Nottingham University Hospitals NHS trust

Use of Resources assessment report

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

Ratings

Overall quality rating for this NHS trust	**Good** ●
Are services safe?	**Requires improvement** ●
Are services effective?	**Good** ●
Are services caring?	**Outstanding** ☆
Are services responsive?	**Good** ●
Are services well-led?	**Good** ●

Our overall quality rating combines our five NHS 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 NHS trust and in the related evidence appendix. (See www.cqc.org.uk/provider/RX1/reports)

Are resources used productively?	**Requires improvement** ●

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 NHS trust taking into account the quality of services as well as the NHS trust's productivity and sustainability. This rating combines our five NHS 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 NHS trusts for their Use of Resources assessments.

The aim of the assessment is to improve understanding of how productively NHS trusts are using their resources to provide high quality and sustainable care for patients. The assessment includes an analysis of NHS 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 NHS trust.

Combined rating for Quality and Use of Resources

Our combined rating for Quality and Use of Resources is awarded by combining our five NHS 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 NHS trust. The combined rating for Quality and Use of Resources for this NHS trust was requires improvement.

We rated the use of resources at this NHS trust as Requires Improvement. Whilst the trust's productivity compares well for some areas, there are several areas where productivity improvements could still be achieved, and the trusts financial position has worsened in-year.

Nottingham University Hospitals NHS trust

Use of Resources assessment report

Date of site visit:
12th December 2018

Tel: 0115 924 9924
www.nuh.nhs.uk/

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This report describes NHS Improvement's assessment of how effectively this NHS trust uses its resources. It is based on a combination of data on the NHS 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 NHS trust's leadership team.

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

How effectively is the NHS trust using its resources?	**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 NHS trust's performance against a set of initial metrics alongside local intelligence from NHS Improvement's day-to-day interactions with the NHS trust, and the NHS 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 NHS trust on 12th December 2018 and met the NHS trust's executive team (including the chief executive), the chair and relevant senior management responsible for the areas under this assessment's KLOEs.

Findings

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

We rated the use of resources at this NHS trust as Requires Improvement. The NHS trust has made productivity improvements within its workforce and clinical services. However, it spends more on pay to deliver activity, and there are several areas for improvement in its support services. The NHS trust's financial position has also worsened in-year.

The NHS trust has improved the utilisation of its bed capacity by reducing the time patients spend in hospital waiting for procedures and out of hospital care (delayed transfers of care). Transformation work undertaken to improve utilisation of outpatient capacity has delivered a significant reduction in the level of missed clinic appointments. Readmissions remain high and further work is required to understand and address all the relevant drivers.

Areas of workforce productivity that compare well include management of sickness absences and staff retention. The NHS trust has also achieved a sustained reduction in premium agency costs, which are maintained below the NHS Improvement agency ceiling. However, despite this improvement, the NHS trust continues to spend more on pay to deliver activity, which position is largely driven by high medical and overall temporary staffing costs.

The areas in support services where the trust does not compare well include pathology, radiology and estates management. There has been limited investment in modernising and improving pathology services, which remain inefficient, with aged facilities and lower levels of process automation.

The NHS trust is part of a radiology consortium which provides benefits of scale including access to modern equipment and more efficient ways of working. The cost of the service however, remains high largely due to the staffing model which is heavily reliant on medical workforce to deliver the reporting.

The maintenance of the NHS trust's buildings and associated infrastructure has not been at the required level. This has led to the build-up of a backlog and a high infrastructure risk. Consequently, the NHS trust has experienced an increased number of plant and asset failures which disrupt operations, and serious fire safety risks have led to the closure of a ward. The NHS trust has increased revenue spending on maintenance of its estate, and has developed a long-term estates improvement strategy, but there has been limited progress due to funding constraints.

The NHS trust's ranking on the NHS Improvement procurement league table indicates that there are opportunities to further improve its procurement processes. Compared with other NHS trusts, it spends more on supplies and services to deliver activity, however it is on track to achieve significant procurement savings for 2018/19, which would improve this position.

