Royal Liverpool and Broadgreen University Hospital NHS Trust

Use of Resources assessment report

Address
Royal Liverpool University Hospital
Prescot Street
Liverpool
L7 8XP
Tel: 0151 706 2000
www.rlbuht.nhs.uk

Date of publication: 17 July 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?	**Good**
Are services effective?	**Good**
Are services caring?	**Outstanding**
Are services responsive?	**Requires improvement**
Are services well-led?	**Requires improvement**

Our overall quality rating combines our five trust-level quality ratings of safe, effective, caring, responsive and well-led. These ratings are based on what we found when we inspected, and other information available to us. You can find information about these ratings in our inspection report for this trust and in the related evidence appendix. (See www.cqc.org.uk/provider/RQ6/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 the hospital as requires improvement for safe, effective, responsive. We rated caring and well led as good. We rated five of the trust's services at this inspection. In rating the trust, we took into account the current ratings of the services not inspected this time.

We rated well-led at the trust level as requires improvement.

We rated community services as good for safe, effective and well led. We rated responsive as requires improvement and caring as outstanding.

It was agreed that we would rate but not aggregate the ratings for community services as part of this inspection

Our decisions on overall ratings take into account, for example, the relative size of services and we use our professional judgement to reach a fair and balanced rating.

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

NHS Improvement

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Date of site visit:
28 January 2019

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 28 January 2019 and met the trust's leadership team including the chief executive and the chair, as well as relevant senior management responsible for the areas under this assessment's KLOEs.

Findings

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

- We rated the trust's use of resources as Requires Improvement.
- The trust failed to balance its budget in 2017/18, reporting a deficit of £26.2 million against a control total surplus of £5.3m. As at quarter three 2018/19, the trust is off track to achieve a deficit of £39.7 million in 2018/19, against a control total of £4.4m and has submitted a revised forecast of a £54.4m deficit. The impact of the collapse of the construction company (Carillion) and the subsequent termination of the PFI funding model of new Royal hospital has contributed to this deficit position.
- The trust has formally signalled to NHS Improvement and its local commissioners that it is financially unsustainable in the long term. The trust has developed significant transformation plans alongside Aintree University Hospital NHS Foundation Trust to address clinical sustainability challenges. It is anticipated that there will be significant financial benefits arising from the planned merger but this in itself is unlikely to fully resolve the two organisations' joint deficit.
- The trust is reliant on external loans to meet its financial obligations and deliver its services.
- The trust spends more on pay and other goods and services per weighted unit of activity (WAU) than most other trusts nationally. In 2017/18 the trust had an overall cost per WAU of £3,619, compared with a national median of £3,486, placing it in the second highest (worst) quartile nationally. This indicates that the trust is less productive at delivering services than other trusts by showing that, on average, the trust spends more to deliver the same number of services.
- The trusts pay cost per WAU, at £2,008, is below the national median of £2,180 and in the lowest (best) quartile. This means the trust spends less on staff per unit of activity than most other trusts. However, the trusts non-pay cost per WAU, at £1,611, is above the national median of £1,307 and in the highest (worst) quartile. This means the trust spends more on goods and other services than most other trusts nationally.
- Individual areas where the trust's productivity compared particularly well included pay cost per WAU, pathology, pharmacy and Delayed Transfers of Care (DTOC). Opportunities for improvement were identified in Did Not Attend (DNA) rates, staff retention, staff sickness, non-pay cost per WAU and procurement.
- As a Global Digital Exemplar, the trust was able to demonstrate a clear theme of using technology and innovation to improve productivity throughout the trust. The trust has developed a digital strategy and vision, 'Digital Liverpool' and through this have introduced projects such as the use of artificial intelligence and virtual reality.

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

- At the time of the assessment in January 2019, the trust was not meeting the constitutional operational performance standards around Referral to Treatment (RTT), Cancer and Accident & Emergency (A&E). A&E performance has consistently been 86-89%; RTT has been relatively static, from 81.5% in March 18 to 81.8% in November 18,

however, Diagnostics performance has improved significantly from 22.5% in November 17 to 1.3% in November 18, although this remains above the 1% standard.

