Royal United Hospitals Bath NHS Foundation Trust

Use of Resources assessment report

Address: Coombe Park,
Bath, Avon. BA1 3NG

Tel: 01225 428331
www.ruh.nhs.uk

Date of publication: 26 September 2018

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

Ratings

Overall quality rating for this trust	**Good** ●
Are services safe?	**Good** ●
Are services effective?	**Good** ●
Are services caring?	**Outstanding** ☆
Are services responsive?	**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/RF4/reports)

Are resources used productively?	**Good** ●

Combined rating for quality and use of resources	**Good** ●

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

Our combined rating for Quality and Use of Resources summarises the performance of the 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 good, because:

- we rated safe, effective and well-led as good. Responsive was rated as requires improvement and caring as outstanding.
- the trust was rated as good for use of resources.

Royal United Hospitals Bath NHS Foundation Trust

Use of Resources assessment report

Address: Coombe Park,
Bath, Avon. BA1 3NG

Tel: 01225 428331
www.ruh.nhs.uk

Date of site visit:
18 June 2018

Date of publication: 26 September 2018

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. A summary of the Use of Resources report is also included in CQC's inspection report for this trust.

How effectively is the trust using its resources?	**Good** ●

How we carried out this assessment

The aim of Use of Resources assessments is to understand how effectively providers are using their resources to provide high quality, efficient and sustainable care for patients. The assessment team has, according to the published framework, examined the trust's performance against a set of initial metrics alongside local intelligence from NHS Improvement's day-to-day interactions with the trust, and the trust's own commentary of its performance. The team conducted a dedicated site visit to engage with key staff using agreed key lines of enquiry (KLOEs) and prompts in the areas of clinical services; people; clinical support services; corporate services, procurement, estates and facilities; and finance. All KLOEs, initial metrics and prompts can be found in the Use of Resources assessment framework.

We visited the trust on 18 June 2018 and met the trust's executive team (including the chief executive), a non-executive director (in this case, the chair and deputy 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?	Good ●

We rated the trust's use of resources as good, supporting it to provide high quality and sustainable care for patients.

- In 2016/17 (latest available data) the trust's cost per weighted activity unit (WAU) was £3,142 compared with a national median of £3,484, placing it in the lowest (best) quartile. This indicates that the trust is more efficient at delivering clinical services than most other trusts.
- The trust is planning to deliver a financial surplus in 2018/19 and has a good track record over the last two years of managing spend within available resources and in line with plan. The trust reported a surplus in 2017/18 of £17.5m surplus including Sustainability and Transformation Funding (STF) of £11.4m. It has agreed its control total for 2018/19 with NHS Improvement, with a planned surplus of £12.8m including Provider Sustainability Funding (PSF) of £11m.
- The trust recognises that 2018/19 is a more challenging financial year and had £2.5m of unidentified savings as at month 2 out of a plan of £13.9m. The trust Board is appraised of the trust's underlying deficit of £10.6m going into 2018/19 and the plans to substantially reduce this through recurrent measures during 2018/19.
- The trust has a £13.9 million Cost Improvement Programme (CIP) in 2018/19 which is an increase from the prior year and equates to 4.1% of operating expense, of which the trust expects to deliver £2.9m non-recurrently (i.e. from one-off savings) that will benefit the trust financially in 2018/19 but not in future years.
- The trust is able to meet its financial obligations and pay its staff and suppliers in the immediate term and meets capital service and liquidity metrics. The trust is maintaining positive cash balances without the need for interim support.
- Individual areas where the trust's productivity compare particularly well include total pay cost per WAU which placed the trust in the best quartile; low Did Not Attend (DNA) rates, placing the trust in the lowest (best) quartile nationally; cost per pathology also in the lowest cost (best) quartile and top ten medicines (savings delivery on top 10 medicines where the trust delivered 150% of the savings target in the relevant month).
- During 2017/18, the trust had a well-established 'Fit for the Future Board' in place with executive and non-executive membership. This oversaw delivery of productivity improvement work across the Trust, including investigation of opportunities highlighted by NHS Improvement's Model Hospital. This has now been succeeded by a new Strategic Assurance Committee, also with non-executive membership.