The NHS trust currently operates with a deficit and although its financial position was better than the control total in 2017/18 (and an improvement on the previous year), it's reported deficit at the time of the assessment was £19.2 million more than the year to date plan. Some of the key drivers for this were; under delivery against the CIP, loss of elective income and costs pressures associated with escalation beds. The historical deficit position means that the NHS trust is reliant on external cash support to fund its operations and maintain a positive cash balance.

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

The NHS trust's performance against the 18-Week Referral to Treatment constitutional operational standard is better than most other NHS trusts. Performance against most of the productivity metrics in its clinical services has improved as a result of targeted efforts in this area. Further work is however required to understand and address the high levels of reported readmissions.

- At the time of the assessment, the NHS trust had variable performance against the constitutional operational standards. It was meeting the 18-Week Referral to Treatment standard and its performance has consistently been better than the national standard, and in the best quartile nationally. The NHS trust has previously met the standards for 62-day cancer screening referral waits and 6-week Diagnostic waits, but its performance has recently deteriorated to below national standards. Performance for the 4-hour wait in Accident and Emergency and the 62-day wait for urgent GP referrals has remained below national standards.
- There has been a reduction in the pre-procedure beds days for both elective and non-elective admissions. This indicates an improvement to the utilisation of bed capacity, as the number of pre-surgery admissions and the time patients spend in hospital waiting for their surgery has reduced.
- The NHS trust attributes the improved performance to the centralisation of its pre-operative services, which included standardisation of key processes across specialties. There have also been changes to emergency pathways, whereby patients do not wait in hospital for further investigations and treatment but are discharged and brought back on pre-arranged dates. This approach is now being trialled for more complex cases such as neurosurgery cancer patients.
- However, the NHS trust's performance on pre-procedure bed days remains slightly worse than national average, which means that there is scope for further improvement. For the period July 2018 to September 2018, non-elective pre-procedure bed days were 0.67 against a national median of 0.65, and Pre-procedure bed days for electives were 0.17 against a national median 0.12.
- For the period July 2018 to September 2018, the emergency readmission rate at 10.65% was worse than the national median of 9.06%, placing the NHS trust in the worst quartile nationally. The NHS trust provided evidence which demonstrated that the above changes to the emergency pathway (where patients are discharged and brought back for treatment) were a contributory factor to this position. Further work is however, required to understand and address the remaining drivers for the high readmission rate.
- The Delayed Transfers of Care (DTOC) rate at 2.9% is better than the national standard of 3.5%. The NHS trust partners with the local community services to provide beds for patients who are fit for discharge but waiting for out of hospital care arrangements. The ward management are responsible for the prompt discharge of patients and they are supported by an integrated discharge team, which includes social workers. The NHS trust's patient record system (Nerve Centre) is a key enabler for improved patient flow, as it provides staff with real time patient status information to support bed management.
- The overall DNA rate for the NHS trust at 6.66% for the period July to September 2018, is lower than the national median of 7.32%, placing the NHS trust in the second best performing quartile. This indicates that the NHS trust's processes support effective utilisation of its outpatient capacity. The NHS trust attributes this success to its outpatients' transformation programme which focusses on reducing unnecessary appointments in hospital, (with follow up care transferred to community services),

targeting improvements in poorly performing specialities and introducing a patient text reminder system. However, further work is required to improve missed appointments in radiology, where DNA rates remains high.

- The NHS trust has actively engaged with 'Getting It Right First Time' (GIRFT) programme and is using the output from the visits to identify and secure opportunities for productivity improvements. Examples highlighted in orthopaedics included; reduction in length of stay for joint replacement procedures, rationalisation of suppliers for joint implants (with cost savings realised) and better utilisation of theatre capacity.
- The NHS trust hosts a GIRFT clinical Ambassador who provides implementation support and advice to other NHS trusts within the East Midlands and East of England GIRFT Hub.

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

Overall, workforce productivity metrics compare well. Sickness absence is well managed, and the NHS trust has maintained high staff retention rates. It is making good use of alternative roles to provide resilience within clinical teams and has reduced agency spend. However, benchmarking information indicates that there is still opportunity to further reduce the pay bill.

