Royal Free London NHS Foundation Trust

Use of Resources assessment report

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www.royalfree.nhs.uk

Date of publication: 10 May 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?	**Requires improvement**
Are services well-led?	**Good**

Our overall quality rating combines our five trust-level quality ratings of safe, effective, caring, responsive and well-led. These ratings are based on what we found when we inspected, and other information available to us. You can find information about these ratings in our inspection report for this trust and in the related evidence appendix. (See www.cqc.org.uk/provider/royalfreenhstrust/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 safe and responsive as requires improvement; and caring, effective and well led as good.
- We rated six of the 12 services inspected this time as requires improvement. In rating the trust, we also took into account the current ratings of the services not inspected this time.
- The trust was rated requires improvement for Use of Resources.

NHS Improvement

Royal Free London NHS Foundation Trust

Use of Resources assessment report

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www.royalfree.nhs.uk

Date of site visit:
20 December 2018

Date of NHS publication:

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?	**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 20 December 2018 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?	Requires improvement

- We rated the trust's use of resources as Requires Improvement.
- For 2018/19, the trust has a surplus control total of £40.2 million (excluding PSF) and a planned deficit of £65.8 million. The trust has not accepted this control total for 2018/19. The surplus control total assumed a land sale of £70m that will not take place during the year. Even after taking into account this land sale, the trust plan is still £36m worse than the control total. As at month 9, the trust is forecasting to deliver a deficit of £67.4m due to the impact of the Agenda for Change shortfall and is £5.0m behind the year to date plan at month 9.
- In 2017/18, the trust reported a deficit of £2.1 million (excluding impairments and including £22.5 million of PSF) against a control total and plan of £11.2m deficit. This position, however, included the profit of £47.7m from sale of land and buildings. The deficit excluding these sales was £49.8m.
- The trust is reliant on short-term loans to maintain positive cash balances. The trust is forecasting to borrow £57m in 2018/19 and will have cumulative borrowing at the end of 2018/19 of £170m.
- For 2017/18 the trust had an overall cost per weighted unit of activity (WAU) of £3,380 compared with a national median of £3,486. This indicates the trust is more productive at delivering services than most other trusts by showing that, on average, the trust spends less to deliver the same number of services.
- The trusts pay cost per WAU for 2017/18, at £1,643, is below the national median of £2,180. However, the trusts non-pay cost per WAU, at £1,737, is above the national median of £1,307.
- Individual areas where the trust's productivity compared particularly well included Delayed Transfers of Care (DTOC) rates, pay cost per WAU and agency spend. Opportunities for improvement were identified in pre-procedure elective bed days, Did Not Attend (DNA) rate, pathology metrics and estates.

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 December 2018, 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 5.18%, emergency readmission rates are significantly below the national median of 9.06% as at quarter 2 2018/19. This has been attributed to a well-developed team which supports vulnerable elderly patients to return home, 48 hour follow up clinics, virtual monitoring of patients in the community by consultant led teams & clinical links with care homes.
- More patients are coming into hospital prior to treatment compared to most other hospitals in England. The trust noted this is in part explained by the complexity of services provided, particularly hepato-biliary and transplant services. The trust is also a major cancer centre which they noted impacts their productivity.
    - On pre-procedure elective bed days, at 0.43, the trust is performing in the highest (worst)

quartile and above the national median of 0.12.
    - On pre-procedure non-elective bed days, at 0.65, the trust is performing on the median when compared nationally – the national median is 0.65.

