St George's University Hospital NHS Foundation Trust

Use of Resources assessment report

St Georges Hospital
Blackshaw Road
Tooting
London
SW17 0QT
Tel: 02086721255
https://www.stgeorges.nhs.uk

Date of publication:
18 December 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?	**Requires improvement**
Are services caring?	**Good**
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/RF4/reports)

Are resources used productively?	**Requires improvement**

Combined rating for quality and use of resources	**Requires improvement**

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

Our combined rating for Quality and Use of Resources summarises the performance of the trust taking into account the quality of services as well as the trust's productivity and sustainability. This rating combines our five trust-level quality ratings of safe, effective, caring, responsive and well-led with the Use of Resources rating.

Use of Resources assessment and rating

NHS Improvement are currently planning to assess all non-specialist acute NHS trusts and foundation trusts for their Use of Resources assessments.

The aim of the assessment is to improve understanding of how productively trusts are using their resources to provide high quality and sustainable care for patients. The assessment includes an analysis of trust performance against a selection of initial metrics, using local intelligence, and other evidence. This analysis is followed by a qualitative assessment by a team from NHS Improvement during a one-day site visit to the trust.

Combined rating for Quality and Use of Resources

Our combined rating for Quality and Use of Resources is awarded by combining our five trust-level quality ratings of safe, effective, caring, responsive and well-led with the Use of Resources rating, using the ratings principles included in our guidance for NHS trusts.

This is the first time that we have awarded a combined rating for Quality and Use of Resources at this trust. The combined rating for Quality and Use of Resources for this trust was requires improvement, because:

- we rated safe, effective, responsive, and well-led as requires improvement; and caring as good;
- we took into account the current ratings of the four core services across the two locations not inspected at this time. Hence, six services across the trust are rated overall as requires improvement, and the remaining two services are rated good;
- the overall ratings for each of the trust's acute locations remained the same; and
- the trust was rated good for Use of Resources.

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Date of site visit:
09 August 2019

Date of publication:
18 December 2019

This report describes NHS Improvement's assessment of how effectively this trust uses its resources. It is based on a combination of data on the trust's performance over the previous twelve months, our local intelligence and qualitative evidence collected during a site visit comprised of a series of structured conversations with the trust's leadership team.

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

How effectively is the trust using its resources?	**Requires improvement**

How we carried out this assessment

The aim of Use of Resources assessments is to understand how effectively providers are using their resources to provide high quality, efficient and sustainable care for patients. The assessment team has, according to the published framework, examined the trust's performance against a set of initial metrics alongside local intelligence from NHS Improvement's day-to-day interactions with the trust, and the trust's own commentary of its performance. The team conducted a dedicated site visit to engage with key staff using agreed key lines of enquiry (KLOEs) and prompts in the areas of clinical services; people; clinical support services; corporate services, procurement, estates and facilities; and finance. All KLOEs, initial metrics and prompts can be found in the Use of Resources assessment framework. We visited the trust on 09 August 2019 and met the trust's executive team (including the chief executive), and relevant senior management responsible for the areas under this assessment's KLOEs.

Findings

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

We rated use of resources as requires improvement because the trust does not consistently manage its resources to allow it to meet its financial obligations on a sustainable basis and to deliver high quality care.

- This is the trust's first Use of Resources assessment. The trust was placed in Quality Special Measures in 2016 and in Financial Special Measures since 2017. In 2017 there were significant changes to leadership and the current substantive Chief Executive Officer, Chief Financial Officer and Chief Operating Officer were appointed.

