Oxford University Hospitals NHS Foundation Trust

Use of Resources assessment report

John Radcliffe Hospital
Headley Way, Headington
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Date of publication: 7 June 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	**Requires improvement**
Are services safe?	**Requires improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Good**
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/RF4/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:

- We rated, effective, caring and responsive as good, and safe and well led as requires improvement.
- At the John Radcliffe Hospital, we rated two of the trust's services as good and three as requires improvement. In rating the trust, we took into account the current ratings of the four services not inspected this time.
- At the Churchill Hospital we rated one of the trust's services as good and one as requires improvement. In rating the trust, we took into account the current ratings of the three services not inspected this time.
- At the Horton General Hospital, we rated one of the trust's service as good and one as requires improvement. In rating the trust, we took into account the current ratings of the six services not inspected this time.
- At the Nuffield Orthopaedic Centre, we rated one of the trust's 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
- The trust was rated requires improvement for Use of Resources. Full details of the assessment can be found on the following pages.

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Date of site visit:
13 December 2018

Date of publication:
7 June2019

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.

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

How effectively is the 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 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 13 December 2018 and met the trust's executive team (including the chief executive), a non-executive director (in this case, the chair) and relevant senior management responsible for the areas under this assessment's KLOEs.

Findings

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

We rated use of resources as requires improvement because the trust does not consistently manage its resources to allow it to meet its financial obligations on a sustainable basis to deliver high quality care. The approach to identifying and realising efficiency opportunities is not embedded across the organisation.

- The assessment of Use of Resources has been made with recognition of the high levels of specialist activity that the trust undertakes, which is materially above the median of all trusts. The nature of this activity leads to expected higher costs in several of the clinical support services and in particular, diagnostic services, which we have adjusted for.
- There were a number of areas of good practice noted, including in the procurement function, electronic rostering and nursing deployment, some clinical areas such as outpatient 'Did Not Attend' (DNA) performance and reduction in stranded patients. We also note that for the current year, the trust is on track to deliver a financial surplus.
- The trust can also demonstrate several areas where performance has improved, although further opportunities exist. These include Accident & Emergency (A&E) performance and improving flow through the hospital sites, reducing the number of patients waiting longer than 52 weeks for an elective procedure (52-week waiters), surgical assessment and pharmacy performance.
- However, the trust has further areas where opportunities have only recently been identified and where further work is required to embed changes and see positive outcomes. These include medical productivity, Referral-To-Treatment (RTT) performance, and radiology and pathology costs.
- The trust's estate is an area for further improvement. This is an area of high cost for the trust, and while there are elements of good management and outcomes (such as on energy costs and waste), an overarching estate strategy will help the trust deliver efficiency improvements in this area.
- We also noted that while the trust can point to a number of discrete efficiency outcomes, there was a weakness in the process for designing and implementing comprehensive efficiency plans for the trust. Moreover, while the trust is forecasting a surplus, the trust

reports a deficit on an underlying basis. Accordingly, a greater focus on operational efficiency across the trust in a holistic way will help to embed efficiency improvements and create a more sustainable financial footing.