- The Did Not Attend (DNA) rate for the trust is high at 9.68% for quarter 2 2018/19. The trust explained this in in part attributed to services which are provided to a highly mobile population. The trust noted it has introduced a text messaging service to address this but at the time of the assessment, could not demonstrate the impact of this.
- At the time of the assessment, the trust reported a delayed transfers of care (DTOC) rate of 2.9% which is lower than average and lower than the trust's own target rate of 3.5%. The super stranded patient data (>21-day Length of Stay) is higher than would be expected in relation to the DTOC data. The trust demonstrated there are differences across their sites reflecting the needs of local populations eg homelessness and care home availability. The trust noted this is being addressed in collaboration with local partners. Examples of this include; fortnightly multi-agency review meetings, executive director management on the Royal Free & Barnet sites and early day discharges.
- The trust positively engages with the Getting It Right First Time (GIRFT) Programme demonstrated there is a clear process for the handling and dissemination of reports which are managed through a single point of contact in the organisation. The trust explained each is assessed through a value grid using volume high/low & cost high/low to prioritise the focus of GIRFT work. GIRFT is monitored through the clinical standards committee with board oversight and delivery of the GIRFT recommendations is done through the Clinical Practice Groups. GIRFT analysis has cited several examples of good practice in the organisation. For example, spinal services were commended, Summary Hospital Mortality Index (SHMI) is below the England national average, the trust have put in place Consultant led ward rounds with a trauma meeting every morning, Spinal emergencies are added to the first slot on MRI list each morning, Reference costs for elective intermediate extradural spinal procedure amongst the best in England.
- In addition, the trust have introduced cross system work to improve patient pathways. For example, supported by the GIRFT data, the urology pathway has been redesigned to now include same day reported MRI scanning. The trust noted this has reduced the need for transrectal ultrasound, which is an invasive procedure for patients, and there has been no increased cost as a result.
- The trust explained the provision of surgical services has been transformed in the organisation through the transferring of services between sites. For example, the majority of basic elective work has been transferred from the Royal Free site to the Chase Farm site and theatre productivity at the Chase Farm site is currently at 80% with an internal ambition to achieve 85%. The trust noted the release of capacity at the Royal Free site enables a focus on specialty services and non-elective surgery, together with an overall reduction in cancellations.
- The Clinical Practice Group (CPG) approach, supported by digital innovation, is designed to systematically reduce unwarranted variation in clinical practice and therefore waste on total pathways. An example of this work is in lung cancer where the time taken to close the lung cancer pathway has improved from 70 days to 24.6 days.

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

- For 2016/17 the trust had an overall pay cost per WAU of £1,643, compared with a national median of £2,180, placing it in the lowest (best) cost quartile nationally. This means that it spends less on staff per unit of activity than most trusts. The trust is in the lowest (best) quartile for nursing pay cost per WAU (£494 compared to a national median of £711) and the lowest (best) quartile for AHP pay cost per WAU (£88 compared to a national median of £130). It is

noted that the trusts current pay cost per WAU metric may be lower than the actual position because of the trusts high use of Homecare services (provision of medicines, and where necessary, healthcare services delivered directly to patients at home). Estimated adjustments for this factor suggest the trust would continue to be better than the national median for this metric.

- Actions underpinning the current pay cost measure for nursing include improvements to the trust's efficiency in rostering and shift pattern changes. The trust noted these actions have resulted in strengthened reporting and control mechanisms for the operational and strategic management of staffing resources. For the AHP staff group, a range of actions have been taken to improve the productivity including implementing a virtual fracture clinic and virtual follow-up joint replacement clinics alongside establishing dietetic telephone follow-up clinics and digital patient non-invasive ventilation monitoring.
- The trust benchmarks in the highest (worst) quartile for medical cost per WAU at £615 compared to a national median of £535. This position is driven in part by the trust's hosting of doctors on the GP vocational training scheme for the NHS in North East London, whereby the associated staff costs are currently allocated to the trust. The trust calculate that for 2017/18 this hosting arrangement equated to c.£50m medical staff costs being allocated to them which if adjusted for, would reduce their medical cost per WAU.
- The trust demonstrated it has taken a range of actions to support increasing the productivity of its workforce including introducing new workforce models. This includes the introduction of physician associate into a range of services including the Acute Assessment Unit and Urology services at the Royal Free Hospital and the Cardiology/Research and Development service at Barnet Hospital. The trust is also supporting the development of advanced care practitioners within nursing and AHP staff groups with 16 staff having this training during 2018/19.
- Electronic staff rostering has been established for several years for the nursing staff group in the trust and for some pharmacy and AHP staff groups. The trust noted work continues to embed electronic rostering for medical staff with a programme to drive this forward launched in July 2018 which is structured into actions required for individual divisions and medical specialties.
- The latest information shows that around 80% of medical staff in the trust currently have an active job plan. The trust advised that a digital system is in place for job planning for all medical staff, however, approximately 20% have not yet been reviewed, so are not yet active. The trust explained a suite of Allocate products (electronic job planning software) are being rolled out to link job plans and rotas, as currently there is not a single system.
- The trust met its agency ceiling as set by NHS Improvement for 2017/18 and was forecasting to deliver its ceiling in 2018/19 despite an in-year increase in agency spend. This increase is being driven by the transition period linked to the new electronic patient record at Barnet and Chase Farm hospitals. The trust's agency staff cost per WAU is £68 compared to the national median of £108 indicating it is spending less than the national average on agency as a proportion of total pay spend.
- The trust noted it has achieved reductions in the cost of agency and locum staff through a range of actions driven by a management focus and underpinned by a detailed assessment of the services with the highest use of temporary staff. The actions have included role conversions for hard to recruit to posts such as physician assistants alongside staff engagement activities (such as a 'What Matters To You Day?') to improve the retention of staff and reduce the reliance on temporary staff.
- The trust manages the workforce skill mix proactively and uses electronic acuity tools to support this management. The trust described the operational management of skill mix as 'live' and explained there is a deliberately localised approach to this which has provided local autonomy and ownership to this agenda.