- For 2017/18, the NHS trust's overall pay cost per weighted activity unit (WAU) is £2,202 compared to the national median of £2,180, placing the NHS trust in the second highest cost quartile nationally. This means that overall it spends more on staff per unit of activity, when compared with other NHS trusts. The breakdown of pay costs per WAU shows that the medical staffing and overall temporary pay staffing costs are a key contributor to this position.
- The medical staffing cost per WAU for 2017/18 at £567, is above the national median of £533 and in the second highest quartile nationally. The NHS trust attributes this cost variation primarily to additional medical hours payments. These are additional payments made to substantive staff to cover service gaps or undertake extra activity to reduce waiting lists. The NHS trust also highlighted that research and teaching costs may be included in this metric.
- The NHS trust's non-substantive cost per WAU at £315 is higher than the national median of £274 and in the second highest cost quartile. This high cost is largely driven by the non-agency temporary staffing costs. The agency cost per WAU is lower than most other NHS trusts.
- The NHS trust has been successful in achieving a sustained reduction in agency spend which is maintained below the agency ceiling set by NHS Improvement. Initiatives that have contributed to this improvement include; improved retention of registered nurses, stricter controls on agency spend, use of alternative roles, local recruitment of junior doctors, effective management of sickness absences and more recently the harmonising of pay and reward benefits within estates department. There has also been a positive and sustained swing away from agency to bank staff, when using temporary staffing solutions. A continued focus is however required to address the overall high non-substantive costs and reduce the pay bill.
- The overall retention rate, which benchmarks above national median and in the second-best quartile nationally, has also improved over the last twelve months from 85.6% in October 2017 to 86.8% in September 2018. Improved retention rates for registered nurses and health support workers are the drivers for the favourable movement. This has been achievement through various initiatives including; engagement with the NHS

Improvement retention schemes for nursing staff, the NHS trust's own Magnet (retention) programme, and introduction of targeted training and career development opportunities for the non-qualified nursing workforce. The NHS trust also directly employs junior doctors to its local NHS trust grade programme which has helped reduce gaps in its junior doctor workforce.

- The NHS trust has embedded the use of alternative workforce models in its services which has provided increased service capacity and resilience in medical teams. Examples of the new roles established include; reporting radiographers who provide additional capacity for plain film reporting, and advanced clinical practitioners (ACPs) who provide cover for junior doctors' gaps and support implementation of improved clinical pathways. Existence of these roles has also provided career development opportunities for existing staff, which has supported staff retention. The NHS trust has one of the largest trainee nurse associate programmes in the region and has also participated in a regional pilot of a medical team administrator role, to reduce the administrative burden on medical staffing.
- E-rostering is used by the NHS trust to support effective deployment of its nursing, midwifery and junior medical workforce, and an acuity model is used to ensure the nursing staffing levels meet patient need. The NHS trust demonstrated that rotas are agreed six weeks in advance to ensure that gaps are identified and addressed promptly, avoiding the use of premium agency staffing.
- For 2017/18, 90% of consultants have an active job plan held electronically. The NHS trust is working to align job plans to service requirements thereby reducing the need for additional medical hour payments. There is also been some progress in developing partnership with other NHS trusts within some of the hard to recruit services. The NHS trust is working with other neighbouring NHS trusts to streamline and provide more sustainable clinical services in areas such as Urology, Stroke, Vascular and Oncology.
- Overall Sickness absence rates have been maintained below national median, with the September 2018 performance at 3.83% compared to a national median of 3.95%, placing the NHS trust in the lowest (best) quartile nationally. The NHS trust has implemented a range of programmes, which have had a positive impact on sickness absence and staff retention rates. The NHS trust has a staff wellbeing programme in place, including increased support for mental health and personal financial management issues.

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

The NHS trust has been successful in achieving the identified savings in the top ten medicines programme and is using some new forms of working in its pharmacy services. However, other areas in clinical support services compare worse than most other NHS trusts, indicating that there are opportunities for further productivity improvements.

- Pathology costs for 2017/18 account for 4% of the NHS trust's operating expenditure. This is above the national average of 3.8%, indicating a relatively higher cost of delivering the service. Factors contributing to this include multi-site provision and a need to modernise processes and equipment.
- The pathology services were brought back in house in 2018 following dissolution of a collaboration with a neighbouring NHS trust, and services are split across the NHS trust's two sites in Nottingham. The laboratory facilities and information technology systems are aged, which means that most of the testing processes have not been

automated. Similarly, there are no shared contracts in place for pathology consumables and equipment.