- Patients are less likely to require additional medical treatment for the same condition at this trust compared to other trusts. At 8.9%, emergency readmission rates are below the national median of 9.06% as at quarter two 2018/19. The trust noted they have introduced a number of programmes to reduce the readmission rate, including the introduction of a frailty unit, community teams and palliative care teams.
- More elective patients are coming into hospital unnecessarily prior to treatment compared to most other hospitals in England.
    - On pre-procedure elective bed days, at 0.29, the trust is performing in the highest (worst) quartile when compared to its nationally – the national median is 0.17. The trust stated this is due to the Regional Transplant Unit and pathways to ensure patients are fit for surgery.
    - On pre-procedure non-elective bed days, at 0.50, the trust is performing in the lowest (best) when compared to its nationally – the national median is 0.65.
- The Did Not Attend (DNA) rate for the trust is high at 9.71% at quarter two 2018/19 compared to the national median of 7.32%. The trust recognises this is a problem and has implemented a number of initiatives to help reduce DNA rates such as the introduction of a text reminder service, virtual clinics and video consultations. The trust has also introduced a self-service appointment application which allows patients to notify if running late for an appointment and check into the hospital on arrival.
- The trust explained DNA rates are a particular challenge for the younger age cohort within the Diabetes service as are a number of other chronic diseases. The trust has held focus groups with patients to discuss ways of improving rates and has developed a Liverpool diabetes partnership as part of its chronic disease management work.
- The trust reports a delayed transfers of care (DTOC) rate of 2.1% in January 2019 which is lower than the national average and lower than the trusts own target rate of 3.5%. Despite this, the trust saw an increase in DTOC rates between June and November 2018. The trust explained the majority of delayed discharges are due to community delays and links in with the wider economy to support reduction of this.
- With the aim of improving clinical productivity, the trust introduced a clinical prioritisation system that looks at the opportunity for patient discharge based on a risk scoring system. The system involves closer working with the local authority and local care homes and the trust explained this has led to discharges that wouldn't have otherwise happened.
- The trust was able to demonstrate engagement with the Getting It Right First Time (GRIFT) programme with an Executive Programme Board for GIRFT in place and the medical director as the executive champion. The trust provided a number of examples of improvements following GIRFT visits, which includes:
    - Increased efficiencies in General Surgery which have generated additional income;
    - Acted to address the trust's outlier length of stay for appendectomies through decision to develop a nurse led discharge

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

- For 2017/18 the trust had an overall pay cost per WAU of £2,008, compared with a national median of £2,180, placing it in the lowest (best) quartile nationally. This means that it spends less on staff per unit of activity than most trusts.

- For 2017/18, the trust's medical cost per WAU (£426 compared to national median of £533) and nursing cost per WAU (£602 compared to national median of £710) were in the lowest (best) quartile and below the national median. The trust's Allied Health Professionals cost per WAU of £125 is just below the national median of £130, placing the trust in the second lowest (best) quartile.
- The trust has increased its use of junior staff through focusing on training and monitoring safety, for example, it has brought in Band 5 grade roles in as speech therapists and then trained staff to a more senior level. The trust has also increased its Band 4 roles across specialities to supplement nursing roles and looked to be more flexible in which staff can hold responsibility or clinical areas.
- The trust met its agency ceiling as set by NHS Improvement for 2017/18 and is forecasting to meet its ceiling in 2018/19. Its proportion of temporary staff has reduced from 2.91% in May 2017, to 1.41% in October 2018, which means it is spending less than the national average (4.6% for 2017/18) on agency as a proportion of total pay spend.
- Agency staff cost per WAU, at £42, is below the national median of £108. The trust explained it had achieved reductions in the cost of agency and locum staff through its implementation of a Pay Improvement Group which meets weekly to review vacancies and additional payments to staff. It has achieved a significant reduction in nursing agency spend through reviewing additional resource at its daily huddles and a greater uptake of bank participation. It has a centralised process for price cap overrides and a weekly 'check and challenge' meeting for long-term locums.
- The trust has a clear understanding of its spend on bank and agency across nursing and scrutinises rotas on a weekly basis. High cost agencies are not utilised and there is a Health Care Assistant trust bank that allocates staff on the day avoiding last minute high cost bookings - the Bank fill rate is at 93%.
- The trust has e-rostering (Roster-pro) in place for its nursing staff and has plans to move to Allocate following the merger with Aintree University Hospital NHS Foundation Trust to enable inclusion of patient acuity. At the moment 80% of rosters are completed six weeks in advance. For clinicians, the trust has a number of different rostering tools in use in the different specialities but has invested in Allocate and will roll out its use in 2019/20.
- The trust has introduced new roles across the workforce that will challenge the traditional medical models. This includes growing Band 4 roles across specialities; and the introduction of physician's associates in a number of specialities.
- The trust is moving to Allocate for its Consultant job plans – 100% are in progress and the Deputy Medical Director has undertaken 'Check and Challenge' meetings with 97% of the consultants. The trust noted this will be fully embedded from 2019 with an annual review in June. The trust is also progressing job plans for its nurse consultants and AHPs.
- The trust's main rota gaps are in areas where there are national supply issues, including histopathology; ortho-geriatricians; trauma and orthopaedics; and dermatology. The clinical benefits of the planned merger with Aintree University Hospital NHS Foundation Trust include the improved ability to staff rotas in specialist areas.
- Staff retention at the trust is low, with a retention rate of 85.3% compared with a national median of 85.9% as at September 2018. The trust explained they have introduced a retention programme which includes conducting exit interviews and building 'Itchy Feet' conversations into ward managers roles. In addition, the trust have introduced an internal transfer programme whereby nursing staff can move within the organisation with support provided. The trust noted this has improved the nursing retention rate by 4% since the beginning of 2018.

