Lancashire Teaching Hospitals NHS FT

Use of Resources assessment report

Royal Preston Hospital
Sharoe Green Lane, Fulwood
Preston
Lancashire
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Date of publication:
17 October 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/RXN/reports)

Are resources used productively?	**Requires improvement**

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 was rated as requires improvement for Use of Resources.
- We rated safe, effective, responsive and well-led as requires improvement and caring as good. We rated two of the trust's eight services as requires improvement and four services as good. In rating the trust, we took into account the current ratings of the two services not inspected this time.
- We rated well-led for the trust overall as requires improvement.
- Our ratings for Royal Preston Hospital and Chorley and South Ribble Hospital were both requires improvement which was the same as the last inspection
- Our ratings for urgent and emergency services and medical care, at both hospitals, were requires improvement which was the same as the last inspection.
- Our ratings for surgery and services for children and young people at Royal Preston Hospital were good which was an improvement from the last inspection. Our rating for surgery at Chorley and South Ribble Hospital was good which was the same as the last inspection.
- We previously inspected maternity jointly with gynaecology and outpatients jointly with diagnostic imaging so we cannot compare our previous ratings. We rated maternity and outpatients good at both hospitals.

NHS Improvement

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Date of site visit:
06 July 2018

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17 October 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.

Proposed rating for this trust?	**Requires improvement**

How we carried out this assessment

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

We visited the trust on 6th July 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?	Requires improvement

- We rated the trust's use of resources as requires improvement.
- The trust failed to balance its budget in 2017/18, reporting a deficit of £37.59 million. As of the first quarter, the trust is on track to achieve a deficit of £46.44 million in 2018/19.
- The trust is reliant on external loans to meet its financial obligations and deliver its services.
- For 2016/17 the trust had an overall pay cost per WAU of £2,231, above the national median of £2,157. This means that it spends more on staff per unit of activity than most trusts.
- For 2016/17, the trust had an overall non-pay cost per WAU of £1,256 which is below the national median of £1,301 and in the second lowest quartile nationally. This means the trust spends less on non-pay and 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 Did Not Attend (DNA) rates, Pathology Cost per Test, staff retention and the cost of corporate services; whilst opportunities for improvement were identified in Delayed Transfer of Care rates (DTOCs), staff sickness, pre-procedure length of stay (elective and non-elective) and backlog maintenance.
- We did, however, note two areas of outstanding practice:
    - The trust has developed a Specialist Respiratory Outreach Service and pathway for patients with a tracheostomy.
    - The trust has appointed mental health and learning disability practitioners in the acute setting to support patients with mental health problems or a learning disability who may present with a physical health need.

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 DNA rates, and has improved performance in others, such as Delayed Transfer of Care (DTOCs). However, the trust is performing worse than the median across a number of indicators, such as pre-procedure length of stay, and had not embedded the opportunities that GIRFT (Getting It Right First Time) presents.
- At the time of the assessment in July 2018, the trust was not meeting the constitutional operational performance standards around Referral to Treatment (RTT) (81.5% in April 18 v 92% target), Cancer (86.2% April 18 v 85% target) and Accident & Emergency (A&E) (83.2% May 18 v 95% target).

