East Lancashire Hospitals NHS Trust

Use of Resources assessment report

Royal Blackburn Hospital
Haslingden Road
Blackburn
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www.elht.nhs.uk

Date of publication:
12 February 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?	**Good** ●
Are services responsive?	**Requires improvement** ●
Are services well-led?	**Good** ●

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/RXR/reports)

Are resources used productively?	**Good** ●

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:

- We rated safe, effective, caring and well-led as good. We rated responsive as requires improvement. Of the ten services we inspected we rated seven as good, two as outstanding and one as requires improvement. In rating the trust, we took into account the current ratings of the services not inspected this time.
- We rated well-led for the trust overall as good.
- Our ratings for Royal Blackburn Hospital and Burnley General Hospital were both good which was the same as the last inspection
- Our ratings for surgery, at both hospitals, were good, which was the same as the last inspection. Our rating for urgent and emergency care at Royal Blackburn Hospital was requires improvement, which was a deterioration from the last inspection, when we rated it as good. Our rating for urgent and emergency care at Burnley General Hospital was good, which was the same as the last inspection. Our rating for medical care at Royal Blackburn Hospital was good which was the same as the last inspection. Our rating for medical care at Burnley General Hospital was also good which was an improvement since the last inspection.
- Our rating for community end of life was outstanding. Our ratings for community adults and community inpatients were good. This was the first time we have inspected these services.
- Our ratings for specialist community mental health services for children and young people was outstanding. This was the first we have inspected this service.
- The trust was rated good for Use of Resources.

NHS Improvement

East Lancashire Hospitals NHS Trust

Use of Resources assessment report

Royal Blackburn Hospital
Haslingden Road
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Tel: 01254263555
www.elht.nhs.uk

Date of site visit:
7 September 2018

Date of publication:
<xx.MONTH.201x>

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.

Proposed rating for this trust?	**Good** ●

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 07 September 2018 and met the trust's executive team (including the chief executive), a non-executive director (in this case, the chair and deputy Chair) and relevant senior management responsible for the areas under this assessment's KLOEs.

Findings

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

- We rated the trust's use of resources as Good.
- For 2016/17 the trust had an overall cost per cost per weighted activity unit (WAU) of £3,470 compared to the national median of £3,484. This indicates that the trust is more productive at delivering services than other trusts by showing that, on average, the trust spends less to deliver the same number of services.
- For the same period the trust had an overall pay cost per WAU of £2,352 which is above the national median of £2,157. This means the trust spends more on staff per weighted unit of activity than most other trusts nationally. The trust had an overall non-pay cost per WAU of £1,118 which is below the national median of £1,301. This means the trust spends less on other goods and services per weighted unit of activity than most other trusts nationally.
- Individual areas where the trust's productivity compared particularly well included Delayed Transfers of Care (DTOC), Medical cost per WAU, staff retention and corporate services costs. Opportunities for improvement were identified in staff sickness, Did Not Attend (DNA) rates and clinical productivity metrics.
- The trust evidenced the use of innovate workforce planning to help bridge the recruitment gaps, including Advanced Nurse Practitioners, Nurse Consultants and Physician Associates. The trust also demonstrated use of new workforce and service models such as the Integrated Eye Service whereby eye care is delivered through community services resulting in a reduction in waiting times and an increase in outpatient activity.
- The trust delivered the agreed control total in 2017/18, reporting a surplus of £2.983 million (including £8.484m Sustainability and Transformation Funding). As of month 5, the trust is on track to achieve the control total deficit of £7.748 million in 2018/19 (including £8.050m Sustainability and Transformation Funding).
- The trust is not reliant on external loans to meet its financial obligations and deliver its services.