- The NHS trust has started taking steps to improve productivity in this area, with the appointment of a service modernisation lead, replacement of some of the aged equipment and is in early stages of scoping opportunities for service collaboration with neighbouring NHS trusts, that have more modern pathology facilities.
- The NHS trust's pharmacy, staff and medicines cost per WAU for 2017/18 was £404, which is above the national average of £359 and is in the most expensive quartile. This is largely driven by the NHS trust's higher proportion of complex treatments, given it is a large regional teaching hospital. This is reflected in the high cost medicines cost per WAU of £155, which is significantly above the national average of £111 and in the most expensive quartile.
- The NHS trust is making use of some of the new forms of medicines optimisation practice such as, deploying a prescribing pharmacist to support flow in the Emergency Department. There is a seven-day pharmacists presence on the Acute Medical Receiving unit, and the dispensary is partially open on weekends. There is however significant scope for further improvement, for instance the use of pharmacy staff more widely on wards and extending the seven-day pharmacy services to other areas.
- As part of the Top Ten Medicines initiative, good progress has been made towards switching patients to best value biosimilar medicines and the NHS trust reported savings of £2.89 million for the health economy in 2017/18. The 2017/18 savings were exactly in line with the target level set by NHS Improvement. The NHS trust has continued to switch patients after the year end, and as a result additional savings of £1.5 million have been realised in 2018/19 to date.
- The NHS trust is part of the East Midlands Radiology consortium, which includes six other NHS trusts. This collaboration enables the NHS trust to access benefits of scale including more modern equipment and information systems, which facilitate flexible ways of working, such as remote access to images and reporting from home. However, the overall cost per report is high at £83.9, compared to the national median of £50.0. There is a high reliance on medical workforce to deliver reporting, and being a hard to recruit area, there have been high vacancy rates which has resulted into use of expensive agency staff to deliver the work. The service has been able to reduce the number of consultant vacancies and expanded access to working from home facilities.

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

The cost of running corporate services in relatively lower than most other NHS trusts and the NHS trust is on track to deliver significant procurement savings this year, which will reduce the overall high supplies and services costs. The historical under investment in the estate has however led to a high maintenance backlog and critical infrastructure risk. The NHS trust needs to work at pace to address this.

- For 2017/18 the NHS trust had an overall non-pay cost per WAU of £1,283 which is below the national average of £1,307. However the supplies and services cost per WAU is £460 which is in the most expensive quartile. The NHS trust is actively working to reduce the supplies and services costs and is on track to deliver over £7 million of procurement savings in 2018/19, by securing value prices on purchases and increased collaboration with other NHS trusts through hubs such as North of England Commercial Procurement Collaborative.

- A clinical procurement specialist team has been set up. It includes three experienced nurses to develop clinical engagement and provide clinical expertise to support procurement activity. The group has reduced the range of products available in the NHS trust's procurement catalogue, to support bulk purchasing discounts. There have been successes in orthopaedics, where primary hip implants are now provided by just one supplier. The NHS trust has increased the use of contract purchases with 93% of the non-pay spending on contract for period July to September 2018, which is in the best quartile nationally.

- New procurement initiatives have been introduced this year such as running electronic auctions, and steps have been taken to market test estates and facilities contracts. There has been some engagement with the national procurement initiatives such as use of the NHS Improvement Purchasing Price Index Benchmark tool, to inform negotiations with suppliers and obtain more competitive prices.

- However, the NHS trust is 111 out of 136 in the NHS Improvement Procurement League Table which is in the worst quartile, and the weighted procurement price metric score in the league table for 2017/18 was 53.9 which was worse than the national average of 63.8. This indicates that the NHS trust may have opportunities to review its procedures in place to drive down its non-pay costs further.

- The 2017/18 estates and facilities costs per square metre is £298 which is below the NHS Improvement benchmark of £379. Maintenance of its buildings and associated infrastructure has not been at the required level which has led to a build-up of backlog.