However, there remain some areas for improvement:

- At 8.6%, emergency readmission rates are above the national median of 7.3% placing the trust in the highest (worst) quartile.
- The trust also recognises there are opportunities in better aligning clinical job plans to the needs of the business to drive further performance.
- Medicines costs are relatively high when benchmarked with other trusts and this requires more detailed investigation to understand fully the drivers of this.
- The trust has a high level of backlog maintenance and it also recognises the need to reduce estates and facilities costs such as cleaning and portering, which benchmark relatively high compared with other providers nationally.

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 has areas of good performance in two of the four constitutional standards. There are some significant areas relating to A&E 4-hour performance. Readmission rates are higher than national averages indicating scope for improvement. There are some strong areas of performance against national comparisons, such as requiring admission prior to treatment (pre-procedure elective bed days). This overall suggests there are areas of efficiency to be gained by the organisation to improve overall waiting times for patients.

- At the time of the assessment in June 2018, the trust was meeting the Cancer constitutional operational performance standard at 88.4% (May 2018). Cancer has been delivered consistently for a year, but the trust's performance against both A&E and Referral to Treatment (RTT) standards were consistently below the national standard and below national average performance over the same period. Regarding the A&E standard the trust is focusing with the support of NHSI Improvement's Emergency Care Improvement Programme on implementing new models of care within the Emergency Department and has commenced work to improve emergency flow across the wider hospital. It has engaged in system-wide work to ensure services in the community and social care have sufficient capacity to meet growing demand for these services when patients are ready to leave acute care.
- The trust's over 18-week RTT backlog for incomplete pathways has seen an annual increase over the last three years (up to 2017/18). However, the trust has started to report decreases in 2018/19 through delivery of increased elective activity. The number of patients waiting over 18 weeks during this period has reduced in all specialties other than Urology and Ophthalmology. The trust has developed plans to ensure its RTT waiting list does not increase over the course of 2018/19 and to minimise 52-week breaches arising in a small number of areas due to clinical workforce shortages.
- Patients are more likely to require additional medical treatment for the same condition at this trust compared to other trusts. At 8.6%, emergency readmission rates are above the national median (7.3%) as at March 2018, placing the trust in the highest (worst) quartile nationally.
- Fewer patients are coming into hospital unnecessarily prior to treatment compared to most other hospitals in England.
    - On pre-procedure elective bed days, at 0.086, the trust is performing in the lowest (best) quartile below the median when compared nationally – the national median is 0.131.
    - On pre-procedure non-elective bed days, at 0.819, the trust is performing below (better than) the median when compared nationally – the national median is 0.812.
- The trust has made improvements to support reduction in length of stay with an ambition of 25% reduction by the end of December 2018. There is further work to do to improve early patient discharges each day and to manage periods of surge to reduce waiting times for emergency patients. Improvement efforts to date include increasing discharge to assess services in conjunction with local community partners to reduce delays experienced by patients leaving hospital, and further extension to the Frailty service alongside ambulatory care services.
- The Did Not Attend (DNA) rate for the trust is low at 5.8% for March 18 compared with a national median of 7.3%, placing the trust in the lowest (best) quartile nationally. This performance is supported by the trust's text reminder service in place for outpatient

services. Further improvement to this service and extension of it to radiology and elective surgery is planned for 2018/19.

- Delayed Transfers of Care (DTOC) rates have been improving between February 2018 (4.89%) and April 2018 (3.15%) and were better than the national standard of 3.5% at that point. The trust has recently ensured that all declared DTOC patients have an agreed plan and that an expected discharge date is set. This measure cannot be met alone by the trust and requires partnership with community partners to deliver improvements. The trust, commissioners and other local partners have developed a System Improvement Plan for 4-hour performance including actions to reduce the number of super stranded patients at the RUH (more than 21-day length of stay). The impact of this work is being seen by a reduced number of DTOC patients.
- The trust, in partnership with its lead commissioner and local partners, has commenced a system-wide demand and capacity review to ensure capacity is available at the right points in the emergency pathway to minimise delays experienced by patients leaving hospital. There is, however, already strength in the trust's delivery of the 'HomeFirst' discharge to assess service run jointly by the trust and key local partners. The trust has self-assessed itself against the eight high impact changes within the High Impact Change Model: Managing Transfers of Care (March 2018), and is focusing on ensuring identified areas for improvement are addressed effectively as part of its improvement plan ahead of winter.
- The trust reported stranded patients (more than a 7-day length of stay) in 52% of its hospital beds as at March 2018 which is a small improvement from 57% for April 2017 and broadly in line with the national average. The trust reported super-stranded patients (more than 21-day length of stay) in 17% of its hospital beds in March 2018 which again is an improvement from 25% in April 2017.
- The trust experienced higher volumes of cancellations during the winter period of 2017/18 against its previous year's cancellation rate. The trust cancelled 106 patients in advance due to a lack of beds throughout March 2018. This allowed the trust to focus on urgent and cancer treatments as well as supporting non-elective pressures due to the increased challenges across non-elective pathways, in line with national guidance issued in response to winter pressures. Cancellation levels are now down to 18 in May 2018.
- The Trust has engaged with NHS Improvement's national Getting It Right First Time (GIRFT) programme, with reviews in General Surgery, Orthopaedics, Spinal and Obs & Gynae having taken place with Urology and ENT planned to analyse potential opportunities. The trust, as part of the Bath, Swindon & Wiltshire Sustainability and Transformation Partnership (STP), is looking to review opportunities as a STP area to further understand unwarranted variation.