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 performs well in some clinical productivity indicators, such as Delayed Transfer of Care (DTOC), and has improved performance in some, such as DNA rates. For others, such as emergency readmissions and pre-procedure bed days, the trust is close to, or slightly above national medians. The trust gave good examples of where co-ordinated services across the health care system had led to improved clinical productivity efficiencies and improved patient outcomes and was also able to demonstrate that the GIRFT (Getting It Right First Time) programme is well embedded within the trust.
- At the time of the assessment in September 2018, the trust was meeting the constitutional operational performance standards around Referral to Treatment (RTT) (92.5% for July 18 vs standard of 92%) but was not meeting the performance standards around Cancer 62 day (76.8% for July 18 vs standard of 85%) and

Accident & Emergency (A&E) (76.1% for August 18 vs Standard of 95%). It should be noted that the trust has consistently delivered against the RTT target over the past 12 months and did deliver against the cancer standard in Q1 18/19 (87.6%).

- Patients are as likely to require additional medical treatment for the same condition at this trust compared to other trusts. At 7.2%, emergency readmission rates are at the national median as at March 2018.
- More patients are coming into hospital unnecessarily prior to treatment compared to most other hospitals in England.
- On pre-procedure elective bed days, at 0.16 (March 18), the trust is performing in the second highest (worst) quartile and slightly above the median when compared nationally – the national median is 0.13.
- On pre-procedure non-elective bed days, at 0.89 (March 18), the trust is performing in the second highest (worst) quartile and slightly above the median when compared nationally – the national median is 0.80.
- The trust was able to demonstrate that they have a good understanding of the specialities which drive these metrics and describe how they are targeting improvements. For example, they provided evidence that for pre-procedure elective bed days for general surgery, the majority of cases admitted the day before were linked to the tertiary Hepatobiliary and Pancreatic (HPB) Surgery. They showed that they benchmarked favourably with other providers of tertiary HPB services. For pre-procedure non-elective bed days they were able to identify that they are a centre for good practice for vascular services, with over 70% of non-elective patients having a procedure on the day they are admitted, compared to a peer average of less than 40%, which they attribute to having daily vascular surgery lists, as well as dedicated non-elective surgery lists at the weekends.
- The trust was able to describe the leadership that the trust provides to the ICS and ICP. In addition, the trust was able to provide specific evidence of several services where clinical productivity had improved as a result of the trust co-ordinating services across the local health and care economy. Examples included the Pennine Lancashire Falls Response Service, The integrated dermatology service and the Integrated Eye Service. An example of impact was within dermatology, where the service redesign has seen a significant drop in demand of around 20 patients per week.
- The Did Not Attend (DNA) rate for the trust is high at 7.7% for March 18 which places the trust in the second highest (worst) quartile and above the national median of 7.3%. This has, however, improved since 2015/16 when the rate was 9.37%. The trust described a number of initiatives, including trialling of different targeted reminder systems which has led to some of this improvement.
- The trust reports a delayed transfers of care (DTOC) rate of 2.75%, lower than average and lower than the trust's own target rate of 3.5%. DTOC rates have been improving over the past 12 months. The trust described their work around the "Home First" programme and the impact this had had on DTOC. The trust described how this programme contributed to allow the trust to reduce escalation beds following the winter period.
- The trust was able to demonstrate that it has engaged with the GIRFT programme, with the Medical Director taking a leadership role. Progress against the GIRFT recommendations are monitored through the Clinical Effectiveness Committee. Examples of improvements were described, such as a reduction in the numbers of different major joints procured within Trauma & Orthopaedics, and work on improving start times and reducing over-runs within vascular services.