- Patients are less likely to require additional medical treatment for the same condition at this trust compared to other trusts. At 4.8%, emergency readmission rates are significantly below the national median of 7.2% 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 in March 18, the trust is in the second highest (worst) quartile and is above the median, 0.13, when compared nationally. The trust recognised this was a particular issue for Neurosciences patients and Vascular patients and is exploring innovative solutions, such as patient hotel facilities.
    - On pre-procedure non-elective bed days, at 1.13 in March 18, the trust is in the highest (worst) quartile and above the median, 0.80, when compared nationally. The trust recognised this was an issue and has a programme running over the next two years to look at emergency theatre and critical care capacity.
- The trust gave examples of services that were co-ordinated across the health economy, such as the Renal Services where they could demonstrate an increase in home dialysis. They also described the recently established CATCH service (Central Allocation Team for Care and Health), which works as part of the "Home First" offering, although this service is new, and the benefits are still being gathered.
- The Did Not Attend (DNA) rate for the trust is at 7.2% for March 2018, just under the national median of 7.3%. This has improved from 9.2% in 2016/17 following the implementation of a trust strategy around DNAs. The trust described areas of good practice, including targeted support for groups with higher rates of DNA, such as those with Learning Disabilities or Mental Health needs.
- The trust reports a delayed transfers of care (DTOC) rate of 7.79% in April 2018, which is higher than average and higher than the trust's own target rate of 3.5%. At the time of the inspection (July), the actual position was 5.8%, improving to 5.24% once validated. DTOC rates have been improving between July 2017 (11.5%) and April 2018 due to a concerted programme of work with all system partners. This included a number of events to allow a step change, along with an ongoing process of daily calls with all partners. In addition, the trust also described a shortening in the total days delayed for DTOC patients, with the longest delay standing at 20 days at the time of the inspection. This reduction in DTOC has allowed the trust to remove the additional beds that it had open over the winter period, with 70 beds being removed. It was noted that the percentage of DTOC attributed to social care has dropped from 72% in July 2017 to 35.2% in April 2018.
- The trust recognised that it did not yet have a robust programme in place to complete the actions following the GIRFT visits. The Medical Director is the executive lead, and will be looking to follow the Plymouth model of implementation, which the trust has identified as best practice. The Orthopaedic action plan has been better developed than others, with the department working with procurement to standardise and reduce stock.

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 £2,231, above the national median of £2,157. This means that it spends more on staff per unit of activity than most trusts.
- The trust is in the second lowest (best) quartile for Medical cost per WAU (£506 compared to a national median of £526), although it benchmarks in the second highest (worst) quartile for Allied Health Professionals (AHPs) cost per WAU (£132 compared to a national median of £127) and Nursing cost per WAU (£737 compared to a national median of £718).
- The trust has an agency cost per WAU of £93 which is better the national median of £137.
- The trust did not meet its agency ceiling as set by NHS Improvement for 2017/18 but is forecasting to meet its ceiling in 2018/19. It is, however, spending less than the national average on agency as a proportion of total pay spend. It achieved reductions in the cost of agency and locum staff through the use of a collaborative staff bank.
- The trust has increased the fill rate for its nurse bank from 34% to 62% over the last 12 months. In relation to medical bank, 52% of eligible medical workforce have now registered which has delivered savings of about £100,000 per month.
- Staff sickness levels, at 5.36%, are above the national median of 4.38%. The trust noted short term sickness was more of a concern than long term sickness. We saw evidence that a number of reviews on sickness absence had been undertaken and leadership regarding robust sickness management was a theme emerging from these. The trust has improved lines of accountability in relation to sickness management and has developed action plans with specific key performance indicators for areas with higher sickness rates. However, it was too early to see significant improvement as a result of this.
- The trust has implemented several measures to support staff returning to work following a period of absence or attempt to prevent a period of sickness. These include holistic interventions such as mindfulness sessions and Schwartz rounds (a structured forum where all staff, clinical and non-clinical, come together regularly to discuss the emotional and social aspects of working in healthcare). The trust also provides resilience training for staff and offers mental health support.
- Staff retention at 89.4% is above the national median of 85.6%, placing it in the lowest (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 have had difficulty recruiting.
- The trust has also introduced a dual consultant role to attract and support the development of potential consultants in other areas of practice. The trust described one such role between Emergency Medicine and Critical Care.

- The trust described how it was reviewing traditional nursing models to adapt these to include therapists and other AHPs to support care delivery.
- All consultants have a job plan; however, the trust acknowledged a review of these job plans was required as it was not clear how stretching these were and not all were aligned to “CAM”, the trust’s clinical activity management system.
- Two areas of notable outstanding practice were:
    - The trust has developed a Specialist Respiratory Outreach Service and pathway for patients with a tracheostomy. The service was established as there are increasing numbers of people surviving neurological injury who require a tracheostomy. Many of these people are discharged into the community with the assumption that this respiratory support will be permanent, although with optimal specialist care and review, many can be removed (decannulated). The trust reported that most people who are discharged from an acute hospital or rehabilitation facility with a tracheostomy previously did not receive any follow up or assessment for potential decannulation. Their care needs were maintained through complex packages of care and there was a lack of skilled clinical teams within the community to assess potential for decannulation or provide specialist support for the teams caring for the individual. As well as the quality improvements for patients, the trust reported savings of over £450k for the pilot phase of the service when working with 6 patients. In addition, a further 12 patients had been identified, with potential savings of over £500k, for work through the next 12-month period.
    - The trust also described the appointment of mental health and learning disability practitioners in the acute setting to support patients with mental health problems or a learning disability who may present with a physical health need. The trust were able to describe the positive experience of a number of families who had been supported by these practitioners. The trust provided case studies to articulate how these practitioners have been used to prepare patients for admission to hospital prior to a procedure and to coordinate any further support the patients required prior to attending hospital.