- Levels of backlog maintenance are £436 per square metre, which is significantly more than the NHS Improvement benchmark of £186. The resulting critical infrastructure risk is £333 per square metre and equates to a value of £103.9 million compared with the NHS Improvement suggested benchmark of £10.8 million. This indicates the level of capital investment needed to eliminate safety and resilience risks from the operational estate.

- The NHS trust has had an increased number of unpredictable plant and asset failures, which disrupt operations, and serious fire safety risks have led to the closure of a ward. The NHS Trust Board have agreed to increase the budget for estates and facilities, and in March 2018 approved a new estates strategy to target increased investment over the next 5 years, as the first part of a 10-year plan. This prioritises major trauma services and critical electrical and gas infrastructure. However, funding for these plans is not in place.

- Soft facilities management costs per WAU are below average at £126, indicating that the NHS trust may be achieving efficiencies from some of the services that are not directly linked to the fabric of the buildings. This includes laundry and linen costs, which are only £0.28 per item compared with the national average of £0.35, portering costs which are £16 per square metre, and in line with the national average.
- In 2017/18, the NHS trust's waste disposal costs were £308 per tonne which was significantly more than the NHS Improvement suggested benchmark of £220. In 2018/19 to date, the NHS trust has renegotiated its contracts to significantly reduce this and has saved £0.2 million in the year to date.
- The cost of running corporate services is relatively lower than most NHS trusts as indicated by their cost per £100 million of turnover. For 2017/18, Human Resources costs per £100 million turnover are £0.48 million, and Finance costs are £0.55 million. Both are below the national medians and suggest that the NHS trust has a higher level of efficiency in these back-office functions. There is a two-year partnership agreement in

place with Nottingham City Council and Leicestershire County Council for some of the transactional services, with a view to share staffing costs and achieve economies of scale in future.

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

Despite achieving an improvement in the previous year, the NHS trust's deficit position has worsened in 2018/19, with an adverse variance of £19.2 million at the time of the assessment. The historical deficit performance also means that the NHS trust requires additional cash support to fund its operations.

- For 2017/18, the NHS trust reported a deficit of £30.8 million before STF which reduced to £2.3 million deficit, after receipt of £28.5 million STF. This was better than its control total of £34.0 million deficit before STF, and an improvement on the previous year's position of £45.7 million deficit STF.
- The NHS trust's financial position however has deteriorated in 2018/19, reporting a higher deficit than plan at the time of the assessment. The reported position for October 2018 was a year to date deficit of £30.1 million before STF, against a plan of £10.9 million deficit. A combination of factors contributed to this deterioration and include, under delivery against the CIP, loss of elective income and unplanned costs associated with escalation beds. The NHS trust expects to recover this position and deliver the control total of £24.9 million, but this is dependent on significant improvement in the remaining part of the year and receipt of external funding for winter resilience.
- The NHS trust is underperforming against its elective income plan with key reasons being displacement of elective activity (due to non-elective demand pressures) and capacity constraints associated with theatres slots and staffing shortages. The NHS trust has continued to invest in escalation beds to keep up with the non-elective demand, the cost of which is not funded in its contract. The drive to deliver the displaced elective activity and recover performance against constitutional operational standards, has meant that activity is delivered at higher cost, resulting into to a lower contribution.
- The NHS trust delivered efficiencies of £39.9 million in 2017/18 (5.72% of Income), which was 97.5% of its cost improvement plan. For 2018/19 the NHS trust has a CIP plan of £41.0 million, and at the time of the assessment it was reporting delivery of £18.6 million, which was £2.9 million less than the year to date planned CIP. This is largely due to a shortfall against the for theatre and bed utilisation productivity schemes. However, interventions have been put in place to ensure delivery of the full £41 million CIP, which include strengthening of CIP delivery structures, more robust expenditure controls and income improvement schemes.
- Due to the NHS trust's historical deficit position it does not internally generate cash and requires additional cash support in the interim to consistently meet its financial obligations and pay its staff and suppliers. Cash requirements for the year are identified during the planning phase, and the NHS trust manages its cash position according to plan. The loan balance at the end of 2017/18 was £83.7 million.
- The NHS trust is well advanced in the use of costing data and service line reporting across its service lines. This is used to generate financial reports that are actively used to manage speciality and divisional financial performance. Costing data is also used to drive more efficient practices across services. The NHS trust is leveraging its costing expertise to identify costs of cross organisational clinical pathways.