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

- The trust's performance across workforce metrics is mixed, with some areas better than the median such as staff retention, whereas other areas are significantly worse than the median, such a sickness absence. The trust has deployed some innovative solutions to tackle the significant national workforce challenges but the overall pay cost per WAU is worse than the national median.
- For 2016/17 the trust had an overall pay cost per WAU of £2,352 which is above the national median of £2,157 and places the trust in the highest (worst) quartile. This means that it spends more on staff per unit of activity than most trusts.
- The trust is in the lowest (best) quartile for Medical cost per WAU (£434 compared to a national median of £526), although it benchmarks in the highest (worst) quartile for Allied Health Professionals (AHPs) cost per WAU (£186 compared to a national median of £127) and Nursing cost per WAU (£872 compared to a national median of £718).
- The trust stated the high cost per WAU was a caused by community services including district nursing and multi-disciplinary teams staffing 122 community beds. The trusts nursing cost and AHP cost per WAU are both lower when adjusted for community services, however, are still above the national median (adjusted nursing cost per WAU £758 compared to national median of £718 and AHP cost per WAU £129 compared to national median of £127).
- The trust has an agency cost per WAU of £206 which is above the national median of £137.
- In 2017/18, the trust had 3.9% of its total pay costs attributable to agency and in 2018/19 they are planning to reduce this to 3%.
- The trust did not meet its agency ceiling as set by NHS Improvement for 2017/18 but is on plan to meet its ceiling in 2018/19. It is, however, spending more than the national average on agency as a proportion of total pay spend. The trust described several incentives that had been implemented to support a reduction in agency spend including increase in bank rates, earlier identification of and offer of bank shifts and prioritising substantive staff or trust bank staff for available shifts over agency staff.
- The trust stated they have continued to focus on recruitment into high agency spend areas. A degree of success had been achieved which supports the planned reduction agency spend. The trust described a recruitment drive for Health Care Assistants (HCA) which had resulted in a 1,500 reduction in HCA bank shifts per month and zero HCA agency shifts since November 2016.
- Staff sickness levels, at 4.7%, are above the national median of 4%. The trust noted this figure is currently rising. We heard evidence how the trust analyses themes and trends of sickness and implemented new initiatives to support staff health and wellbeing. The trust described through their analysis, they identified the main causes of staff sickness are related to muscular skeletal (MSK) problems and mental health related conditions such as stress, anxiety and depression. As a result, the trust have established a MSK service within Occupational Health and introduced mental health first aiders to support staff with mental health problems, both to support a reduction in these areas of staff sickness.
- Staff retention at 89.8% is above the national median of 85.8%, placing it in the highest (best) quartile.

- The trust uses a blended medical workforce which includes utilising Advanced Nurse Practitioners, Nurse Consultants and Physician Associates to support gaps in medical rotas where the trust has had trouble recruiting.
- The trust described how it was reviewing traditional workforce models and adapted these to support care delivery particularly with AHPs. One innovative example the trust described was how Ward Based Pharmacy staff had extended their roles to undertake traditional nursing roles such as cannulation and intravenous (IV) medication administration.
- All consultants, Advanced Nurse Practitioners and Nurse Consultants have a job plan. In addition, we heard from the trust that there was a plan to roll out job planning to for AHPs. Job plans are based on analysis of demand and capacity within each specific specialty. The trust described how job planning was focused on activity, however, plans are to also focus job plans on productivity.
- An area of notable outstanding practice in which the trust had developed an innovative workforce and service model was in relation to the Integrated Eye Service. This service was developed because of the high demand for the Hospital Eye Service but a limited speciality ophthalmology workforce. As a result, appointments were limited, there were lengthy waiting times for procedures and patient experience was less than optimum. The integrated service has resulted in eye care delivered in community healthcare facilities with a step-up/step-down ability between the community and hospital eye service. To address the limited ophthalmology workforce and increase utilisation of community optometrist, capacity specialist accredited training has been designed and delivered to community optometrists. Following implementation of this service, the trust evidenced a reduction in hospital referrals and the ability to increase outpatient activity resulting in reduced waiting time for appointments., In addition, there has been a reduction in the waiting time for cataract procedures to be performed and 95% of post cataract demand is now provided in the community whereby previously 100% of post cataract activity was provided in the hospital. The trust has stated this service has received national recognition.