- While the trust remains in both Quality and Financial Special Measures the current leadership have overseen a number of improvements to both quality, financial and operational performance. The trust leadership described the strategy put in place for sustainable recovery and evidence of this was seen in a number of areas. It will however take time for improvements to be embedded in all areas. Particular areas of good performance are:
    - The trust has performed well against diagnostics and has achieved this target over the past 12 months. In May 2019 the trust's performance was 99.30% against a national median of 97.23%. This places it in the first (best) quartile nationally.
    - In January 2019 the trust returned to RTT reporting following significant data quality challenges over 2018/19 and 2017/18. In June 2019 the trust is ahead of trajectory for its elective care patient tracking list.
    - The trust benchmarks in the top quartile for its cost per WAU for nursing spend and makes good use of e-rostering (completing rosters 7.5 weeks in advance) to support reductions in agency spend.
    - Sickness and absence rate for November 2018 was 3.76% against a national median of 4.35%. This places it in the first (best) quartile nationally.
    - The trust's Procurement Process Efficiency and Price Performance Score for October to December 2018 is 78 against a national median of 66. This places it in the second (best) quartile nationally. The trust also performs well in the procurement league table ranking scoring 42 in 2018/19 against a national median of 67. This places the trust in the second (best) quartile.
    - The trust planned a CIP programme of £50 million (5.6% of expenditure) in financial year 2018/19 and delivered 100%.

- Over the past year the trust has however experienced a number of substantial challenges which include:
    - Medical spend and job planning. Medical spend was over plan by £7 million in 2018/19 contributing to non-achievement of the control total. At the time of the assessment only 12% of consultant job plans were signed off. The trust recognises there is significant work still to do in this area.
    - Cardiac surgery. In March 2018 Cardiac Surgery was subject to a National Institute for Cardiovascular Outcomes Research (NICOR) safety alert and has since undergone two

independent reviews. The outcome of the Lewis Review is currently pending. One impact of this from a use of resources perspective has been an £11 million adverse variance to financial plan which contributed to non-achievement of the control total.

- Estates. The trust benchmarks in the bottom quartile nationally in most estates and facilities metrics. The trust has wide ranging, significant estates risks due to historical under investment and lack of planned preventative maintenance due to a scarcity of available capital. The trust is acting to address these challenges and emergency capital loans of £27 million were approved in 2019/20 to address patient safety critical issues. Estates remains a very significant challenge and work is ongoing to address in the short, medium and long term.

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 did not meet the A&E performance target over the past 12 months and overall performance has declined, although it still benchmarks well against other non-specialist trusts. In June 2019 its performance was 87.00% which compares against a national median of 84.95%. This places it in the second quartile nationally. The trust has expanded its Ambulatory Assessment Area (AAA) to try and reduce the need for unnecessary admissions. Currently 68% of people seen in AAA are discharged home rather than being admitted.
- In May 2019 the trust's performance against the national Referral to Treatment (RTT) standard was 86.61% against a national median of 85.75%. In January 2019 the trust returned to RTT reporting following significant data quality challenges over 2018/19 and 2017/18. At June 2019 the trust is ahead of trajectory for its elective care patient tracking list.
- The trust has performed well against diagnostics and has achieved this target over the past 12 months. In May 2019 the trust's performance was 99.30% against a national median of 97.23%. This places it in the first (best) quartile nationally. The trust continues to look for further opportunities to improve performance in areas such as cystoscopy and endoscopy.
- The trust's 62 day Cancer performance from urgent GP referral was 71.43% in May 2019 against a national median of 76.12%. Over the past 12 months has been variable. Between July 2018 and March 2019, the trust achieved the target apart from in the months of September 2018 and February 2019. Performance in April and May 2019 has declined to 76% in April and 72% in May. Recovering performance and maintaining sustainable delivery of the cancer targets remains a significant challenge for the trust. The most recent data available for June and July 2019 shows some improvement with performance of 85.8% and 92.7% respectively.
- Pre-procedure elective bed days in in January to March of 2018/19 were 0.17 against a national median of 0.12. This places it in the third quartile nationally. The trust recognises this is an area with scope for improvement and is looking at initiatives such as such as introducing outpatient pre-procedure for low risk patients.
- Pre-procedure non-elective bed days in January to March of 2018/19 were 0.33 against a national median performance of 0.66. This places it in the top (best) quartile nationally. The trust has implemented interprofessional standard within in A&E to improve the time it takes for patients to be reviewed specialty teams.