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

- The trust clearly recognises the fundamental importance of clinical support services in delivering high quality care, which is reflected in good performance against a range of metrics and the plans for a pathology collaborative.
- The overall cost per pathology test is £1.70, which is in the second lowest (best) quartile nationally. The trust is developing plans to network pathology services with other trusts locally and a governance structure has been set up to oversee this. The trust has introduced point of care pathology testing in areas such as the Emergency Department and Ambulatory Care, which has enabled it to rapidly identify the best way to treat patients which has positively influenced admission rates and bed occupancy.

- The trust has formed a pathology collaborative with nearby trusts and has initiatives in place to address the national shortage of radiographers by working with Health Education England and Lancashire University.
- The trust's medicines cost per WAU at £348 is higher than the national average of £320. As part of the Top Ten Medicines programme, the trust's medicine procurement manager works closely with clinical teams to make sure the best value medicines are used and arrangements are in place to resolve any potential issues that may prevent this. The trust is making good progress in delivering nationally identified savings opportunities, achieving 121% of the savings target in 2017/18.
- The trust has implemented an Electronic Prescribing and Medicines Administration system on four wards and continues to roll this out. Similar systems are being adopted by trusts across the country and learning here can be shared with others.
- The trust holds low levels of drugs in stock but there are still some opportunities to improve in antibiotic consumption, e-commerce ordering, % of pharmacists actively prescribing and Sunday on ward clinical pharmacy hours.
- The trust scores well on the national digital maturity index and cited examples of using technology in innovative ways to improve its productivity which included paperless critical care services, the Lancashire patient record exchange, virtual fracture clinics, Skype enabled clinics and electronic discharge summaries and operation notes.

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

- The trust performs well across the full range of corporate, procurement, estates and facilities metrics. However, the significant level of backlog maintenance is a concern given the potential risk to delivering high quality care and suggest estates and facilities expenditure is too low and should be reviewed by the trust.
- For 2016/17, the trust had an overall non-pay cost per WAU of £1,256 which is below the national median of £1,301 and in the second lowest (best) quartile nationally. However, within this there are areas, such as supplies and services, medicines and clinical negligence and purchased healthcare where the trust is above the national median.
- The trust collaborates on a range of corporate functions and the cost of running its Finance (£479,040 per £100m turnover) and Human Resources (£561,656 per £100m turnover) departments are both lower than the national average and in the lowest (best) quartile nationally. Within areas where the trust appears to be efficient, such as recruitment and occupational health, the trust must assure itself that outcomes such as recruitment time and staff sickness rates are not adversely affected, which may lead to decreased productivity overall. Spend on Information Management and Technology is below the national average, but within this there are areas of spend, such as data centre costs, where the trust is above the national average and where efficiency opportunities may lie.
- The trust's cost of supplies and services is £404 per WAU, which is above the national median of £375. The trust reports that this is the result of a conscious decision to invest in a stock inventory management system that improves its ability to identify and manage its inventory. The material management team plan to use the system to reduce inventory

holdings by 10% which will be equivalent to circa £600,000. The trust is part of a procurement collaboration with East Lancashire Hospitals NHS Trust and Blackpool Teaching Hospital NHS Foundation Trust and is purchasing at scale to deliver efficiencies.