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

- Overall the trust is making good progress with its collaborative working arrangements and progressing the development of a pathology network. In addition, work is progressing regarding the development of a strategic outline case document for the development of “hub and spoke” arrangements for non-urgent tests.
- The trust is using its clinical support services in an effective way to deliver high quality services for its patients. Its overall cost per test is £0.96 which places it in the highest (best) quartile nationally and below the median cost of £1.99. A large part of this success has been down to the trust’s attempts to reduce levels of unwarranted variation through, for example, reducing the number of allergy tests by requested 50%, the development of appropriate “prompts” in the laboratory’s information system to guide the number and types of tests required, and testing for biological drug therapies which supports a reduction in the use of high cost drug use.
- Whilst the trust’s overall cost per test benchmarks quite low, the trust’s cost per FTE benchmarks high at £47,673 in comparison to national median level of £46,103, however, the trust is aware of this and believe that an element of this was down to a percentage of their population which they serve not being included in the analysis (i.e. Darwen population).

- With regards to Imaging Services it was confirmed that the trust is in the process of developing more collaborative arrangements with neighbouring trusts through the development of a shared PACs service which would allow them to share images more easily. This should enable the trust to minimise / reduce any outsourcing costs.
- The trust is a positive outlier with regards to its medicines spend with a cost per WAU of £267 in comparison to a national median of £320. As part of the Top Ten Medicines Programme, the trust is making some progress in delivering on national identified savings opportunities, achieving 81% of the savings target which places the trust above the lower benchmark of 80% but below the upper benchmark of 100%. The end of year performance for 2017/18 saw an increase of this to 92%.
- The trust have achieved a 74% pharmacists clinical activity level in comparison to national median of 70% and the number of pharmacists actively prescribing on wards is 35% as compared to national median of 38%. The trust's investment in its ward-based pharmacy model has helped support improvements in wider operational productivity areas including, supporting a reduction in length of stay levels falling from between 1.4 – 2.2 days. Improvements have also been made with regards to the number of stockholding days reducing from 22 days (16/17 data), to 18 days at present.
- The trust are using technology in a number of innovative ways to improve operational productivity including, for example, the development of the trust's clinical and patient portals which help to support improved patient flow through the hospital; text reminders to patients to help reduce the number of outpatient DNAs; and also through the development "placental screening" which has seen a reduction in the number of still births rate falling from 40 down to 32 as a result of earlier scanning and better risk detections.

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

- For 2016/17, the trust had an overall non-pay cost per WAU of £1,118 which is below the national median of £1,301 and in the lowest (best) quartile nationally.
- The cost of running the trusts HR and Finance functions are lower than the national average. The trust's finance function cost of £453,927 per £100m turnover compares well against the national median of £670,510 per £100m, placing the trust in the lowest (best) quartile. However, there was an increase in the spend within the team from £2.1m to £3.2m between 2016/17 and 2017/18. The trust noted this was as a result in part of moving HR into the Finance function (there was a similar reduction in the HR spend over the same period); as well as additional investment being made by the trust on contract management arrangements in support of the PFI contract which is proving beneficial for the trust. For 2016/17, the trusts HR function cost per £100m turnover was £868,830 in comparison to national median of £874,010, placing the trust in the second lowest (best) quartile nationally.
- The trust is also working on a collaborative basis across its Integrated Care System (ICS) looking at the possibility of sharing a number of corporate service functions including HR, Finance and Informatics – a strategic outline case is being developed to support potential options.
- The trust is the lead partner for the shared procurement function of the Lancashire Procurement Cluster on behalf of Lancashire Teaching Hospitals NHS FT and Blackpool Teaching Hospitals NHS FT that was formed in November 2017. Model Hospital data published in 2016/17 was the catalyst which spurred improvements in

the function. Based on the work which has been done by the trust over the last 12 months, we expect the position to improve when the data is updated and published for 2017/18.