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

The trust has controlled pay costs, with agency expenditure remaining within the ceiling and a low pay cost per WAU compared to the national median. The trust has identified skill mix planning as an area for further focus and is considering how it can enable the workforce to work more flexibly to aid retention.

- For 2016/17 the trust had an overall pay cost per WAU of £1,918, compared with a national median of £2,157, 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

second lowest (best) quartile for allied health professional, medical and nursing cost per WAU.

- The trust met its agency ceiling as set by NHS Improvement for 2017/18 and is forecasting to meet its ceiling in 2018/19. It is spending less than the national average on agency as a proportion of total pay spend and has a low number of price cap overrides compared to the average for peers within the region. The trust has been successful in increasing bank usage through specific initiatives to incentivise people, for example, through enhanced pay over winter.
- The trust uses the evidence-based Safer Nursing Care Tool (SNCT) and other recognised benchmarks, including Care Hours Per Patient Day (CHPPD). The trust plans to further develop the use of CHPPD to support staffing requirements.
- The trust's Heads of Nursing undertake staffing reviews following the SNCT review but also undertake Divisional reviews as part of their yearly business planning cycle. The Director of Nursing and Midwifery is sighted on any proposed changes both at Divisional level and at Board level.
- The trust has introduced Assistant Practitioners (Band 4), Trainee Nursing Associates (Band 3) and ward Therapists (Band 5). These support the nursing team skill mix so there is appropriate flexibility in how the trust staffs its ward areas to achieve safe staffing levels.
- The trust has an e-rostering system (Rosterpro) used for nursing staff, with rosters planned and agreed six weeks in advance. Whilst Rosterpro and the patient acuity tool are not linked, skill mix is considered every six months and there is a full review annually. Skill mix planning is a particular area of focus for the newly appointed Director of People.
- The trust's electronic rostering system is still under review as there are some limitations to the current electronic rostering system. The Nursing and Midwifery Workforce Planning Group are supporting initiatives that will release opportunities for added benefits and efficiencies from an electronic staff rostering system. The procurement and implementation of an improved e-rostering system has been put forward as part of the programme of work for 2018-20 for the Health Informatics Service and a business case is in development to support this.
- The trust conducts a consultant job planning process annually and has job plans in place for most consultants. However, there are opportunities to better align clinical job plans to the needs and priorities of the trust. The trust has recently commenced an external review of job planning to help achieve this.
- At March 2018 88% of consultants had a job plan, which is in line with the national median of 89%. There are opportunities for the trust to use its e-rostering system more widely to support productivity. The trust has identified and will take steps to address the current lack of a consistent approach to recording consultant job plans across the divisions.
- There are some gaps in hard to fill clinical rotas especially in Medicine. The trust has a proactive approach to recruitment and works in partnership with other local providers on booking agency staff so there is a single booking approach and set of prices where agency staff are needed across a network of acute hospitals across Bath, Somerset and Bristol.
- Staff retention at the trust is very slightly below the national median, with a retention rate of 85% in February 2018 against a national median of 86%. Focus groups have been held and findings triangulated with staff survey results to understand how turnover can be reduced further. Flexible working has been identified as an area which could bring the greatest gain and is being explored by the trust.

- Staff sickness rates were 4.62% in January 2018, slightly below the national average of 5%. The trust's approach to sickness management is good, and this is reflected in the latest staff survey.