- At 4.58% in September 2018, staff sickness rates are worse than the national median of 4%, placing the trust in the highest (worst) quartile. The trust recognises staff sickness is an area for improvement and have implemented initiatives to support staff and prevent sickness absence. For example, the trust has implemented a new health and wellbeing strategy which includes wellbeing programmes focussing on both physical and mental health such as; yoga, Pilates and a mindfulness programme. The trust also noted that an element of its sickness absence is as a result of a cultural issue and is focusing on addressing this with staff through deep dives in hot spot areas.

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

- The overall cost per test at the trust, at £1.53 for 2017/18, benchmarks below the national median of £1.86, placing the trust in the lowest (best) quartile nationally. The trust explained this was due to the economies of scale of a merged service across the city of Liverpool and the established of a Joint Venture.
- The trust was able to provide evidence of working collaboratively with the Cheshire and Mersey Pathology Network to continue to implement the recommendations from the Carter Review into operational productivity in the NHS of a hub and spoke delivery model at scale. The trust demonstrated it is very actively engaged in this programme both at a local delivery level and at the Network and is sharing its learning from the consolidation.
- For imaging, the trust benchmarks in the lowest (best) quartile for cost per report at £33.36 compared with a national median of £34.44. The trust demonstrated engagement with the Cheshire and Mersey Imaging Network and are involved in the father development and opportunities to collaborate at scale.
- The trust's medicines cost per WAU, at £399, is relatively high when compared to the national median of £320. The trust explained this was due to the number of specialist service areas and high cost drugs provided by the trust (such as HIV and Hepatitis C). The trust also demonstrated this is impacted by the staff costs associated with the hosted Specialist Pharmacist Service (SPS) and in-house and commercial aseptic unit.
- As part of the Top Ten Medicines programme, it is making good progress in delivering on nationally identified savings opportunities, achieving 121% of the savings target against a lower benchmark of 80% and an upper benchmark of 100% (as of March 2018).
- The trust was able to demonstrate an understanding of its pharmacy costs and wider medicines optimisation with 90% of pharmacy time spent on clinical activity compared to a national median of 76% and 80% of pharmacists actively prescribing against a national median of 36%. In addition, the trust have a 12-hour Sunday on-ward clinical pharmacy service compared to 4-hour national median.
- The trust is a Global Digital Exemplar (GDE) and has developed a digital strategy and vision, 'Digital Liverpool'. Through the GDE programme, the trust has developed a number of projects, including:
    - The use of virtual reality as distraction therapy for patients in palliative care at the Royal Liverpool University Hospital and Marie Curie Hospice Liverpool. The trust were able to demonstrate all patients using virtual reality had a positive experience and felt it could be beneficial in the management of their symptoms. The trust noted the project has been extended to include some patients in critical care and high dependency units.
    - Working with Deontics (a health technology company) to use artificial intelligence (AI) to improve care for heart attack patients and reduce the risk of reoccurring heart attacks. The trust have piloted the use of AI technology to help doctors make

decisions about patient care through assessing data, evidence and guidance, and making recommendations on individual patient's needs.

- The trust was also able to demonstrate a clear theme of using technology and innovation to improve productivity throughout the trust and provided some examples, including a fully digitised nurse observation system, an admission, discharge and transfer whiteboard system and development of an e-sepsis programme. The trust has also been chosen as a pilot site for 'Sensor City' which aims to investigate the opportunities of 5G community wi-fi in health and social care.