- Procurement CIP level of £1.37m was delivered in 17/18 against a target of £1.35m and a new target for 2018/19 has been set of £6.2m on behalf of all three trusts in the cluster. The trust is also actively using the PPIB tool to help them reduce price variations and secure the best price for products on behalf of the cluster. They are currently focusing on the top 100 products to target savings and will be then widening this to include the top 500 products. The function has attained a Level 1 accreditation level status and have had confirmation that some elements are achieving level 2 status.
- The trust has a strong and well performing Estates and Facilities Management service. At £214 per square metre, the trust's estates and facilities costs benchmark significantly below the national median of £351 per square metre and the trust has seen reductions in the level of its costs over the past 5 years. The trust noted this is in part down to having an effective Estates Strategy in place which has targeted the use of limited capital investment to the right areas, the decisions of which are monitored through the trust's Capital Planning Board on a regular basis.
- For 2016/17 the trust has a backlog maintenance cost of £89 per square metre. The trust was also able to demonstrate a methodological process for releasing buildings which were surplus to requirement, thereby further reducing backlog maintenance cost pressures.
- The trust's soft facility management (FM) costs of £92 per square metre also benchmark well against the national median of£116 per square metre; as does the trust's critical infrastructure risk with £29 per square metre compared to the national median of £75 per square metre.
- A CIP level has been agreed of £3m for the estates and facilities management function concentrating on the transformation of facilities.

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

- In 2017/18 the trust reported a surplus of £2.983m (0.6% of turnover) against a control total and plan of £863k deficit which represents a favourable variance of £3.846m. For 2018/19, the trust has accepted a control total of a £7.748m deficit, which they are on target to deliver at month 5. The trust financial plan moved from (£12.1m) in 2017/18 to (£15.8m) in 2018/19 to recognise operational pressures from operating multiple sites and the Private Finance Initiative estate.
- The trust has an ambitious cost improvement plan (CIP) of £18.0m (or 3.50% of its expenditure) and is currently forecasting to deliver against its plans. At month 5 the trust is planning 94% of its CIP to be delivered recurrently in 18/19. The trust delivered 135% of its planned savings in the previous financial year. However, 69% were non-recurrent and the trust recognises that it need to increase the proportion of CIP that is recurrent.
- The trust has relatively low cash reserves but through internal cash management initiatives is able to meet its financial obligations and pay its staff and suppliers in the immediate term, as reflected by its capital service (0.34 – May 2018) and liquidity (-9.30 days – May 2018) metrics.
- The trust issues Service Line Reports in addition to the budget statements on a monthly basis, reported throughout the trust at trust, divisional and specialty level.

The trust has recently invested in a new improved software system (PCG) to enable a better reporting at Patient level (PLICS) in the organisation.

- The trust is currently looking at the opportunity of employing nurses from overseas in partnership with UCLan Private Patients Service (PPS) as a way of supporting private patient income. At present the trust generates minimal private patient income and is looking to maximise various opportunities.
- The trust does not rely on management consultants and spend in 2017/18 was only £0.3m.

Outstanding practice

- The trust has developed an innovative workforce and service model was in relation to the Integrated Eye Service. The integrated service has resulted in eye care delivered in community healthcare facilities with a step-up/step-down ability between the community and hospital eye service. To address the limited ophthalmology workforce and increase utilisation of community optometrist, capacity specialist accredited training has been designed and delivered to community optometrists. Following implementation of this service, the trust evidenced a reduction in hospital referrals and the ability to increase outpatient activity resulting in reduced waiting time for appointments. In addition, there has been a reduction in the waiting time for cataract procedures to be performed and 95% of post cataract demand is now provided in the community whereby previously 100% of post cataract activity was provided in the hospital. The trust has stated this service has received national recognition.