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

The trust benchmarks relatively well for pathology costs. Medicines costs are relatively high when benchmarked with other trusts, and this requires more detailed investigation to understand fully the drivers of this. While overall Medicine costs are relatively high, the trust performed well for the level of savings achieved to reduce the amount it spends on the 'Top Ten' high-cost medicines during 2017/18. The trust is using technology to avoid unnecessary hospital attendances and to improve access and efficiency.

- The overall cost per test for Pathology at the trust benchmarks in the lowest (best) quartile nationally at £1.49 per test compared to £1.96 nationally with the trust making the most of the new pathology estate.
- The trust's medicines cost per WAU is relatively high when compared nationally (£476 compared to national median of £354 placing the trust in the highest (worst) quartile nationally). The trust reported that it has a high volume of tertiary rheumatology that inflates the cost per WAU but further investigation is needed to understand the drivers of high medicines costs and to identify financial savings opportunities.
- While overall medicines costs are high compared with other trusts, as part of the Top Ten Medicines programme, the trust is making good progress in delivering on nationally identified savings opportunities, achieving 150% of the savings target against a national median of 122%. This has been driven by embedded pharmacists in each of the key specialities that work with leads to ensure biosimilars and best practice are implemented. The trust has a drug and therapeutic committee that reviews NICE guidance and supports the work done by the divisional pharmacists to reduce the variation in drugs issued.
- The trust implemented an e-prescribing system in November 2017 to improve the efficiency and consistency in the use of medicines. Work is still ongoing with the specialities to ensure staff are completely confident with the processes and in using the system.
- The trust is using technology in innovative ways to reduce the number of attendances and admittances including a well-established Consultant Connect in all key specialties that allows GPs direct access to trust consultants for advice. It also has a developing virtual clinic approach where appropriate patients can speak to a consultant without travelling to the hospital. The trust's Emergency Surgical Ambulatory Clinic allows the trust to assess and diagnose patients and where appropriate operate as a 'one stop shop' for conditions such as appendicitis, gallstones, hernias, abscesses and pancreatitis avoiding unnecessary hospital admissions and inpatient stays.

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

The cost of providing payroll services is higher than most other trusts and the trust reports high levels of backlog maintenance. However, the trust performs very well for costs when benchmarked against other trusts for finance, human resources and procurement (both cost of providing and output).

- For 2016/17 the trust had an overall non-pay cost per WAU of £1,224, compared with a national median of £1,284, placing it in the second best cost quartile nationally. This represents an improvement on its relative position from 2015/16.
- The cost of running its Finance and HR functions are lower than the national median at £620k and £893k per £100m turnover against national median of £743k and £1,005k. However, the cost of running its Payroll function is slightly higher than the national median at £113k per £100m turnover compared to the national median of £100k.
- The cost of the procurement function is very low compared with both the national median and its peers (£121k per £100m turnover compared to £210k nationally). Despite this, the trust's procurement processes are relatively efficient and tend to successfully drive down costs on the things it buys. This is reflected in the trust's Procurement Process Efficiency and Price Performance Score of 52.3, which places it in the second best quartile compared with a national mean of 55.4. The trust has also integrated materials management and stores departments into Procurement to drive out waste in supply chain processes.
- At £383 per square metre in 2016/17, the trust's estates and facilities costs benchmark as slightly more expensive than the national median (£340 per square metre). Opportunities for improvement lie in the soft facilities management areas including cleaning, portering and laundry and linen. The trust has outsourced its laundry and linen contract and will renegotiate once this is up for renewal. The trust has carried out a review of its portering and cleaning services and is using technology to monitor and improve the way the departments work.
- The trust has a high level of backlog maintenance and benchmarks in the highest (worst) quartile with a cost of £353 per sqm compared to a national median of £197 per sqm. The trust is investing in this area and has a Premises Assurance model in place to help tackle the issues. A temporary ward for decanting patients is planned during 2018/19 to allow some of the work to be carried out. However, the trust remains concerned that the level of capital expenditure it is able to earmark for backlog maintenance as part of its overall capital programme is not sufficient to make significant progress in reducing this backlog.
- The trust is reviewing opportunities to collaborate on corporate services within its STP but this work has not progressed to a clear delivery plan. The trust and partners are aiming to have developed a plan by the end of the 2018/19 financial year. Discussions are taking place with partners regarding occupational health and the finance ledger system with NHS Improvement supporting the discussions.