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 an overall non-pay cost per WAU of £1,611, compared with a national median of £1,307, placing it in the highest (worst) quartile nationally. This shows the trust is spending more on other goods and services than most other trusts nationally. The trust explained this is in part due to the impact of high costs drugs and devices and the specialist services provided by the trust, such as dialysis.
- For 2017/18, the trust has a finance function cost per £100m turnover of £548,000 compared with a national median of £676,480, placing the trust in the lowest (best) quartile.
- However, for the same period the trust has Human Resources (HR) function cost per £100m turnover of £1.25m compared with a national median of £898,020, placing the trust in the highest (worst) quartile nationally. The trust noted the higher function cost is as a result of their education costs, particularly in relation to medical education.
- The trust has an IM&T function cost per £100m turnover of £4.06m compared with a national median of £2.47m. The trust explained this is in part due to being a Global Digital Exemplar (GDE) and the inclusions of costs within the financial year that are inflated, such as paying for 2 data centres and renewed licences.
- The trust is an active member of the Cheshire and Mersey Carter at Scale Board, which is a formal part of the Cheshire and Mersey Health Care Partnership. The Board members and workstreams are working to consolidate and standardise across all corporate services where appropriate.
- The trust's procurement processes are relatively inefficient and tend not to successfully drive down costs on the things it buys. This is reflected in the trust's Procurement Process Efficiency and Price Performance Score of 20, which placed it in the lowest (worst) quartile when compared with a national average of 57. The trust does not currently submit a full data set on a monthly basis (Carter Metrics) to allow further analysis, however, they are expecting to be in a position to start this soon. The trust also recognises this is an area for improvement and has designed a programme of targeted work and proposals for a redesigned procurement function with the aim changing the current model used.
- At £335 per square metre for 2017/18, the trust's estates and facilities cost per square metre benchmark below the national average of £379. The trusts hard facilities management (FM) cost per metre square, at £77, benchmark below the national median of £93; however, the trusts soft FM costs, at £132, benchmark above the national median of £122. The trust noted its estates and facilities costs were in some degree driven by the delay in the build of its new hospital and where looking to understand the impact of running both the build and existing infrastructure.

- The trust's backlog maintenance cost per metre square, at £31, benchmarks low against a national median of £186. However, it is recognised that there has been lack of investment in backlog maintenance with the expectation that the new build was near completion and close to becoming operational. The trust acknowledged that due to the delay in the new build the board and estate function would re-evaluate the critical infrastructure risk.

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

- The trust is not currently managing its financial resources to deliver high quality and sustainable services; however, it does understand the circumstances driving its financial performance.
- The trust's control total in 2017/18 was set as a £5.3m surplus, excluding Sustainability and Transformation Funding (STF). The trust submitted a 2017/18 plan to NHSI with a deficit of £4.6m, excluding STF, and then subsequently the trust board agreed a revised internal plan of £14.4m deficit, excluding STF, and eventually reported a deficit of £26.2m, excluding STF.
- For 2018/19, the trust was set a control total (excluding STF) of a £4.4m surplus. The trust submitted a plan of £39.7m (excluding STF). As at month 9 the trust's position is a deficit of £43.1m which is £5.2m adverse from plan YTD. The trust has revised its forecast deficit for 2018/19 to £54.5m, which is 8.9% of turnover. The impact of the collapse the construction company (Carillion) and the subsequent termination of the PFI funding model of new Royal hospital has contributed to this deficit position.
- Drivers of this position include undelivered efficiency savings, non-delivery of assumed system wide savings and additional costs for maintenance of the current estate, due to the delay in the completion of the build of its new hospital.
- The trust is reliant on external loans to meet its financial obligations and deliver its services and at the end of 2018/19 is forecast to have £110.4m in the Department of Health and Social Care working capital loans.
- The trust has formally signalled to NHS Improvement and its local commissioners that it is financially unsustainable in the long term. The trust has developed significant transformation plans alongside Aintree University Hospital NHS Foundation Trust but acknowledges that at present, these will deliver clinical sustainability and reduce the financial deficits of the two organisations, but not achieve financial sustainability.
- The trust reported 2017/18 savings of £11.9m (2.1% expenditure), with 50% classified as recurrent. As at month 9 2018/19, the trust was forecasting to deliver cost savings of £21m (3.9% of expenditure) against a target of £31.4m (5.8% of expenditure) of which £11.9m (57%) classified as recurrent.
- The capital servicing capacity is a measure of the trust's ability to meet its borrowing obligations. This metric was -0.39 at the end of 2017/18 and is expected to deteriorate to -0.92 at the end of the 2018/19. This is due to the deterioration in the trust's deficit, resulting in reduced ability to meet financial obligations, thus requiring increased cash support.
- The trust is exploring opportunities to maximise its oversea visitor income, having improved from a recovery of £92k in 2016/17 to £350k in 2018/19 as at month 9 and has plans to further improve.
- The trust has used its service line reporting (SLR) data to inform its savings schemes and has realised £0.7m in savings in 2018/19 through SLR work linking to theatre productivity and length of stay. Through the use of SLR, it identified deficits in general surgery