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 is proactively managing its resources in the face of operational demands and has shown improvements across some metrics over the previous 12 to 18 months including reducing stranded patients, improving flow throughout the emergency pathway and sustaining low Did Not Attend (DNA) rates. However, the trust has further challenges in reducing emergency readmission rates and has opportunities across elective pathways such as reducing long waiters and streamlining pre-operative assessments.
- The Did Not Attend (DNA) rate for the trust was 5.8% in June 2018. This compares favourably to the national median of 7.29%. The trust notes that General Practitioner (GP) helpline, email response and video conferencing are embedded in high volume specialties to avoid unnecessary face-to-face appointments and that Netcall and Remind+ have been in place in key services since Quarter 3 (October-December) of financial year 2016/17 to help deliver this level of performance.
- The data suggests that more patients are coming into hospital prior to planned treatment compared to most other hospitals in England as of March 2018. On pre-procedure elective bed days, at 0.17 days, the trust is performing worse than the national median of 0.13 days. The trust has not met the Referral to Treatment (RTT) national standard of 92% since February 2016. As of October 2018, the trust has reported 82% which is worse than the peers such as trust type on clinical output (85.92%) and other providers in the South region (86.16%). Moreover, the trust has 137 patients waiting over 52 weeks as at October 2018. We note that this has reduced from 199 in August 2018 and has continued to reduce into March 2019.
- The trust notes that pre-operative assessment has historically been conducted differently across sites and specialities, and that work is currently underway to streamline this into five surgery hubs by financial year 2019/20.
- The trust's A&E performance was 86.50% in October 2018. This is above the regional peer median of 85.92%. The trust cites good practice in reducing stranded patients and improving flow, working with system partners and implementing changes to ambulatory and out of hospital care models.
- On pre-procedure non-elective bed days, at 0.51 days, the trust is performing better than the national median. Non-elective length of stay has also improved. The trust points to reduction in stranded patients through good practice on the reablement service and frailty intervention team for delivering this outcome. The trust has also set up a dedicated surgical unit for emergencies.
- However, at 8.93%, emergency readmission rates are significantly higher than the national median of 7.76% as at June 2018. This means patients are more likely to require additional medical treatment for the same condition at this trust compared to other trusts nationally. The trust notes that there is no single reason for the performance but that a proportion is due to the approach of using an Ambulatory Assessment Unit and Surgical Emergency Unit to manage patients needing urgent hospital care which enables patients to be treated in those setting and to go home. However, all returns are counted as re-admissions. The trust sets out that it uses NHS Choices Clinical Indicators, Specialist Services Quality Dashboards, Dr Foster and national audits related to readmissions to review readmission rates.

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

- The trust has had issues with the recruitment and retention of staff over the previous 12 to 18 months, which has an impact on operational performance at the trust. Despite this, the trust has been able to deploy some innovative staffing models and good use of rostering across the nursing establishment. However, the trust recognises there are further opportunities for efficiency improvements across the medical workforce, including through job planning.
- In financial year 2017/18 the trust had an overall pay cost per Weighted Activity Unit (WAU) of £2,042, compared with a national median of £2,180, placing it in the second lowest (best) cost quartile nationally. While this means that it spends less on staff per unit of activity than most trusts, it is partly explained due to staff employed on facilities management under the Private Finance Initiative (PFI) not being reflected in the pay costs (rather these are part of non-pay costs).
- Within this headline metric, the trust's pay cost per WAU is better than the national median for nursing professional staff group (£593, national median £710) but is worse than the median for the medical professional staff group (£601, national median £533).
- The trust's agency costs for financial year 2017/18 of £11.4m were below its ceiling of £18.1m. However, within this, the trust spent more on medical locums of £5.0m against a plan of £4.5m. For financial year 2018/19 the trust is forecasting to spend more than their agency ceiling; its expected cost outturn is £9.7m against a ceiling of £8.3m.
- Staff retention at the trust has improved over the 6 months to September 2018 from 82.5% to 83.5%. This compares to a national median is 85.9%. At 3.0% in August 2018, staff sickness rates are among the best nationally (national average of 3.9%). The trust is taking steps to improve recruitment including through Oxford Brookes University to make early conditional offers to students. This has increased the number of Oxford Brookes graduates starting at the trust. The trust is also incentivising nursing to work additional hours through a number of schemes.
- The trust demonstrates strong performance on nurse rostering and related outcomes. The trust has 7-day per week electronic rostering via SafeCare and HealthRoster. The trust has also implemented a flexible staffing pool to support short term demand for temporary staff. This is augmented through centralised control of the use of bank and agency staffing via the Oxford University Hospitals (OUH) staff bank (managed in partnership with NHS Professionals).
- Job plans for consultants are currently paper based or on excel spreadsheets, but the trust has put in place measures (which began in November 2018) to implement electronic job planning with a deadline for completion of 31 March 2019. The trust also has plans to implement electronic job planning at sub consultant level. The trust will need to ensure that the full implementation takes place over the planned period and that the tools can be utilised to deploy their medical workforce in the most effective manner.

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

- The trust's medicines cost per WAU (£428) is in the highest quartile nationally (national median £309). The trust's medicines spend is also higher than trust type peer median of

£396 which is based on clinical output (which takes into account the higher proportion of specialist work undertaken by the trust).