- The NHS trust has undertaken a range of actions to improve its income position. They include; improved activity capture and income billing, and making use of income generating opportunities for example, pharmacy manufacturing, catering services and research and development.
- The NHS trust is not routinely reliant on advice from external advisors or consultants, however they commissioned external consultancies in 2018/19, at a cost of £1.5 million, to provide support and expert advice in the areas of tax, procurement, legal, governance and costing.

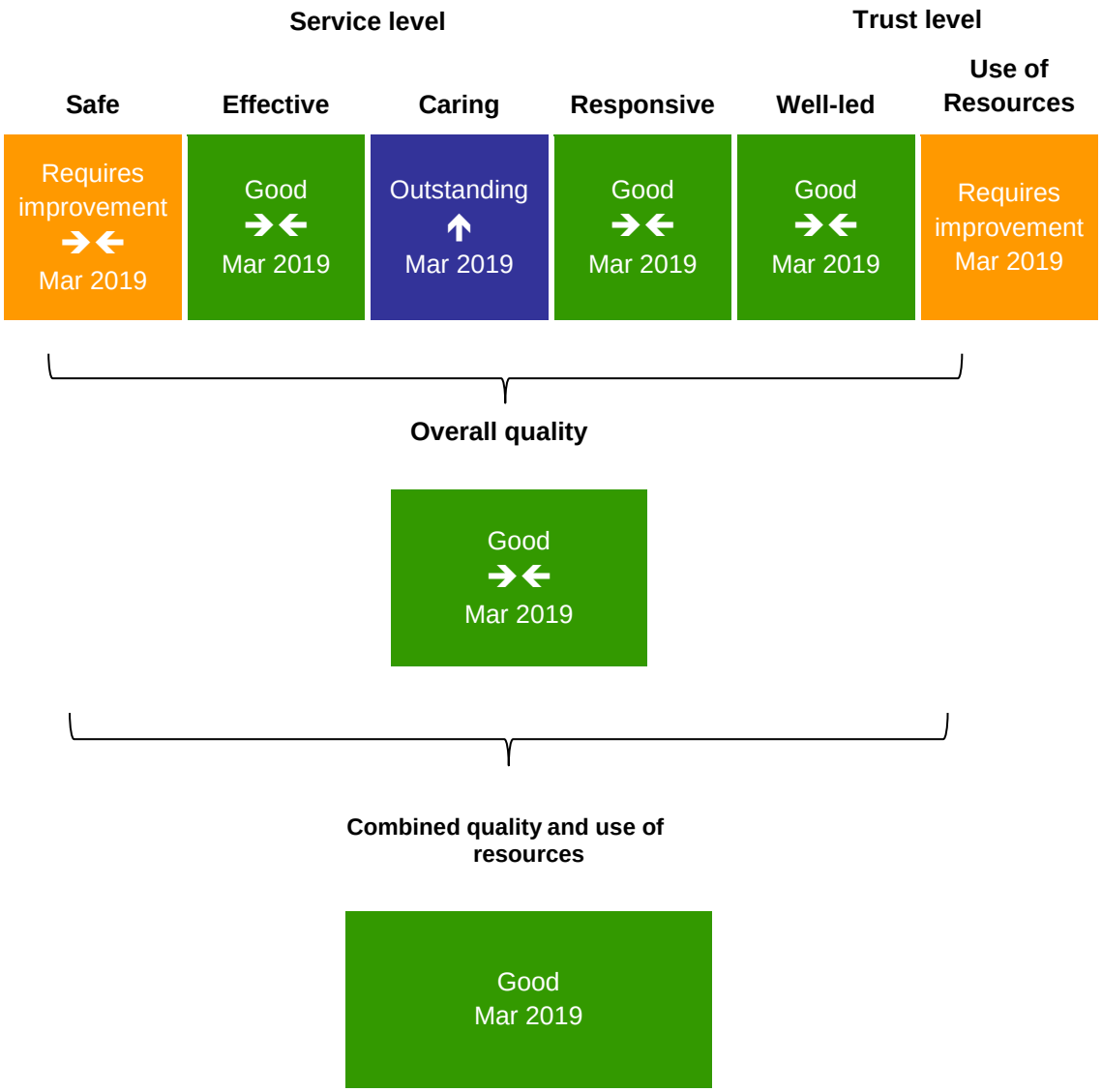
Outstanding practice

- The NHS trust's retention rate for its nursing workforce is better than most NHS trusts. It achieved significant improvement through initiatives such as engagement with the NHS Improvement retention schemes and its own magnet retention programme.
- The NHS trust's patient record system (Nerve Centre) is a key enabler for improved patient flow, as it provides staff with real time patient status information to support bed management.

Areas for improvement

We have identified scope for improvement in the following areas:

- The backlog maintenance and critical infrastructure risk is high and needs to be reduced so that patient safety does not become compromised in the future.
- Further work is required to understand and address all the drivers for the high readmission rates.
- The NHS should continue to focus on reducing its pay bill, with focus on medical workforce and overall temporary staffing costs.
- The NHS trust needs to work at pace, in collaboration with neighbouring NHS trusts, to form a network which will deliver pathology services at scale.
- The level of pharmacy support available on-wards at weekends needs to be increased to support quicker discharge of patients.


Service level
Trust level
Safe
Effective
Caring
Responsive
Well-led
Use of Resources
Requires improvement
Mar 2019
Good
Mar 2019
Outstanding
Mar 2019
Good
Mar 2019
Good
Mar 2019
Requires improvement
Mar 2019
Overall quality
Good
Mar 2019
Combined quality and use of resources
Good
Mar 2019

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 NHS 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 NHS 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 NHS trust boards, governing bodies and chief executives of NHS 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 NHS trust save costs on unconfirmed appointments and increase system efficiency.
Distance from financial plan	This metric measures the variance between the NHS trust's annual financial plan and its actual performance. NHS 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 NHS 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 NHS 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 NHS 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 NHS trust's HR department for each £100 million of NHS 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 NHS 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 NHS 