- Staff retention at the trust shows room for improvement, with a retention rate of 79.3% in July 2018 against a national median of 85.8%. The trust advised that their hosting of doctors on the GP vocational training scheme for the NHS in North East London skews this number given the expected turnover dimension to this cohort. With an adjustment for this the trust estimate their retention rate to be c.85% which is closer to the national median but an area they still consider to be room for improvement. There are other one-off factors to the current staff retention metric, including the changeover to the Group model in 2017 and the transfer out of genitourinary medicine service and the pathology service at Chase Farm Hospital, also both in 2017.
- The trust demonstrated they undertake a range of actions to support this improvement by encouraging regular staff appraisal conversations, simplifying the process for staff transferring between roles within the trust and holding listening events for staff to hear issues that are impacting on staff satisfaction. More strategically the trust continues to embed its Clinical Practice Group approach across the organisation part of which is the introducing a quality improvement methodology; the aspiration being to ensure it remains a learning organisation and which should contribute to higher staff retention as a result of increasing job satisfaction.
- At 3.12% in June 2018, staff sickness rates are better than the national average of 3.76%. The trust noted this is due to the actions taken to support the health and wellbeing of staff, including work with their charity on wellbeing support. The trust's wellbeing activities include; making available to staff 'Care first Lifestyle' resource via which staff can make direct contact in response to challenges they face impacting on them at work, holding wellbeing days, team building events for all staff groups and employing mental health first aiders. The trust also promotes flexible working and self-rostering which the trust view as a contributing factor to the better than average absence rates.

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. The laboratory provision of pathology series is provided by a joint venture Health Services Laboratories (HSL) which is owned by the Royal Free London NHS Foundation Trust, University Colleges NHS Foundation Trust and Sonic/TDL (private partner).
- For pathology, the 2017/18 overall cost per test for the trust is £2.68 against a national median of £1.90, placing the trust in the highest (worst) quartile nationally. The trust noted this was due to the number of specialised tests the trust carries out and is also skewed by their pathology workforce costs. The trust explained a demand management programme was developed to reduce overall Pathology costs rather than cost per test which is now under consideration.
- The trust is working collaboratively with the North Central London 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 noted it is very actively engaged in this programme both at a local delivery level and at the Network.
- There is an established history of working together and the trust benchmarks well against plain x-ray reports by radiographer at 39.3% (2017/18).
- The trust was an outlier for vacancy rates for sonographers and radiographers in March 2017 this has improved to 1% and 8.45% respectively. This is due to a rolling recruitment programme for permanent sonographers and bank sonographers. A review of all ultrasound services will now see a consultation start to implement a new structure to reduce/remove all agency work and provide an attractive working option to support recruitment and retention.
- As part of the Top Ten Medicines programme, the trust is making good progress in delivering

on nationally identified savings opportunities, achieving 134% of the savings target.

- The trust's medicines cost per WAU at £704 is above the national median of £320 which places the trust in the highest (worst) quartile and one of the highest in England. However, the trust's headline medicine spend is not a representative comparison because it includes significant medicine spend on several services where the trust is one of only a handful of trusts providing the highly specialised service, such as a national HIV service and the largest national centre for Lysosomal storage diseases incurring over £40m per annum medicine costs.
- The trust explained there is a 4-year pharmacy transformation programme in place which is designed to improve patient care, reduce unwarranted variation and drive productivity gains from the pharmacy services. This includes improvement against; Pharmacy time on clinical activity (50% against a national median of 70% for 2016/17), percentage of pharmacists actively prescribing (17.9% against a national median 28% for 2016/17) and Sunday on ward clinical pharmacy hours of service (0 against a national median of 4 for 2016/17).
- The stockholding days for medicines reported by the trust is 17 days compared to a national median of 20 days.
- The trust also has a substantial pharmacy manufacturing service, which was subject to significant upgrade in 2017/18 with a view to ensuring compliance and resilience as well as driving efficiency and productivity in the unit, including driving commercial profitability, which in turn supports the wider NHS.