- The trust can evidence that it has achieved a 109% against its savings targets on biosimilars to March 2018. The trust has agreed gain share agreements with their commissioners on reducing high cost drugs spend and has achieved systemwide savings of £15.2m against £121m expenditure in financial year 2017/18.
- The trust can also evidence good practice through the To-Take-Out (TTO) Drugs Listing project across wards. The trust noted that the TTO turnaround time reduced from 313 minutes to 196 minutes and the percentage of patients discharged prior to noon increased from 8% to 24% in the wards that the programme was rolled out in. However, while there are constraints to the set-up of an outsourced pharmacy which the trust has considered, there are still has further opportunities this area.
- The trust's radiology cost per report is £69.37 against a national median of £50.06. Analysis by the trust indicates that their higher cost per test is due to the complex nature of neurosciences and cancer services provided, but it is noted that the trust's costs are higher than the peer median (based on trust clinical output) of £56.30.
- The trust's DNA rates across Computed Tomography (CT), Magnetic Resonance Imaging (MRI), non-obstetric Ultrasound and Dual-Energy X-ray Absorptiometry (DEXA) were all in the worst performing quartiles. The trust also faced significant resourcing pressures in this area and notes vacancies of 45 Whole Time Equivalents (WTEs) across the service. Accordingly, the trust's agency and bank usage in this area is 9.1% of total imaging costs (compared to 4.8% for peers). The trust has set out a strategic plan for improving the Radiology service; implementing and delivering this high-level strategy is a focus for the trust in financial year 2019/20.
- The trust's overall pathology cost per test is £3.48 against a national median of £1.92 as at the quarter ended September 2018. Some of the higher cost is explained due to the trust's position as a tertiary referral centre with specialist testing; the trust notes that 25% of lab costs are driven by 1% of activity. However, we note that both the microbiology and genetics cost per test (£5.37 and £150.75) are higher than national median of £4.27 and £124.50 respectively. This is therefore an area for the trust to consider their cost base and plan to deliver greater efficiencies where possible.

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

- For financial year 2017/18 the trust had an overall non-pay cost per WAU of £1,459 compared with a national median of £1,307. This places it in the fourth (worst) cost quartile nationally. The trust notes that the overall non-pay costs are higher than peers due the cost of the trust's estate, including pay costs of facilities management (FM) staffing and high cost drugs. This is considered in further detail below.
- The cost of the finance function is £535,040 per £100m of turnover, against a national median of £676,480. Similarly, the Human Resources (HR) function costs £532,805 per £100m turnover compares below the national median of £898,020. However, the outcomes from such a lean corporate service is not evidenced across the trust. As noted in the workforce section above, the trust has had issues with recruitment and retention of staff. Similarly, (as set out in further detail below), the level of support and challenge to divisions and other services in planning and delivery of efficiencies could be increased.
- The trust's Procurement Process Efficiency and Price Performance Score of 63.7, compares favourably to the lower national benchmark of 50.0, but is still below the upper benchmark of

79.0 and the peer median of 69.6. This suggests that the trust's procurement processes have been broadly efficient and that it has historically succeeded in driving down costs on the things it buys.

- It is noted however, that the Procurement function cost per £100m trust turnover is £328,500, which is significantly higher than both national median (£209,900) and peer median (£279,300). The function does however, include agency category expertise, with this having a significant financial impact on agency expenditure. The trust has a cost improvement plan (CIP) of £5.9m but have previously under-delivered against CIP targets in this area. In 2018/19, the trust delivered £5.2m savings against a target of £7.2m (71% delivery)
- The trust's estates and facilities (E&F) cost per m2 is £452, which compares against trust type peer median of £379. The trust estate comprises 3 PFI hospitals, plus a large retained estate of aging building stock. The age of the estate (24% of the estate was built before 1948), results in a large backlog maintenance cost to the trust.
- Hard facilities management (FM) costs are 87% above (worse than) peer median, although soft FM are 15% better than peer medians across the total estate with the key components of particularly high cost being the same as with the PFI. The total Hard FM opportunities are £11.81m (of which £3.7m relates to the PFI estate). Total soft FM opportunities are £3.13m (£0.2m PFI). The trust has an in-house team which manages the PFI contracts including effectively managing the liquidation of the trust's PFI provider, but further work on benchmarking and market testing on the opportunities above must remain a focus for the trust.
- The trust has also evidenced several examples of achieving efficiencies across the estate including the delivery of an award-winning Combined Heat and Power energy centres, reduction of 5,900 tonnes of CO2 through reduced heat and energy consumption and no waste to landfill through increased recycling. The trust also notes that they have begun initiatives to address backlog maintenance, increase space utilisation and consolidate non-clinical operations away from frontline healthcare space.
- However, the trust did not deliver against a CIP target in estates of £12m in financial year 2017/18 and is still in the process of developing an estate strategy which will allow structured actions to be undertaken to deal with the high costs of the running the estate. Developing this and achieving greater efficiencies across the estate must be a priority for the trust.