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 NHS trust cost to produce one WAU across all areas of clinical activity. A lower than average figure is preferable as it suggests the NHS trust spends less per standardised unit of activity than other NHS trusts. This allows NHS 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 NHS 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 NHS trust cost to produce one WAU across all areas of clinical activity. A lower than average figure is preferable as it suggests the NHS trust spends less on staff per standardised unit of activity than other NHS trusts. This allows NHS trusts to investigate why their pay is higher or lower than national peers.
Peer group	Peer group is defined by the NHS 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 NHS 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 NHS trusts (the performance element). A high score indicates that the procurement function of the NHS trust is efficient and is performing well in securing the best prices.
Sickness absence	High levels of staff sickness absence can have a negative impact on organisational performance and productivity. Organisations should aim to reduce the number of days lost through sickness absence over time.
Single Oversight Framework (SOF)	The Single Oversight Framework (SOF) sets out how NHS Improvement oversees NHS trusts and NHS foundation NHS trusts, using a consistent approach. It helps NHS Improvement to determine the type and level of support that NHS trusts need to meet the requirements in the Framework.
Service line reporting (SLR)	SLR brings together the income generated by services and the costs associated with providing that service to patients for each operational unit. Management of service lines enables NHS 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 NHS trust or directorate level.
Supporting Professional Activities (SPA)	Activities that underpin direct clinical care, such as training, medical education, continuing professional development, formal teaching, audit, job planning, appraisal, research, clinical management and local clinical governance activities.
Sustainability and Transformation Fund (STF)	The Sustainability and Transformation Fund provides funding to support and incentivise the sustainable provision of efficient, effective and economic NHS services based on financial and operational performance.
Staff retention rate	This metric considers the stability of the workforce. Some turnover in an organisation is acceptable and healthy, but a high level can have a negative impact on organisational performance (eg through loss of capacity, skills and knowledge). In most circumstances organisations should seek to reduce the percentage of leavers over time.
Top Ten Medicines	Top Ten Medicines, linked with the Medicines Value Programme, sets NHS 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 NHS trusts' % achievement against these targets. NHS 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.