- The trust reported emergency readmission rates of 7.84% in Q4 of 2018/19 against a national median of 7.73%. This places it in the third (second worst) quartile nationally.
- The Did Not Attend (DNA) rate in January to March of 2018/19 financial year was 7.84% against a national median of 7.73%. This places it in the third quartile nationally. The trust has implemented a programme of improvement to reduce DNA rates which includes a two way texting service for patients. This has delivered some initial reductions in DNA, but the trust will be closely monitoring the impact of these actions.
- The trust has engaged with the Get It Right First Time Programme (GIRFT) and 20 services have undertaken deep dive reviews so far. The trust is starting to see clinical productivity improvements in some areas such as improved time from assessment to treatment for elective aortic aneurysm in vascular. The approach to managing these improvements across all services in a consistent and established way is still developing. Clinical productivity improvements from GIRFT are not yet fully integrated with the CIP programme and the approach to use GIRFT, Model Hospital and other information sources in a coordinated way is still developing.

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

- In financial year 2017/18 the trust had an overall pay cost per Weighted Activity Unit (WAU) of £2,195 against a national median of £2,180. This places it in the third (worst) quartile nationally. Within this headline metric the trust's pay cost per WAU is better than the national median for Nursing staff of £635 compared to the national median of £710 but is worse than the national median for Medical and Allied Health Professional (AHP) staff (£654 for medical, national median of £533, and £133 for AHP, national median of £130).
- The trust has reduced its agency expenditure from £43 million in 2016/17 to £20 million in 2017/18 and £17 million in 2018/19 which is £3.5 million below its agency ceiling for the financial year. This is in part due to the implementation of a system to support the monitoring of acuity across the trust and the appropriate redeployment of nursing staff.
- The staff retention rate was 79.2% in December 2018 against a national median of 85.6%. This places the trust in the bottom (worst) quartile nationally. This is however an improvement compared to August 2018 where performance was 77.6% and comparable to the London average performance of 80.9%. The trust has been part of the NHS England and Improvement Retention Direct Support programme since 2017. As part of their plan of actions they have introduced a Ward Manager Development Programme to support the growth of this staff group.
- Sickness and absence rate for November 2018 was 3.76% against a national median of 4.35%. This places it in the first (best) quartile nationally. The trust has seen a reduction in sickness absence to 3.49% in May 2019. The trust outlined a robust process for monitoring sickness absence through their eRostering system. Through the Ward Manager Development Programme, they have also developed the skills of the Ward Managers in supporting and proactively managing staff sickness.
- The trust's job planning governance has been established, and the trust is building in house, demand and capacity capability to ensure alignment to job plans. At the time of the assessment 12% of consultant job plans were signed off.
- The trust an established eRoster system for all nursing staff and are using this to effectively deploy the nursing workforce. They have also launched a programme of work to implement an eRoster for all medical staff with the aim of rolling out to all 63 services that cover both junior doctors and consultants by the end of March 2020. Progress to date includes eight

services going live on the new system. The system is already in place for all other staff groups with 480 rosters covering 5,500 staff including nurses.

- The trust has embedded an evidence based programmed to set nursing establishments across the trust and reports the safe staffing levels to the trust Board every six months.

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

- The trust has performed well against the top ten medicines savings target and achieved 147% in 2017/18. Pharmacy metrics in model hospital for 2017/18 such as pharmacist time spent on clinical activity (75% in 2017/18 against national median of 76%, third quartile), and pharmacy staff with appraisals completed (73% in 2017/18 against national median of 93%, bottom quartile) have improved. Pharmacist time spent on clinical activity has improved to 80% in 2018/19 and pharmacy staff with appraisals completed has improved to 98% in July 2019. The trust reports there are further opportunities for collaborative working across the local system.
- The pathology service is delivered through the South West London Partnership where the trust is the host. This partnership is well established and in its fifth year. Pathology delivered a £2.7 million CIP in 2018/19 and over performed the 2018/19 annual business plan by £170,000. The trust's overall cost per test compares favourably and for financial year 2017/18 is £1.74 against a national median of £1.86. This places it in the second (best) quartile nationally.
- The trust has consistently achieved the diagnostics constitutional target (DM01) over the past year. This positive performance is despite the age of the trust's imaging assets. The trust's imaging assets are in the bottom or third quartile nationally for percentage of machines over 10 years old. (41% of static X-rays versus national median of 22%, 20% of CT machines versus national median of 0%, 33% of MRI machines versus national median of 0%). The trust reports it is not currently experiencing high levels of downtime due to machine breakages but there are some limitations to the functionality of the older machines. The trust is looking at different funding mechanisms to replace these older machines given the challenges on capital expenditure budgets.

