Initiative (PFI)</strong></td>
<td>PFI is a procurement method which uses private sector investment in order to deliver infrastructure and/or services for the public sector.</td>
</tr>
<tr>
<td><strong>Patient-level costs</strong></td>
<td>Patient-level costs are calculated by tracing resources actually used by a patient and associated costs</td>
</tr>
<tr>
<td><strong>Pre-procedure elective bed days</strong></td>
<td>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</td>
</tr>
</tbody>
</table>
### 20180713 RPA combined rating Use of Resources report FINAL.docx

| **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. |