- The trust uses the Purchase Price Index Benchmarking tool; however, data shows that the trust is above the national average for the top 100 products purchased nationally and the trust's Procurement Process Efficiency and Price Performance Score is 51.1, which places it above peers (47.8) but below the national benchmark (79.0).
- At £243 per square metre in 2016/17, the trust's estates and facilities costs are in the lowest (best) quartile nationally. However, 2016/17 data also showed that the trust had high levels of backlog maintenance at £189 per square metre and critical infrastructure risk of £121 per square metre, which is the 7th highest nationally. The trust board recognises that there are significant risks around the condition of its estate and its ability to invest sufficient amounts in maintenance to constrain further growth in backlog maintenance and critical infrastructure risk.
- Data showed that in 2016/17 the trust had 37.4% non-clinical space, which was higher than its peers and the recommended benchmark of 35%. The trust reported that it has looked to improve this metric through the leasing of some of its estate to other organisations, although it does still fall short of the 35% benchmark.

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

- The trust has a significant deficit and is unable to manage spending within available resources. The trust did not deliver its financial plan in 2017/18 and does not have a plan to return to financial balance. The trust has agreed with NHS Improvement that a Sustainability Plan will be submitted in October 2018.
- In 2017/18 the trust reported a deficit of £37.590m (8.01% of turnover) against a control total and plan of £7.766m deficit which represents an adverse variance of £29.824m. For 2018/19, the trust was set a control total deficit of £1.037m but was unable to accept this and is planning a deficit of £46.441m (9.85% of turnover), which it is on target to meet as at quarter 1.
- The trust has an ambitious cost improvement plan (CIP) of £25.0m (or 4.60% of its expenditure) and is currently forecasting to deliver against its plans. The trust delivered 59% of its planned savings in the previous financial year, of which 61% were non-recurrent.
- In 2017/18, 63% of the CIP plan was delivered non-recurrently and in 2015/16, the corresponding figure was 75%. In 2018/19, the trust is planning for a CIP of £25m, of which £22m (88%) is planned to be delivered recurrently. As at month 2, the trust has delivered £11m of savings.
- The trust has negative cash reserves and is reliant on short term borrowing to meet its financial obligations and pay its staff and suppliers in the immediate term, as reflected by its capital service (-2.48) and liquidity (-27.7 days) metrics.
- The trust produces quarterly Service Line Reporting (SLR) and has adopted the Costing Transformation Programme (CTP) costing standards. The trust described several real-life examples of where they have used SLR data to make informed business decisions which

have resulted in increased income through better coding and a reduction in length of stay in Neurosurgery.

Outstanding practice

- The trust has developed a Specialist Respiratory Outreach Service and pathway for patients with a tracheostomy. The service was established as there are increasing numbers of people surviving neurological injury who require a tracheostomy, and many of these are discharged into the community with the assumption that this respiratory support will be permanent, although with optimal specialist care and review many can be removed (decannulated). As well as the quality improvements for patients, the trust reported savings of over £450k for the pilot phase of the service when working with 6 patients.
- The trust described the appointment of mental health and learning disability practitioners in the acute setting to support patients with mental health problems or a learning disability who may present with a physical health need. The trust provided case studies to articulate how these practitioners have been used to prepare patients for admission to hospital prior to a procedure and have been used to coordinate any further support the patients required prior to attending hospital.

Areas for improvement

There are a number of areas that the trust recognised needed further development in order to realise efficiencies:

- The trust needs to develop a plan to return to financial balance and remove the requirement for borrowing to meet its financial obligations.
- The trust relied on significant levels of non-recurrent savings, 63% in 2017/18.
- Pre-procedure length of the stay for elective and non-elective are a significant outlier and present an opportunity for the trust to improve productivity.
- Whilst improving, Delayed Transfers of Care are above the national average.
- The GIRFT recommendations are not being embedded and becoming business as usual.
- Sickness absence rates are significantly above the national average.
- Nursing Pay Cost per WAU is high. The trust recognises this and believes that this is linked to length of stay which is a clear area of clinical productivity gain, suggesting that this needs to be an area of continued focus.

- The trust has high levels of backlog which requires urgent review given the risk to delivering high quality care and the impact of operational performance and patient flow.