through the cost of complex pancreatic surgery. The development of a new endoscopic method of treatment has resulted in c£27k savings per patient.

Outstanding practice

- The trust has developed a strong and consistent approach across the trust to the use of agency staffing, from the understanding of ward acuity; the development of nurse pools to move staff flexibly across the trust; and the clear accountability held through the Pay Improvement Group
- The trust is a Global Digital Exemplar (GDE) and has developed a digital strategy and vision, 'Digital Liverpool'. Through the GDE programme, the trust has developed a number of projects, including:
    - The use of virtual reality as distraction therapy for patients in palliative care at the Royal Liverpool University Hospital and Marie Curie Hospice Liverpool. The trust were able to demonstrate all patients using virtual reality had a positive experience and felt it could be beneficial in the management of their symptoms. The trust noted the project has been extended to include some patients in critical care and high dependency units.
    - Working with Deontics (a health technology company) to use artificial intelligence (AI) to improve care for heart attack patients and reduce the risk of reoccurring heart attacks. The trust have piloted the use of AI technology to help doctors make decisions about patient care through assessing data, evidence and guidance, and making recommendations on individual patient's needs.

Areas for improvement

- The trust has formally signalled to NHS Improvement and its local commissioners that it is financially unsustainable in the long term as a standalone organisation, and so should develop a plan for achieving financial sustainability, linked with the progression of the merger with Aintree University Hospital Foundation Trust.
- The trust is currently failing to achieve financial targets in 2017/18 and at the time of the inspection was forecasting not to achieve financial targets for 2018/19.
- The trust is reliant on financial loans from the Department of Health to meet its financial obligations.
- DNA rates are high at the trust and although some initiatives have already been introduced, further work is required to reduce these.
- The trusts non-pay costs are higher than the national average.
- The trust has a number of workforce challenges; Staff sickness absence levels are higher than the national median and staff retention at the trust is below the national median.

- The trust's procurement processes are relatively inefficient and at present the trust does not submit monthly data to track procurement process performance, an area they recognise improvement is required.
- The trust is failing to meet NHS Constitutional Standards including A&E Waiting Times; Referral to Treatment waiting times; and Cancer waiting times.