Areas for improvement

We identified a number of areas of improvement for the trust:

- Staff sickness levels, at 4.7%, are above the national median of 4%. The trust noted this figure is currently rising despite interventions to support staff health and well-being.
- Whilst improving, DNA rates are high compared to the national average.
- Pre-procedure elective and non-elective bed days are both above the national average.
- Further work is required to address the higher than average cost per WAU for Nursing and AHP staff, although some of this is attributable to the running of community services.
- With regards to the Top Ten Medicines Programme, the trust are not using the benchmarking data available to them through ‘define’ to drive efficiencies. The trust needs to take advantage of all the benchmarking data available in order to identify and target opportunities to improve its use of resources.
- Increase the level of recurrent CIP that is delivered

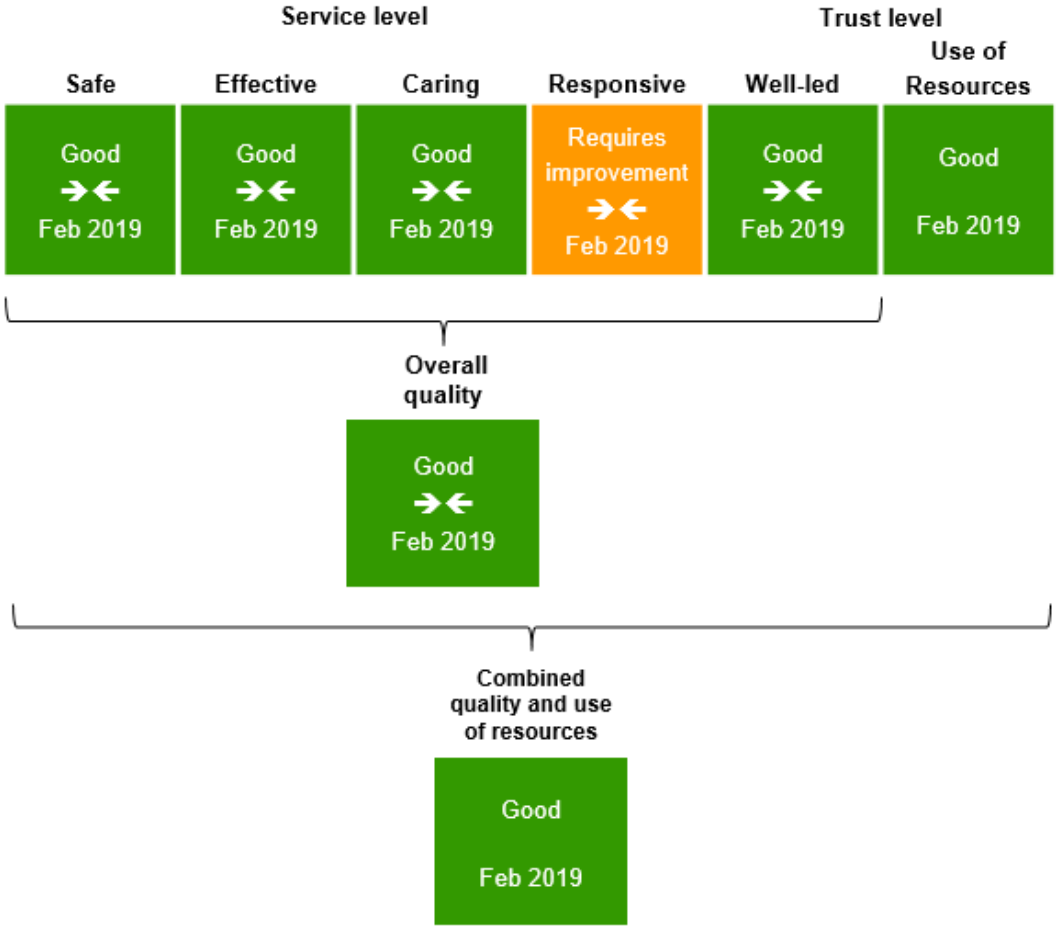
Ratings tables

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

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

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

Ratings for the whole trust



Use of Resources report glossary

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

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

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

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