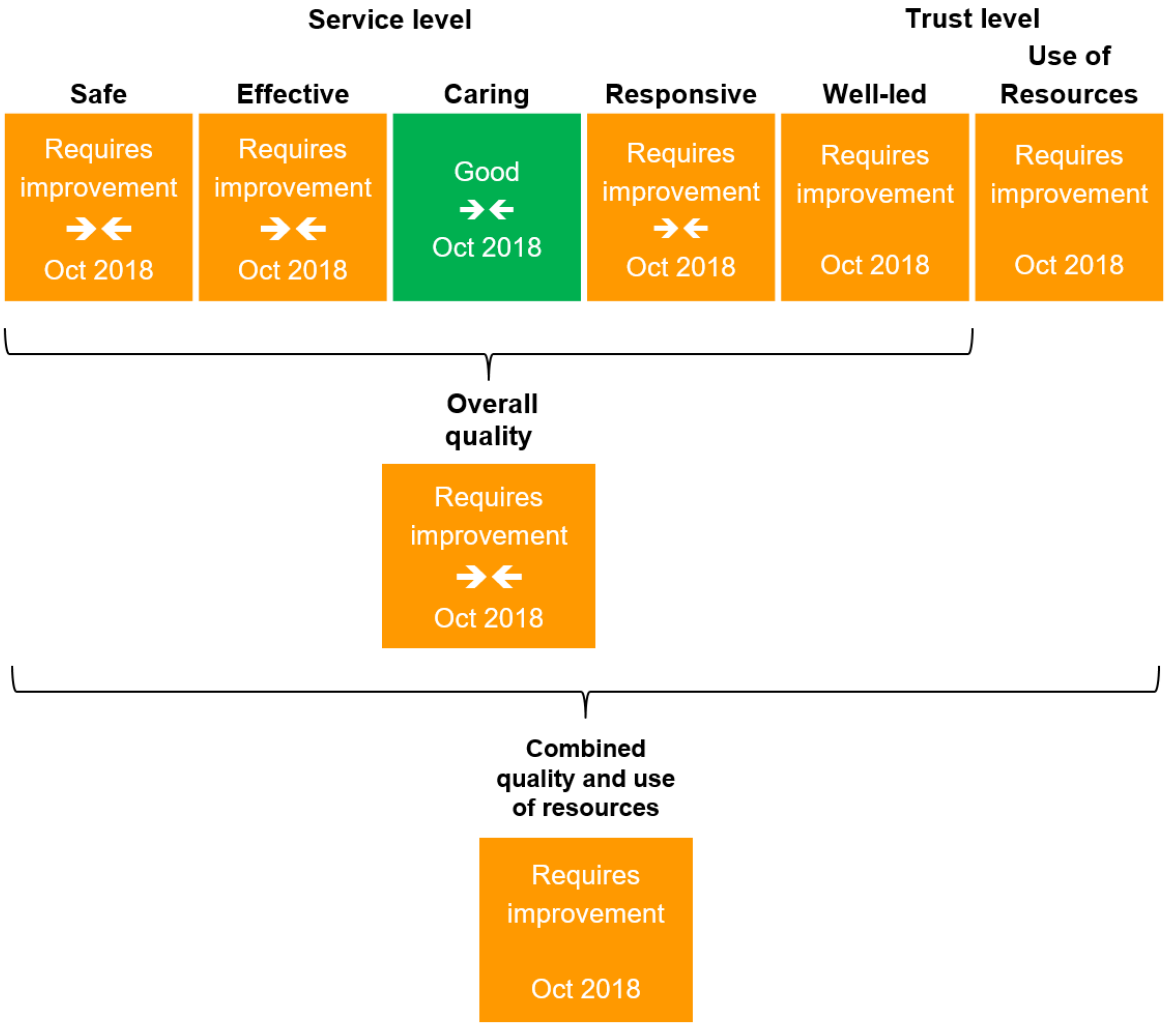
Ratings tables

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

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

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

Ratings for the whole trust



Use of Resources report glossary

Term	Definition
18-week referral to treatment target	According to this national target, over 92% of patients should wait no longer than 18 weeks from GP referral to treatment.
4-hour A&E target	According to this national target, over 95% of patients should spend four hours or less in A&E from arrival to transfer, admission or discharge.
Agency spend	Over reliance on agency staff can significantly increase costs without increasing productivity. Organisations should aim to reduce the proportion of their pay bill spent on agency staff.
Allied health professional (AHP)	The term ‘allied health professional’ encompasses practitioners from 12 diverse groups, including podiatrists, dietitians, osteopaths, physiotherapists, diagnostic radiographers, and speech and language therapists.