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

- For financial year 2017/18 the trust had an overall non-pay cost per WAU of £1,435 compared with a national median of £1,307. This places it in the fourth (worst) quartile nationally.
- The cost of the finance function for financial year 2017/18 is £809,540 per £100m of turnover against a national median of £676,480. This places it in the fourth (worst) quartile nationally. The trust's finance function has undergone major changes over the past few years following entry into Special Measures for finance. In 2017/18 a large proportion of senior finance staff were interims which contributed to a high cost in the data. In the 2018/19 corporate services model hospital return the finance function has reduced its cost by £1.7million. This has primarily been achieved through recruiting substantive staff and improving transactional processes in the department. This should improve how the finance function benchmarks once this is uploaded into model hospital.
- The cost of the Human Resources (HR) function for the financial year 2017/18 is £1.17 million per £100m turnover against a national median of £898,020. This places it in the fourth (worst) quartile nationally. The trust reviewed in detail its HR cost per £100m turnover and

found it had incorrectly included £2.5 million costs of training GP doctors in the return. With this error removed the trust should benchmark more favourably.

- The trust's Procurement Process Efficiency and Price Performance Score for October to December of financial year 2018/19 is 78 against a national median of 66. This places it in the second (best) quartile nationally. The trust also performs well in the procurement league table ranking scoring 42 in 2018/19 against a national median of 67. This places the trust in the second quartile. The trust also performs well against a number of other procurement metrics including PPIB score (65.9 against a national median of 59.3, second quartile), percentage of non-pay spend on purchase orders (100% against national median of 92.2%, top quartile), percentage of transactions on e-Catalogue (100% against national median of 93.7%, top quartile). The trust has invested in its procurement function and the positive results of this can be seen in this favourable performance. These improvements include reduced use of interim staff through improved recruitment and retention, improved analytical capability through the switch from excel to Tableau and a new stock system (IMS) which identified a £300,000 opportunity through better control of stock levels. The trust has also recently started acute provider collaboration in procurement under the South West London Procurement partnership which went live in June 2019. This has plan to identify further efficiencies across the region.
- The trust's estates and facilities (E&F) cost per m² for the financial year 2017/18 is £578 compared to a national median of £342. This places it in the fourth (worst) quartile nationally. Facilities management (FM) cost per m² for both hard and soft FM benchmarks in the bottom quartile nationally. Hard facilities management (FM) cost per m² for the financial year 2017/18 is £99 against a benchmark value of £93. The soft facilities management (FM) cost per m² is £149 against the benchmark of £122. The trust also does not benchmark favourably against a number of other estates and facilities metrics. Total backlog maintenance (£ per m²) is £622 in financial year 2017/18 against a benchmark value of £186 (bottom quartile). Critical infrastructure risk (£ per m²) in 2017/18 is £164 against a benchmark value of £57 (bottom quartile). Cleanliness – patient led assessment score in financial year 2017/18 is 98% against a benchmark value of 99.3% (bottom quartile). The trust has wide ranging, significant estates risks due to historical under investment and lack of planned preventative maintenance. Emergency capital loans of £27 million were approved in 2018/19 to address patient safety critical issues in, water safety, Cath labs, IT, critical backlog maintenance and outdated medical equipment. The trust has also taken a number of other actions over the past year to address this risk. The cleaning contract has been re-tendered which will generate a £3 million annual saving. Three buildings have been closed and vacated and are awaiting demolition and five theatres have undergone refurbishment. The trust's estate remains a very significant challenge and work is ongoing to address in the short, medium and long term.