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

- For 2017/18 the trust had a non-pay cost per WAU of £1,737 compared with a national median of £1,307 which places the trust in the highest (worst) quartile. The trust indicated that this is due to specialist services and high drugs costs. The overall non-pay performance metric is driven by two areas: Medicines cost per WAU which relates to high cost drugs and Clinical Negligence and Purchased Healthcare costs per WAU which relates to CNST premium. Adjusting for these services will reduce the overall non-pay cost per WAU figure for benchmarking purposes.
- For 2017/18 the trust has a finance function cost per £100m turnover of £626,610 compared with a national median of £676,480, placing the trust in the second lowest (best) quartile. The trust noted it has partnered with Ernst and Young to automate processes within all finance functions using Robotic Process Automation (RPI) technology. The automation will see a virtual workforce enabling shared service provision at lower cost per whole time equivalent (WTE).
- For 2017/18 the trust has a Human Resources function cost per £100m turnover of £1.08m compared with a national median of £898,020, placing the trust in the second highest (worst) quartile. The trust is pioneering streamlined recruitment and use of RPI to undertake administrative processes within a lead and fully digitalised recruitment process. The trust noted it is actively engaged in exploring further collaboration, is fully participative and is leading initiatives across the STP to standardise recruitment and other processes such as mandatory training to improve staff mobility and reduce duplication on movement.
- The trust spends significantly more on information services with IM&T function cost per £100m turnover of £3.92m compared to a national median of £2.47m, placing the trust in the highest (worst) quartile. The trust explained one of the reasons for this high cost is due to being a Global Digital Exemplar and therefore there are significant non-recurrent costs in relation to this.
- For 2017/18, the trust had a Supplies and Services cost per WAU of £303 which was below the national median of £364. This shows, on average, the trust spends less on supplies and

services per WAU across all areas of clinical activity than most other trusts nationally.

- The trust's overall Price and Performance score (March 18) is 49.1 with a national peer median of 63.1. The trust has made significant progress on procurement, with performance against the Purchase Price Index Benchmark (PPIB) Top 100 opportunities. showing a 9.1% variance with a peer median of 5.9%, and national median of 6.5%. The Trust is 110th out of 136 in the Procurement League table this is an improvement of 5 places from the 2016/17 table.
- The procurement services are carried out by a Shared service led by the Whittington Hospital and will move to commons system across all trusts, so the operational buying teams will also align. In 2018/19 procurement has been focussed on implanting a new eProcurement front-end at March 18 % of transactions on e-Catalogue was 100% against a national median of 84.1%
- The trust's 2017/18 estates cost per square metre is £507 which places it in the highest (worst) quartile and significantly above the national median of £379 per square metre. The trust did highlight data quality issues with the cost per square metre metric that is was investigating and receiving support for. The trust also noted it has been active in improving the functionality of its estate and have invested in key areas such as A&E, critical care and theatres which have been rebuilt at Chase Farm Hospital to address the most inefficient estate. At Chase Farm this has seen a reduction from circa 60,000 square metres to 24,000 square metres without a drop in capacity or clinical activity. The driver of these costs are satellite sites such as community rents and costly old estate.
- The total backlog maintenance for 2017/18 is £269 per metre squared compared to the national median of £186 per square metre. For the same period, the trust has a critical infrastructure risk of £120 per square metre compared to a national median of £57 per square metre.

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

- The trust is in deficit and has an inconsistent track record of managing spending within available resources and in line with plans.
- In 2017/18, the trust reported a deficit of £2.1 million (including £22.5 million of PSF) of against a control total and plan of £11.2m deficit. This position, however, included the profit of £47.7m from sale of land and buildings. The deficit excluding these sales was £49.8m.
- For 2018/19, the trust has a surplus control total of £40.2 million (excluding PSF) and a planned deficit of £65.8 million. The surplus control total assumed a land sale of £70m that will not take place during the year. Even after taking into account this land sale, the trust plan is still £36m worse than the control total. As at month 9 the trust is forecasting to deliver a deficit of £67.4m due to the impact of the Agenda for Change shortfall and is £5.0m behind the year to date plan at month 9.
- The trust cites the following factors as drivers of the deficit: operational issues (under achievement of CIP, productivity opportunity, decline in private patient margin), strategic issues (commissioner income pressures, Barnet and Chase Farm acquisition, loss of services) and structural issues (unfunded services, PFI costs). The trust demonstrated it is developing a strategy to address these drivers.
- The trust has a cost improvement plan (CIP) of £45.4m (or 4.4% of its expenditure) and is currently forecasting to fall short of its plans by £3.3m. The trust delivered 99% of its planned savings in the previous financial year, of which 28% were non-recurrent. For 2018/19, 43% of the savings are forecast to be non-recurrent. The level of non-recurrent savings has increased over the two-year period which is exacerbating the underlying pressure being carried forward in 2019/20.
- The trust has relatively low cash reserves and is not 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 reliant on short-term loans to maintain positive cash balances. The trust is forecast to borrow £57m in 2018/19 and will have cumulative borrowing at the end of 2018/19 of £170m.