AHP cost per WAU	This is an AHP specific version of the pay cost per WAU metric. This allows trusts to query why their AHP pay is higher or lower than national peers. Consideration should be given to clinical staff mix and clinical staff skill mix when using this metric.
Biosimilar medicine	A biosimilar medicine is a biological medicine which has been shown not to have any clinically meaningful differences from the originator medicine in terms of quality, safety and efficacy.
Cancer 62-day wait target	According to this national target, 85% of patients should begin their first definitive treatment for cancer within 62 days following an urgent GP referral for suspected cancer. The target is 90% for NHS cancer screening service referrals.
Capital service capacity	This metric assesses the degree to which the organisation's generated income covers its financing obligations.
Care hours per patient day (CHPPD)	CHPPD measures the combined number of hours of care provided to a patient over a 24 hour period by both nurses and healthcare support workers. It can be used to identify unwarranted variation in productivity between wards that have similar speciality, length of stay, layout and patient acuity and dependency.
Cost improvement programme (CIP)	CIPs are identified schemes to increase efficiency or reduce expenditure. These can include recurrent (year on year) and non-recurrent (one-off) savings. CIPs are integral to all trusts' financial planning and require good, sustained performance to be achieved.
Control total	Control totals represent the minimum level of financial performance required for the year, against which trust boards, governing bodies and chief executives of trusts are held accountable.
Diagnostic 6-week wait target	According to this national target, at least 99% of patients should wait no longer than 6 weeks for a diagnostic procedure.
Did not attend (DNA) rate	A high level of DNAs indicates a system that might be making unnecessary outpatient appointments or failing to communicate clearly with patients. It also might mean the hospital has made appointments at inappropriate times, eg school closing hour. Patients might not be clear how to rearrange an appointment. Lowering this rate would help the trust save costs on unconfirmed appointments and increase system efficiency.
Distance from financial plan	This metric measures the variance between the trust's annual financial plan and its actual performance. Trusts are expected to be on, or ahead, of financial plan, to ensure the sector achieves, or exceeds, its annual forecast. Being behind plan may be the result of poor financial management, poor financial planning or both.
Doctors cost per WAU	This is a doctor specific version of the pay cost per WAU metric. This allows trusts to query why their doctor pay is higher or lower than national peers. Consideration should be given to clinical staff mix and clinical staff skill mix when using this metric.

Delayed transfers of care (DTOC)	A DTOC from acute or non-acute care occurs when a patient is ready to depart from such care is still occupying a bed. This happens for a number of reasons, such as awaiting completion of assessment, public funding, further non-acute NHS care, residential home placement or availability, or care package in own home, or due to patient or family choice.
EBITDA	Earnings Before Interest, Tax, Depreciation and Amortisation divided by total revenue. This is a measurement of an organisation's operating profitability as a percentage of its total revenue.
Emergency readmissions	This metric looks at the number of emergency readmissions within 30 days of the original procedure/stay, and the associated financial opportunity of reducing this number. The percentage of patients readmitted to hospital within 30 days of discharge can be an indicator of the quality of care received during the first admission and how appropriate the original decision made to discharge was.
Electronic staff record (ESR)	ESR is an electronic human resources and payroll database system used by the NHS to manage its staff.
Estates cost per square metre	This metric examines the overall cost-effectiveness of the trust's estates, looking at the cost per square metre. The aim is to reduce property costs relative to those paid by peers over time.
Finance cost per £100 million turnover	This metric shows the annual cost of the finance department for each £100 million of trust turnover. A low value is preferable to a high value but the quality and efficiency of the department's services should also be considered.
Getting It Right First Time (GIRFT) programme	GIRFT is a national programme designed to improve medical care within the NHS by reducing unwarranted variations.
Human Resources (HR) cost per £100 million turnover	This metric shows the annual cost of the trust's HR department for each £100 million of trust turnover. A low value is preferable to a high value but the quality and efficiency of the department's services should also be considered.
Income and expenditure (I&E) margin	This metric measures the degree to which an organisation is operating at a surplus or deficit. Operating at a sustained deficit indicates that a provider may not be financially viable or sustainable.
Key line of enquiry (KLOE)	KLOEs are high-level questions around which the Use of Resources assessment framework is based and the lens through which trust performance on Use of Resources should be seen.
Liquidity (days)	This metric measures the days of operating costs held in cash or cash equivalent forms. This reflects the provider's ability to pay staff and suppliers in the immediate term. Providers should maintain a positive number of days of liquidity.
Model Hospital	The Model Hospital is a digital tool designed to help NHS providers improve their productivity and efficiency. It gives trusts information on key performance