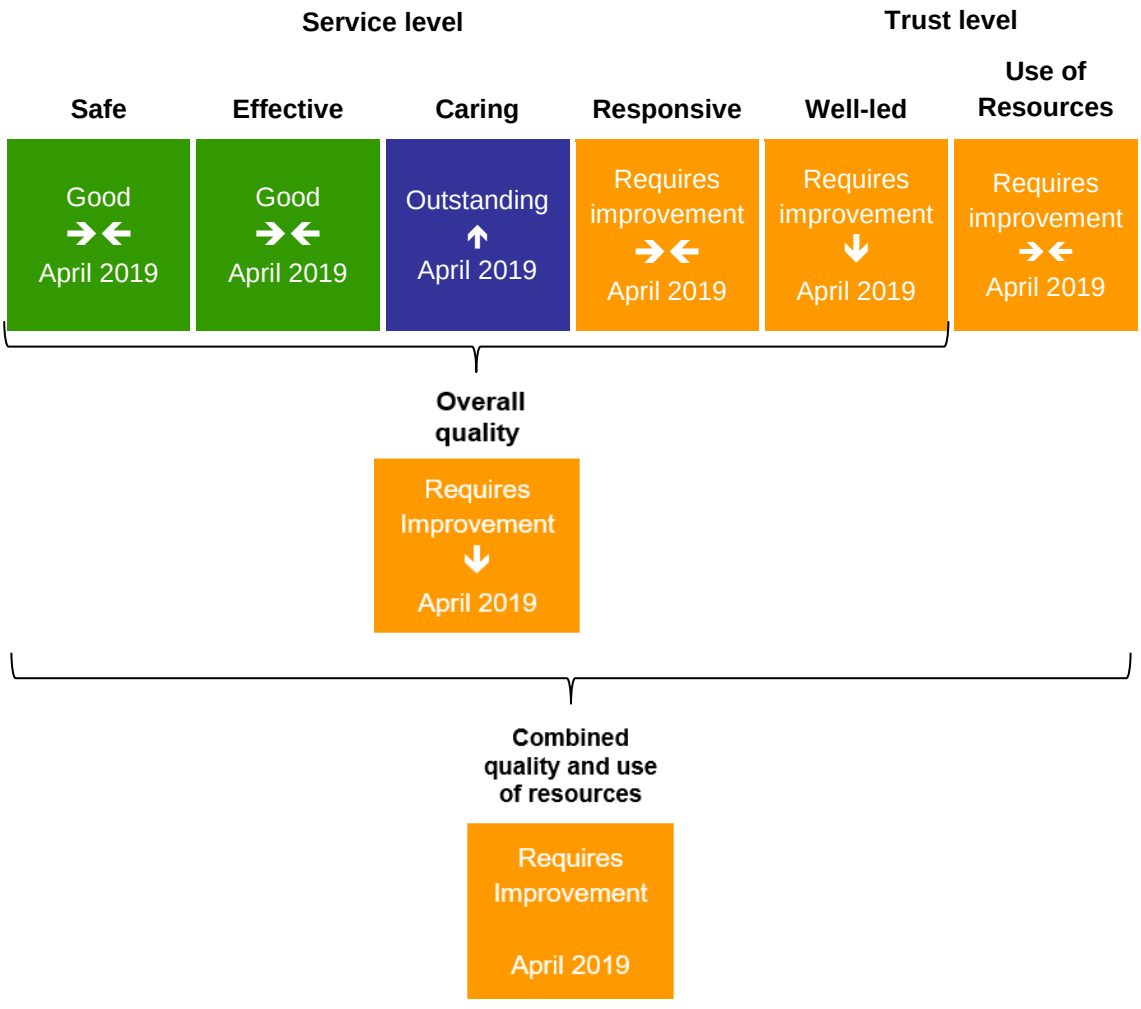
Ratings tables

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)	This metric shows the annual cost of the trust's HR department for each £100 million of trust turnover. A low value is preferable to a high value but the quality and efficiency of the department's services should also be considered.

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

Pre-procedure elective bed days	This metric looks at the length of stay between admission and an elective procedure being carried out – the aim being to minimise it – and the associated financial productivity opportunity of reducing this. Better performers will have a lower number of bed days.
Pre-procedure non-elective bed days	This metric looks at the length of stay between admission and an emergency procedure being carried out – the aim being to minimise it – and the associated financial productivity opportunity of reducing this. Better performers will have a lower number of bed days.
Procurement Process Efficiency and Price Performance Score	This metric provides an indication of the operational efficiency and price performance of the trust's procurement process. It provides a combined score of 5 individual metrics which assess both engagement with price benchmarking (the process element) and the prices secured for the goods purchased compared to other trusts (the performance element). A high score indicates that the procurement function of the trust is efficient and is performing well in securing the best prices.
Sickness absence	High levels of staff sickness absence can have a negative impact on organisational performance and productivity. Organisations should aim to reduce the number of days lost through sickness absence over time.
Service line reporting (SLR)	SLR brings together the income generated by services and the costs associated with providing that service to patients for each operational unit. Management of service lines enables trusts to better understand the combined view of resources, costs and income, and hence profit and loss, by service line or speciality rather than at trust or directorate level.
Supporting Professional Activities (SPA)	Activities that underpin direct clinical care, such as training, medical education, continuing professional development, formal teaching, audit, job planning, appraisal, research, clinical management and local clinical governance activities.
Staff retention rate	This metric considers the stability of the workforce. Some turnover in an organisation is acceptable and healthy, but a high level can have a negative impact on organisational performance (eg through loss of capacity, skills and knowledge). In most circumstances organisations should seek to reduce the percentage of leavers over time.
Top Ten Medicines	Top Ten Medicines, linked with the Medicines Value Programme, sets trusts specific monthly savings targets related to their choice of medicines. This includes the uptake of biosimilar medicines, the use of new generic medicines and choice of product for clinical reasons. These metrics report trusts' % achievement against these targets. Trusts can assess their success in pursuing these savings (relative to national peers).
Weighted activity unit (WAU)	The weighted activity unit is a measure of activity where one WAU is a unit of hospital activity equivalent to an average elective inpatient stay.