Manchester University NHS Foundation Trust

Use of Resources assessment report

Address
Cobbett House
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Date of publication: 23 April 2019

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

Ratings

Overall quality rating for this trust	**Good** ●
Are services safe?	**Good** ●
Are services effective?	**Good** ●
Are services caring?	**Outstanding** ☆
Are services responsive?	**Good** ●
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/RW3/reports)

Are resources used productively?	**Good** ●

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

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.

The trust was rated Good for use of resources. Full details of the assessment can be found on the following pages.

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30 January 2019

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This report describes NHS Improvement's assessment of how effectively this trust uses its resources. It is based on a combination of data on the trust's performance over the previous 12 months, our local intelligence, the trust's commentary on its performance, and qualitative evidence collected during a site visit comprised of a series of structured conversations with the trust's leadership team.

Are resources used productively?	**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 30 January 2019 and met the trust's leadership team including the chief executive and the chair, as well as relevant senior management responsible for the areas under this assessment's KLOEs.

Findings

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

- We rated the trust's use of resources as Good.
- At the time of the assessment, the trust was 15 months into a post-merger integration process and has delivered a number of early benefits and efficiency gains, such as: the standardisation of prosthesis and reduced Length of Stay in stroke rehabilitation. The trust have established a clear strategy and methodology for more significant service changes in years 2 and 3 which are likely to improve productivity further.
- The trust balanced its budget in 2017/18, reporting a surplus of £7.2 million excluding Sustainability and Transformation Funding (STF) for the final six months of the year from 1 October 2017 when the trust was established. This was £8.2 million better than the 2017/18 plan. When including STF, the surplus was £29.3 million. For 2018/19, at month 10, the trust is forecasting to a deficit of £2.1 million, which is £10.0 million better than the control total. When including Provider Sustainability Funding (PSF), the surplus is £39.4 million.
- As at month 10, the trust is forecasting to achieve savings of £43.9 million of in year savings which represents 2.6% of expenditure and of which, 83% of these savings are recurrent savings.
- The trust is not reliant on external loans to meet its financial obligations and deliver its services.
- For 2017/18, the trust had an overall cost per Weighted Activity Unit (WAU) of £3,694, compared with a national median of £3,486.
- The trusts pay cost per WAU for 2017/18, at £2,113, is below the national median of £2,180. This means trust spends less on pay per unit of activity than most other trusts nationally. However, the trusts non-pay cost per WAU, at £1,582 is above the national median of £1,307. This means the trust spends more on other goods and services per WAU then most other trusts nationally.
- At the time of the assessment, the trust was not meeting the operational performance standards for Referral to Treatment (RTT), Cancer and Accident & Emergency (A&E).
- Individual areas where the trust's productivity compared particularly well included emergency readmission rates, pay cost per WAU, corporate services and procurement. Opportunities for improvement were identified in clinical productivity, DNA rates, sickness absence and estates and facilities.
- The trust was able to demonstrate it had embraced the use of innovative workforce models including, being selected by Health Education England as an implementor site for the Nursing Associate role and securing funding for the development of new Allied Health Professional (AHP) apprenticeships within Greater Manchester (GM).
- The trust evidence the effective use of technology throughout the organisation, in particular through the innovative approach to virtual clinics whereby, using kinetic technology, games are used for exercise and patients can track their rehabilitation progress.