- The trust has a well-established private patient business that makes a significant contribution to the running of the hospital. The trust is part of a joint venture for laboratory services (Health Services Laboratories) and is looking at opportunities to expand this business to other providers in the area.
- The trust has well embedded patient level costing systems that has significant clinical engagement. This information is used when making business decisions, for example the budgets at the new Chase Farm Hospital were set using patient level costing data.
- The trust is forecasting to spend £4.5m on consultancy in 2018/19.

Outstanding practice

- Emergency readmission rates are significantly below the national median due to a well-developed team which supports vulnerable elderly patients to return home, 48 hour follow up clinics, virtual monitoring of patients in the community by consultant led teams & clinical links with care homes
- Staff sickness rates are better than the national average due to the actions taken to support the health and wellbeing of staff, including work with their charity on wellbeing support. The trust's wellbeing activities include; making available to staff 'Care first Lifestyle' resource via which staff can make direct contact in response to challenges they face impacting on them at work, holding wellbeing days, team building events for all staff groups and employing mental health first aiders. The trust also promotes flexible working and self-rostering which the trust view as a contributing factor to the better than average absence rates.
- The trust has partnered with Ernst and Young to automate processes within all finance functions using Robotic Process Automation (RPI) technology. The automation will see a virtual workforce enabling shared service provision at lower cost per whole time equivalent (WTE). The trust is also pioneering streamlined recruitment and use of RPI to undertake HR administrative processes within a lead and fully digitalised recruitment process.
- The trust introduced a Clinical Practice Group approach which reduces unwarranted variation in clinical practice. The trust utilises this approach, alongside full clinical engagement, to ensure the successful delivery of GIRFT recommendations and GIRFT analysis has cited several examples of good practice, such as spinal services.

Areas for improvement

- The trust was not meeting the constitutional operational performance standards around Referral to Treatment (RTT), Cancer and Accident & Emergency (A&E) at the time of the assessment.
- The Did Not Attend (DNA) rate for the trust is high compared to the national average.

- The trust is performing in the highest (worst) quartile for pre-procedure elective bed days.
- The level of non-recurrent savings delivered has increased over the last two years which is exacerbating the underlying pressure being carried forward. In 2018/19, 43% of savings are forecast to be non-recurrent.