	metrics, from board to ward, advises them on the most efficient allocation of resources and allows them to measure performance against one another using data, benchmarks and good practice to identify what good looks like.
Non-pay cost per WAU	This metric shows the non-staff element of trust cost to produce one WAU across all areas of clinical activity. A lower than average figure is preferable as it suggests the trust spends less per standardised unit of activity than other trusts. This allows trusts to investigate why their non-pay spend is higher or lower than national peers.
Nurses cost per WAU	This is a nurse specific version of the pay cost per WAU metric. This allows trusts to query why their nurse pay is higher or lower than national peers. Consideration should be given to clinical staff mix and clinical staff skill mix when using this metric.
Overall cost per test	The cost per test is the average cost of undertaking one pathology test across all disciplines, taking into account all pay and non-pay cost items. Low value is preferable to a high value but the mix of tests across disciplines and the specialist nature of work undertaken should be considered. This should be done by selecting the appropriate peer group ('Pathology') on the Model Hospital. Other metrics to consider are discipline level cost per test.
Pay cost per WAU	This metric shows the staff element of trust cost to produce one WAU across all areas of clinical activity. A lower than average figure is preferable as it suggests the trust spends less on staff per standardised unit of activity than other trusts. This allows trusts to investigate why their pay is higher or lower than national peers.
Peer group	Peer group is defined by the trust's size according to spend for benchmarking purposes.
Private Finance Initiative (PFI)	PFI is a procurement method which uses private sector investment in order to deliver infrastructure and/or services for the public sector.
Patient-level costs	Patient-level costs are calculated by tracing resources actually used by a patient and associated costs
Pre-procedure elective bed days	This metric looks at the length of stay between admission and an elective procedure being carried out – the aim being to minimise it – and the associated financial productivity opportunity of reducing this. Better performers will have a lower number of bed days.
Pre-procedure non-elective bed days	This metric looks at the length of stay between admission and an emergency procedure being carried out – the aim being to minimise it – and the associated financial productivity opportunity of reducing this. Better performers will have a lower number of bed days.
Procurement Process Efficiency and Price Performance Score	This metric provides an indication of the operational efficiency and price performance of the trust's procurement process. It provides a combined score of 5 individual metrics which assess both engagement with price benchmarking (the process element) and the prices secured for the goods purchased compared to other trusts (the performance element). A high score indicates that the procurement function of the trust is efficient and is performing well in securing the best prices.

Sickness absence	High levels of staff sickness absence can have a negative impact on organisational performance and productivity. Organisations should aim to reduce the number of days lost through sickness absence over time.
Service line reporting (SLR)	SLR brings together the income generated by services and the costs associated with providing that service to patients for each operational unit. Management of service lines enables trusts to better understand the combined view of resources, costs and income, and hence profit and loss, by service line or speciality rather than at trust or directorate level.
Supporting Professional Activities (SPA)	Activities that underpin direct clinical care, such as training, medical education, continuing professional development, formal teaching, audit, job planning, appraisal, research, clinical management and local clinical governance activities.
Staff retention rate	This metric considers the stability of the workforce. Some turnover in an organisation is acceptable and healthy, but a high level can have a negative impact on organisational performance (eg through loss of capacity, skills and knowledge). In most circumstances organisations should seek to reduce the percentage of leavers over time.
Top Ten Medicines	Top Ten Medicines, linked with the Medicines Value Programme, sets trusts specific monthly savings targets related to their choice of medicines. This includes the uptake of biosimilar medicines, the use of new generic medicines and choice of product for clinical reasons. These metrics report trusts' % achievement against these targets. Trusts can assess their success in pursuing these savings (relative to national peers).
Weighted activity unit (WAU)	The weighted activity unit is a measure of activity where one WAU is a unit of hospital activity equivalent to an average elective inpatient stay.