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

- At the time of the assessment in January 2019, the trust was not meeting the constitutional operational performance standards around Referral to Treatment (RTT), Cancer and Accident & Emergency (A&E).
- Patients are less likely to require additional medical treatment for the same condition at this trust compared to other trusts. At 7.28%, emergency readmission rates are in the lowest (best) quartile and significantly below the national median of 9.06% for quarter 2 2018/19.
- More patients are coming into hospital unnecessarily prior to treatment compared to most other hospitals in England.
    - On pre-procedure elective bed days, at 0.37, the trust is performing in the highest (worst) quartile and above the national median of 0.12. The trust noted this is in part due to the specialist services it provides and the requirement for longer work up times for these services, for example, transplant services.
    - On pre-procedure non-elective bed days, at 0.84, the trust is performing in the highest (worst) quartile and above the national median of 0.65. The trust has been working on transformation plans to improve access to emergency theatres in 1819.
- With a view to improving productivity, the trust is taking a lead role in co-ordinating services across the health and care community, including the development of a Local Care Organisation (LCO) which will create a vertically integrated system offering primary, community, mental health and acute care. Whilst still early in development, the trust is already reporting that the LCO's community response team has been responsible for a decrease in Length of Stay of 5 days. A pilot High Impact Primary Care service has reduced acute demand by up to 60% for the cohort involved.
- The Did Not Attend (DNA) rate for the trust for quarter 2 2018/19 is high at 9.28% compared with a national median of 7.32%. The trust reported that DNA rates are higher in several of the central campus hospitals, with highest opportunities for reduction in Ophthalmology, Gastroenterology, Cardiology and Gynaecology. Whilst the trust reports that some DNA rates are comparable to specialist hospital peers, it is recognised as an area for improvement. The trust demonstrated it has rolled out text reminder services and have introduced measures such as patient pager systems to improve the experience for outpatients.
- The trust has introduced virtual orthopaedic clinics which they were able to demonstrate had led to the avoidance of circa 900 face to face outpatient appointments per annum. In addition, virtual physiotherapy clinics have been introduced aided by kinetic sensors which allows patients to perform exercises using games and track the rehabilitation process. The trust noted this is expected to reduce the number of standard physiotherapy sessions.
- The trust reports a delayed transfers of care (DTOC) rate, at 3.8% in December 2018, that is slightly below the national average but higher than the trust's own target rate. DTOC rates have shown a slight improvement between January 2018 and December 2018, with specific improvements attributed to the integrated discharge team established on the Wythenshawe hospital site. Despite examples of length of stay reductions attributable to initiatives such as ERAS+ or intervention by the Local Care Organisation, the trust have not been successful at reducing stranded patient numbers significantly and cancellations of elective surgery to support urgent care flow remain at similar levels to previous years.
- The trust was able to demonstrate how the Getting It Right First Time (GIRFT) programme has been embedded in clinical governance architecture, with each hospital site having its own GIRFT forum and executive leadership from the Medical Director. The trust has incorporated the findings of these reports into speciality 'opportunity packs' which are informing and providing focus for the post-merger clinical integration process. The trust provided specific examples of where recommendations have led to productivity

improvements, such as prosthesis standardisation and introduction of new ambulatory general surgery pathways.

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

- For 2017/18 the trust had an overall pay cost per WAU of £2,113, compared with a national median of £2,180, placing it in the second lowest (best) quartile nationally. This means that it spends less on staff per unit of activity than most other trusts. The trust is in the lowest quartile for Medical cost per WAU (£457 compared with national median of £533) and in the second lowest (best) quartile for Nursing cost per WAU (£690 compared with national median of £710) and Allied Health Professional (AHP) cost per WAU (£113 compared with national median of £130).
- The trust is not within its agency ceiling as set by NHS Improvement. However, it is spending less than the national average on agency as a proportion of total pay spend. The trusts agency cost per WAU is £44 compared to a national median of £107 and placing the trust in the lowest (best) quartile and with the 11th best agency cost per WAU nationally. The trust noted a number of specialties, including dermatology and ophthalmics, as the highest areas of agency spend.
- The trust explained it has a site-based approach to manging agency spend and has been working with each hospital site to review each agency worker and coming up with an exit strategy. The trust is in partnership with NHS Professionals (NHSP) for nursing staff and has also worked in collaboration with several other trusts who use NHSP to agree set rates of pay.
- The trust has had Nursing e-rostering in place for nearly six years. This is well established and is the only rostering tool used for the nursing and midwifery staff group. In addition, Health Care Assistants (HCAs) are on these rosters, as well as Advanced Nurse Practitioners (ANPs), matrons and specialist nurses, and theatre practitioners. Rosters are published 4-6 weeks in advance in line with the Duty Rostering Policy; this is regularly monitored as part of monthly Key Performance Indicator reporting.
- The trust has licenses to rollout Health Roster to AHPs with a view to begin this work in 2019. E-rostering for medical staff has been rolled out across the Wythenshawe campus (formerly UHSM), with most areas now live for a year. Licenses were more recently acquired for the Oxford Road Campus (formerly CMFT) with plans to begin implementation of the rostering software in March 2019.
- The trust noted it has experienced challenges with nurse and midwife recruitment. At the time of the assessment there was a vacancy rate of 13.5% for band 5 and band 6 nurses and midwifes. The trust explained it undertakes international recruitment and recruitment campaigns as well as undertaking monthly Skype interviews. The trust described some success with international recruitment with 236 nurses employed over the past 2 years and a further 60 nurses due to commence in post before the end of 2018/19.
- The trust was able to demonstrate it has embraced the Nursing Associate role and was selected by Health Education England to be an implementer site to develop the role over the next two years. The trust currently has 221 trainee nurse associates with 81 scheduled to qualify in February 2019, all of whom have been appointed into a position. In addition, the trust also described how they had secured funding to develop new AHP apprenticeship roles and are currently in the process of designing a level 5 AHP associate foundation degree apprenticeship and a level 3 AHP apprenticeship.
- 96% of consultants have a job plan. This equates to 1,102 consultants out of 1,144. The trust noted it is currently exploring team job planning as a method to drive efficiencies.