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

- Excluding incentive payments (Sustainability and Transformation Funding – STF and Provider Sustainability Funding – PSF), the trust reported a deficit of £14.7m in the financial year 2017/18. This was an adverse variance of £33.7m against a planned surplus and Control Total (CT) of £18.9m.
- However, for the financial year 2018/19, the trust is on track as at Month 9 (December), to deliver a surplus (excluding incentives) of £10.4m. This is in part due to one-off items including land sales in the current year. However, the trust's underlying position is on track to improve from a deficit of £34.8m in financial year 2017/18 to a deficit of £25.6m in financial year 2018/19. This has been achieved through cost control and increased elective activity. Accordingly, while the trust is able to demonstrate good outcomes and improvement in this area, the underlying position suggests that this must continue to remain an area of focus for the trust. Embedding the operational improvements set out in other parts of this report may enable the trust to further improve their underlying financial performance.

- The trust operates on a divisional basis across sites, with each division responsible for a bottom line Earnings before Interest, Tax, Depreciation and Amortisation (EBITDA) target. While individual efficiency targets for areas such as estates, pathology and pharmacy are set out, it was not clear how the trust has embedded in a systematic way either a culture or process to deliver or monitor as an organisation productivity and efficiencies in all divisions.
- Moreover, in some of the areas where Cost Improvement Programme (CIP) targets were set out, plans were not fully delivered. We noted that efficiency targets set for estates and pathology were significantly below planned levels for financial year 2017/18.
- The trust is not reliant on cash support from the Department of Health and Social Care (DHSC). Given the underlying deficit position, the trust is able to articulate a system of robust cash management.

Areas of outstanding practice

- The trust demonstrates strong performance on nurse rostering and related outcomes. The trust has 7-day per week electronic rostering via SafeCare and HealthRoster. The trust has also implemented a flexible staffing pool to support short term demand for temporary staff. This is augmented through centralised control of the use of bank and agency staffing via the Oxford University Hospitals (OUH) staff bank (managed in partnership with NHS Professionals).
- The trust can evidence that it has achieved a 109% against its savings targets on biosimilars to March 2018. The trust has agreed gain share agreements with their commissioners on reducing high cost drugs spend and has achieved systemwide savings of £15.2m against £121m expenditure in financial year 2017/18.
- The trust has also evidenced several examples of achieving efficiencies across the estate including deliver of an award-winning Combined Heat and Power energy centres, reduction of 5,900 tonnes of CO2 through reduced heat and energy consumption and no waste to landfill through increased recycling.

Areas for improvement

- The trust's estates and facilities (E&F) cost per m2 is £452, which compares against trust type peer median of £379. The trust estate comprises 3 Private Finance Initiative (PFI) hospitals, plus a large retained estate of aging building stock. The age of the estate (24% of the estate was built before 1948), results in a large backlog maintenance cost to the trust. The trust has an in-house team which manages the PFI contracts including effectively managing the liquidation of the trust's PFI provider, but further work on benchmarking and market testing on the opportunities above must remain a focus for the trust.
- While individual efficiency targets for areas such as estates, pathology and pharmacy are set out, it was not clear how the trust has embedded in a systematic way either a culture or process to deliver or monitor as an organisation productivity and efficiencies in all divisions. Putting in place a systematic integrated approach to delivering and monitoring efficiencies at

divisions level, including providing sufficient capacity and capability, must remain a focus for the trust.

- The trust's overall pathology cost per test is £3.37 against a national median of £1.86 and a peer median of £2.52. Some of the higher cost is explained due to the trust's position as a tertiary referral centre with specialist testing; the trust notes that 25% of lab costs are driven by 1% of activity. However, we note that both the microbiology and genetics cost per test (£6.78 and £170.69) are higher than peer median of £3.62 and £139.22 respectively. This is therefore an area for the trust to consider their cost base and deliver greater efficiencies.
- Job plans for consultants are currently paper based or on excel spreadsheets, but the trust has put in place measures (beginning in November 2018) to implement electronic job planning with a deadline for completion of 31 March 2019. The trust also has plans to implement electronic job planning at sub consultant level. The trust will need to ensure that the full implementation takes place over the planned period and that the tools can be utilised to deploy their medical workforce in the most effective manner