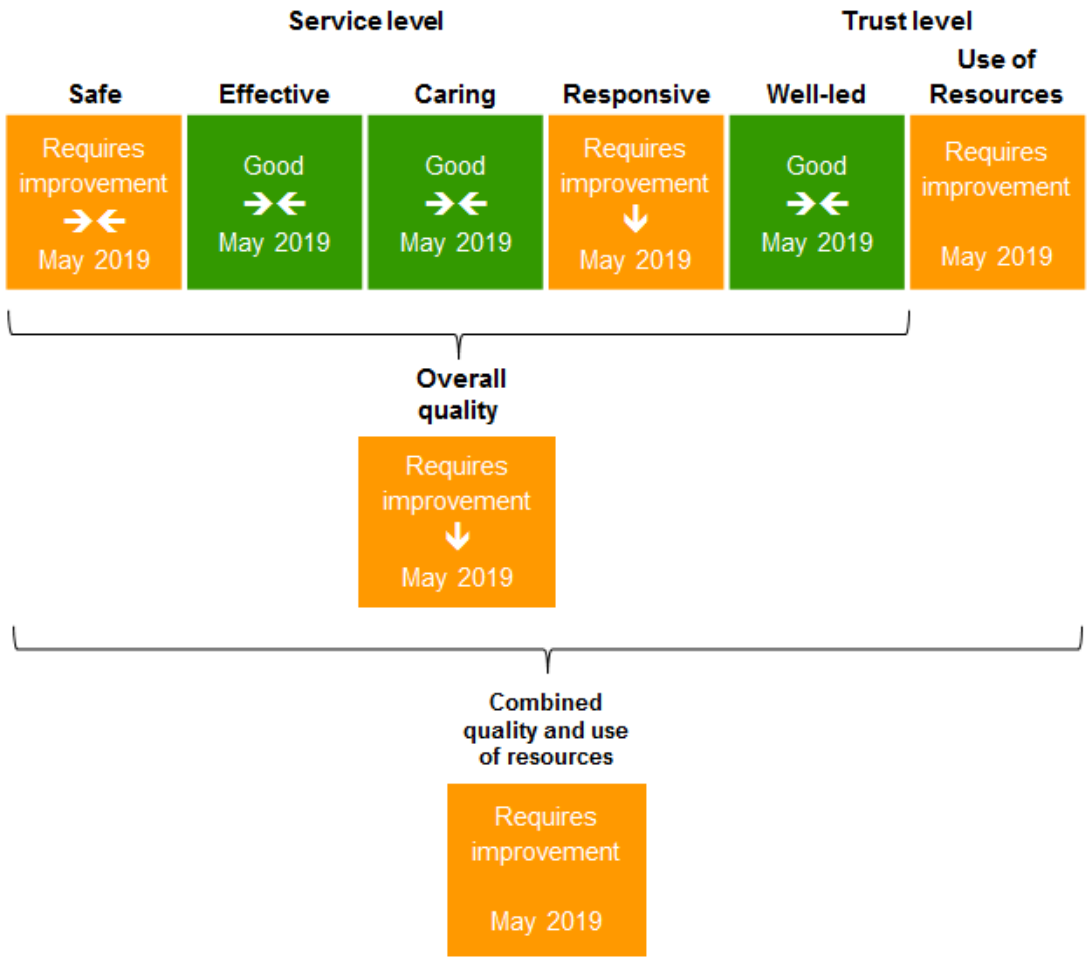
Ratings tables

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

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

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

Ratings for the whole trust



Use of Resources report glossary

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

Diagnostic 6-week wait target	According to this national target, at least 99% of patients should wait no longer than 6 weeks for a diagnostic procedure.
Did not attend (DNA) rate	A high level of DNAs indicates a system that might be making unnecessary outpatient appointments or failing to communicate clearly with patients. It also might mean the hospital has made appointments at inappropriate times, eg school closing hour. Patients might not be clear how to rearrange an appointment. Lowering this rate would help the trust save costs on unconfirmed appointments and increase system efficiency.
Distance from financial plan	This metric measures the variance between the trust's annual financial plan and its actual performance. Trusts are expected to be on, or ahead, of financial plan, to ensure the sector achieves, or exceeds, its annual forecast. Being behind plan may be the result of poor financial management, poor financial planning or both.
Doctors cost per WAU	This is a doctor specific version of the pay cost per WAU metric. This allows trusts to query why their doctor pay is higher or lower than national peers. Consideration should be given to clinical staff mix and clinical staff skill mix when using this metric.
Delayed transfers of care (DTOC)	A DTOC from acute or non-acute care occurs when a patient is ready to depart from such care is still occupying a bed. This happens for a number of reasons, such as awaiting completion of assessment, public funding, further non-acute NHS care, residential home placement or availability, or care package in own home, or due to patient or family choice.
EBITDA	Earnings Before Interest, Tax, Depreciation and Amortisation divided by total revenue. This is a measurement of an organisation's operating profitability as a percentage of its total revenue.
Emergency readmissions	This metric looks at the number of emergency readmissions within 30 days of the original procedure/stay, and the associated financial opportunity of reducing this number. The percentage of patients readmitted to hospital within 30 days of discharge can be an indicator of the quality of care received during the first admission and how appropriate the original decision made to discharge was.
Electronic staff record (ESR)	ESR is an electronic human resources and payroll database system used by the NHS to manage its staff.
Estates cost per square metre	This metric examines the overall cost-effectiveness of the trust's estates, looking at the cost per square metre. The aim is to reduce property costs relative to those paid by peers over time.
Finance cost per £100 million turnover	This metric shows the annual cost of the finance department for each £100 million of trust turnover. A low value is preferable to a high value but the quality and efficiency of the department's services should also be considered.
Getting It Right First Time (GIRFT) programme	GIRFT is a national programme designed to improve medical care within the NHS by reducing unwarranted variations.

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

costs	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.