- Staff retention at the trust is good, with a retention rate of 88.52% in November 2018. The trust noted it has achieved this through a continued focus on staff engagement and wellbeing. The trust has introduced several schemes including 12 hour shifts to support staff, and rehydration stations to ensure staff remain hydrated throughout their working day.
- At 4.9% in September 2018, staff sickness rates are worse than the national average of 4.0%. The trust explained it has developed a new model for health and wellbeing which is designed to provide increased support for staff, which includes the introduction of Schwartz rounds and a mindfulness week two times a year. The trust have also developed an application which can signpost staff to specific support, resilience training and 24-hour access to staff support services.

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 against a range of metrics and the investment in systems and collaborative working.
- For pathology, the overall cost per test for the trust is £3.99 (2017/18) against a national median of £1.91, placing the trust in the highest (worst) quartile. However, the trust noted this higher cost per test is due to the specialist nature of the tests they provide and due to providing tests in Greater Manchester (GM) and the North West for a number of tertiary hospitals and Clinical Commissioning Groups (CCGs).
- The trust was able to demonstrate plans to reduce the overall cost per test through the implementation of a Total Laboratory Automation system in microbiology to support activity and analysis. The trust noted it is also in the process of integrating microbiology laboratories across the 4 sites. In addition, the trust have implemented an Integrated Clinical Environment (ICE) through which a system highlights any previous test results in order to reduce the number of repeat tests undertaken.
- The trust is working collaboratively with the Greater Manchester Pathology Network to continue to implement the recommendations from the Carter Review into operational productivity in the NHS of a hub and spoke delivery model at scale. The trust is actively engaged in this programme both at a local delivery level and at the Network.
- With regards to imaging, the trust is engaged with the Greater Manchester Imaging Group and demonstrated it is influential in further development and opportunities to collaborate at scale. As at March 2018, the trust benchmarks in the second lowest (best) quartile for x-ray reports by radiographer, with Central Manchester NHS Foundation Trust at 21.3% and South Manchester NHS Foundation Trust at 23.4%, when compared with the national median of 24.7%.
- There is limited to no home reporting by Radiologists and the trust recognised this as an area for improvement and has developed an improvement plan for efficient reporting, additional capacity and working with HR on recruitment.
- As part of the Top Ten Medicines programme, the trust is making good progress in delivering on nationally identified savings opportunities. Due to nature of the data available at the time of the assessment, the pharmacy metrics are separated into the two previous trusts pre-merger. As at March 2018 Central Manchester NHS Foundation Trust had achieved 107% of the savings target and South Manchester NHS Foundation Trust had achieved 116% of the savings target. With regards to biosimilars, the trust has made good progress in implementing switching opportunities where possible.

- The trust demonstrated they are taking opportunities to collaborate on pharmacy and are a lead player within the Pharmacy and Medicines Optimisation oversight group across the GM partnership.
- The trust was able to demonstrate effective use of technology in innovative ways to improve productivity, including the implementation of automated drug cabinets, total laboratory automation in microbiology and development of an application to support staff morale. The trust have also introduced virtual clinics including virtual physiotherapy clinics aided by kinetic technology which allow patients to use games for exercise and track their rehabilitation progress.

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 services, procurement, and estates and facilities, with a few areas for improvement outlined below. The trust is an integral part of the Greater Manchester Partnership for the Procurement services and Corporate Services.
- For 2017/18, the trust has a non-pay cost per WAU of £1,582 against a national median of £1,301 which places the trust in the highest (worst) quartile. This indicates the trust spends more on other goods and services per WAU than most other trusts nationally.
- The cost of running its Finance and Human Resources (HR) departments are lower than the national average placing the trust in the lowest (best) quartile for both metrics. For 2017/18, the trust has a finance cost per £100 million turnover of £541,015 which is below the national median of £676,480. For the same period, the trust has a HR function cost of £520,498 per £100m turnover compared to a national median of £898,020.
- For 2017/18, the trust had an IM&T function cost of £1.7 million per £100m turnover compared to a national median of £2.47 million.
- The trust's procurement processes are efficient and tend to successfully drive down costs on the things it buys. This is reflected in the trust's Procurement Process Efficiency and Price Performance Score of 79.5, which places it in the highest (best) quartile nationally.
- The trust performs well against all procurement metrics including a PPIB usage score of 93.8 compared to a national median of 52.1; % of non-pay spend in PPIB at 55.3% compared to a national median of 20.3%; and a procurement cost per £100m turnover of £166,010 compared to a national median of £206,250. The trust is also ranked number 1 in the National Procurement League Table.
- The trust has a single finance and procurement system that underpins a single Manchester University Hospital FT Procurement plan. This includes best practice service standardisation across the group which is demonstrated in them being the first trust to achieve Level 2 National Procurement Standards (framework for consistent approaches and practices, delivering benefits across the NHS in procurement performance) and the trust will be reaccredited at Level 2 in January 2019.
- At £372 per square metre in 2017/18, the trust's estates and facilities costs benchmark above the national median of £342 per square metre, placing the trust in the second highest (worst) quartile. At £110 per square metre, the trusts backlog maintenance is below the national median of £186. The trust recognised the issues with the suitability of the aged estate for delivering clinical services. The trust noted it is taking a risk-based approach to capital expenditure which is anticipated to reduce the total backlog in 2019/20.