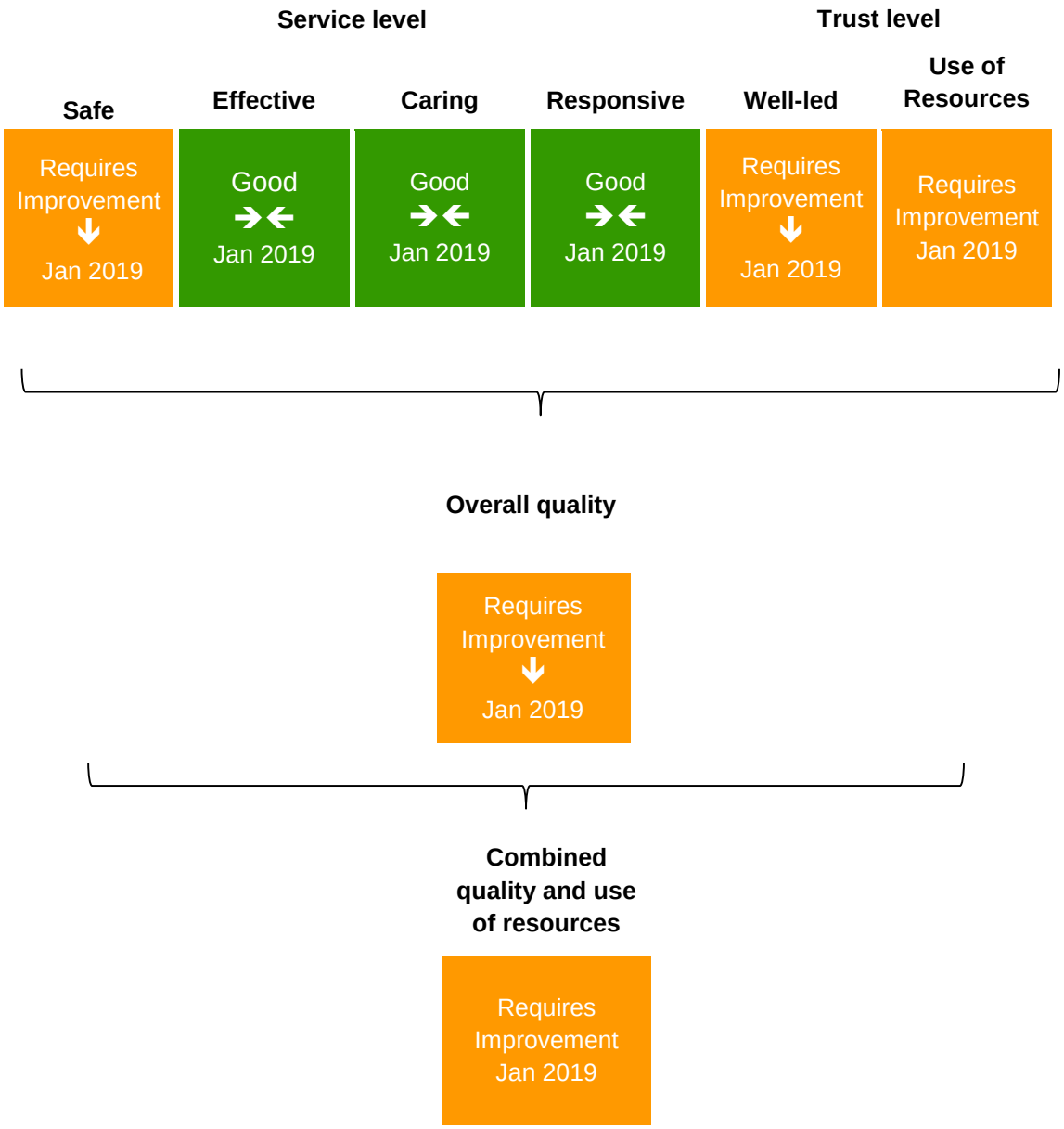
Ratings tables

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



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.
Single Oversight Framework (SOF)	The Single Oversight Framework (SOF) sets out how NHS Improvement oversees NHS trusts and NHS foundation trusts, using a consistent approach. It helps NHS Improvement to determine the type and level of support that 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 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.
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 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.