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

The trust has delivered its financial plan for the last two years. The trust is planning to deliver its control total for 2018/19. However, it has a more challenging CIP programme to deliver to meet its control total than in 2017/18. It had not delivered the cumulative CIP target for the first two months of the 2018/19 financial year and is taking action to recover the position. The trust acknowledges that the plan for 2018/19 carries a higher risk to delivery, largely due to a level of unidentified CIP. Overall, however, the trust has a good track record of managing its financial resources in recent years and the Board has been kept abreast of the financial challenges facing the organisation in the coming years.

- The trust is forecasting an in-year surplus for 2018/19 and has a good track record of managing spending within available resources and in line with plans. However, it should

be noted that in 2017/18, the trust benefited from the profit arising from a land sale (£15m) to support the financial position. Its underlying deficit increased during 2017/18 by £5.3m to £10.6m, largely driven by elective income reduction due to winter emergency pressures. The trust is tackling this deficit during 2018/19 with a recurrent CIP plan. However, delivery of this remains a risk given the deterioration in 2017/18.

- In 2017/18 the trust reported a £17.5m surplus, which is 5.4% of turnover including Sustainability & Transformation Fund (STF) income of £11.4m, exceeding the control total and planned surplus of £12.8m. For 2018/19 the trust has a control total and plan of £12.8m, representing 3.8% of turnover (including STF).
- In 2018/19, the trust has a cost improvement plan of £13.9m (or 4.1% of its expenditure) and is currently forecasting to recover the year-to-date shortfall in delivery (£0.3m shortfall against plan at month 2 of 2018/19). The trust delivered £8.4m savings, 9.1% above its planned savings, in the previous financial year.
- For the 2018/19 year the trust expects to deliver 21% of its savings as one-off (non-recurrent) plans. In 2017/18 this percentage was 30%. In 2018/19, £2.5m remains unidentified at month 2 but the trust is working hard with its divisions to identify further savings. The trust had a robust planning round for 2018/19 with savings being identified from the ground up by divisions and with clinicians being fully engaged in the process. The planning process takes place over a 2-year period to account for more transformational programmes, given the existing relative efficiency of the trust and the challenge in identifying additional CIPs.
- The trust has adequate cash reserves and is able to meet its financial obligations and pay its staff and suppliers in the immediate term, as reflected by its capital service and liquidity metrics. The trust is not reliant on short-term loans to maintain positive cash balances.
- The trust has outsourced the production of its Service Line Reporting (SLR) data and the supplier has not met its obligations, providing limited useful information in this area and therefore the trust recognises that it needs to resolve this before SLR can be used for decision making purposes. It is important that the trust takes action to improve in this area or the it may struggle to deliver productivity improvements at the scale and pace of other organisations with effective SLR.
- The Model Hospital shows that the trust's commercial income in 2015/16 was £7.5m (2.57% of total income) which is slightly above the national median of £7.29m. The trust recognises the opportunity to recover increased overseas visitor income and has recently recruited appropriate personnel.
- The trust has made use of one consultancy firm within the last three years to help identify financial savings opportunities. However, it does not routinely rely on external firms for this purpose.

Outstanding practice

The trust has created a Frailty Flying Squad to support frail patients avoid unnecessary hospital admissions that can often lead to extended lengths of stay and deterioration in patients' conditions. Within this service the trust has been creative in allowing a variety of health professionals to carry out the roles required. This means nurses, clinicians, therapists and other allied health professionals work together as a single team, minimising boundaries between teams. This ensures patients' needs are met quickly, and they can leave hospital quickly with appropriate care in place.

Areas for improvement

Further whole-hospital flow improvement work is needed to minimise delays experienced by patients in hospital and maximise the clinical activity delivered across the hospital.

The trust needs to progress its review of job planning and adopt a consistent trust-wide approach to job planning so that individual and team job plans consistently support organisational priorities, for example, via emergency pathway improvement.

The trust's medicines cost per WAU is relatively high when compared nationally (£476 compared to national median of £354). It is important that the trust investigates and benchmarks in detail to understand the drivers of its relatively high costs in full, and to identify savings opportunities.

The trust needs to prioritise a plan for the full roll-out of service line reporting, completing this work in-house if necessary.

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.