- The trust has a high level of non-clinical space usage (Trafford General site at 40%, Wythenshawe site at 37% and the Island site at 32%). However, the trust noted that this is impacted by the high level of academic and research spaces across the sites. For example, the trust leases space to the University of Manchester and demonstrated this was reviewed regularly to ensure efficient usage. The trust also explained that the increase in non-clinical space at the Trafford site is part of the long-term strategy in integrating the 4 sites following the merger.

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

- Including Provider and Sustainability Funding (PSF), the trust is in surplus and has an excellent track record of managing spending within available resources and in line with plans.
- The trust balanced its budget in 2017/18, reporting a surplus of £7.2 million excluding Sustainability and Transformation Funding (STF) for the final six months of the year from 1 October 2017 when the trust was established. This was £8.2 million better than the 2017/18 plan. When including STF, the surplus was £29.3 million.
- For 2018/19, at month 10, the trust is forecasting a deficit of £2.1 million, which is £10.0 million better than the control total. When including PSF, the surplus is £39.4 million.
- The trust has an ambitious cost improvement plan (CIP) of £51 million (or 3% of its expenditure) and is currently forecasting to deliver £43.9 million against its plans. The trust delivered 99% of its planned savings in the previous financial year (for 6 months from 1st October 2017 when the trust was established), of which 2% were non-recurrent.
- The trust has adequate cash reserves and is able to consistently meet its financial obligations and pay its staff and suppliers in the immediate term, as reflected by its capital service and liquidity metrics. The trust is not reliant on short-term loans to maintain positive cash balances.
- The trust has robust systems regarding clinical coding regarding depth and accuracy of coding and performs well in clinical coding audits.
- The trust has maintained strong commissioner/provider relationships and has successfully negotiated growth to match increased demand including ongoing shifts in patient dependency and co-morbidities.
- Patient level costing is well developed and provides further information to inform decision making. Business case proposals include an assessment of profitability of the service area.
- The trust has utilised management consultancy support if additional capacity is deemed to be required to make progress at pace, e.g. detailed analysis of bed occupancy/Length of Stay and theatre utilisation to enable capacity and flow modelling in support of the service transformation agenda.

Outstanding practice

- The trust developed and implemented the ERAS+ programme, an innovative model of enhanced recovery aimed at reducing the level of post-operative complications following pulmonary surgery. The model has a specific focus on maximising the condition of patients ahead of surgery through a consultant-led 'surgery school'. Following implementation, the median length of stay for this cohort of patients has reduced from 12 days to 9 days.
- The trust have introduced virtual physiotherapy clinics aided by kinetic technology which allows patients to use games for exercise and track their rehabilitation progress, therefore reducing the levels of physiotherapy appointments required.
- The approach to Procurement delivery is outstanding within the new trust, bringing together structural unification through a single finance and procurement system that underpins a single Manchester University Hospital FT Procurement plan. This includes best practice service standardisation across the group which is demonstrated in them being the first trust to achieve Level 2 National Procurement Standards (framework for consistent approaches and practices, delivering benefits across the NHS in procurement performance) and the trust will be reaccredited at Level 2 in January 2019. Whilst focusing on the framework and plan there is strong evidence of clinical alignment which includes a Clinical Procurement Matron which is the first in the Greater Manchester footprint. The trust was also ranked number 1 in the 2018 National Procurement League Table.

Areas for improvement

The assessment team identified a number of areas of improvement for the trust, however, recognise that the trust has acknowledged and planned to address these across a range of initiatives and programmes throughout the post-merger transformation plan.

- The trust benchmarks above the national median for pre-procedure elective and non-elective bed days and presents an opportunity to improve clinical productivity.
- The Did Not Attend (DNA) rate for the trust is high compared to the national median. The trust recognises this as an area for improvement and despite introducing some initiatives already, would benefit from further work to reduce these.
- Further work is required to address the high sickness absence rates within the trust.
- Continued work to reduce the overall cost of the estate, reduce the backlog and ensure stability for delivering clinical services.

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.