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

- The trust reported a deficit (including Provider Sustainability Funding - PSF) of £45.1 million in the financial year 2018/19. Excluding, PSF the deficit position of the trust was £52.0 million. This was an adverse variance to control total of £28.7million including PSF and by £23.0 million excluding PSF. £11 million of this adverse variance is driven by the impact of the cardiac surgery review, £7 million was medical pay overspend and £4 million was due to under achievement of the trust's elective activity plan. The trust has accepted its Control Total for financial year 2019/20 and as at June 2019, is on plan to deliver their financial outturn.

- The trust's reported and underlying position has not improved over the past 12 months. Excluding PSF the financial year 2017/18 reported deficit was £53.1 million and in financial year 2018/19 this improved to £52.0 million. The underlying deficit has also not improved over this period. In financial year 2017/18 the underlying deficit was £55.0 million, in financial year 2018/19 this was £56.4 million (6.9% of turnover).
- The trust planned a CIP programme of £50 million (5.6% of expenditure) in financial year 2018/19 and delivered 100%.
- In 2019/20 the trust's planned CIP programme is £45.8 million (5.0% of expenditure) and as at month three the trust is on plan for its CIP delivery.
- £42.6 million (85.2%) of the financial year 2018/19 CIP was planned to be recurrent and the trust was close to plan with £40 million (80%) delivered recurrently. In 2019/20 89% of the CIP is planned to be recurrent.
- The trust is in receipt of revenue funding from the Department of Health and Social Care due to its deficit. In financial year 2018/19 it planned and reported at year end a financial risk rating of segment 4 (lowest segment) for its capital service metric. This illustrates the high level of debt the organisation has (£285 million borrowings from the Department of Health and Social Care). The trust also planned for and reported a financial risk rating of segment 4 for its liquidity rating. For March 2019 the trust's performance against the Better Payment Practice Code was not compliant and was below the national acute trust average for both NHS (49% versus 69% national acute average) and non-NHS payments (52% versus 79% national acute average).

Areas of outstanding practice

- The trust has performed well against diagnostics and has achieved this target over the past 12 months. In May 2019 the trust's performance was 99.30% against a national median of 97.23%. This places it in the first (best) quartile nationally
- Sickness and absence rate for November 2018 was 3.76% against a national median of 4.35%. This places it in the first (best) quartile nationally. The trust has seen a reduction in sickness absence to 3.49% in May 2019.
- The trust planned a CIP programme of £50 million (5.6% of expenditure) in financial year 2018/19 and delivered 100%. In 2019/20 the trust's planned CIP programme is £45.8 million (5.0% of expenditure) and as at month three the trust is on plan for its CIP delivery.
- The trust has embedded an evidence based programme to determine safe levels of staffing and set nursing establishments across the trust. This is reported to the trust Board every six months. This has supported reductions in the use of temporary staffing and has enabled the effective deployment of staff through the use of their eRostering system.

Areas for improvement

- Pre-procedure elective bed days in in January to March of 2018/19 were 0.17 against a national median of 0.12. This places it in the third (worst) quartile nationally. The trust recognise this is an area with scope for improvement and is looking at initiatives such as such as introducing outpatient pre-procedure for low risk patients.
- The trust's job planning governance has been established, and are building in house, their demand and capacity capability to ensure alignment to job plans. At the time of the assessment 12% of consultant job plans were signed off.
- The trust reported a deficit (including Provider Sustainability Funding - PSF) of £45.1 million in the financial year 2018/19. Excluding, PSF the deficit position of the trust was £52.0 million. This was an adverse variance to control total of £28.7 million including PSF and by £23.0 million excluding PSF. £11 million of this adverse variance is driven by the impact of the cardiac surgery review, £7 million was medical pay overspend and £4 million was due to under achievement of the trust's elective activity plan.
- The trust's reported and underlying position has not improved over the past 12 months. Excluding PSF the financial year 2017/18 reported deficit was £53.1 million and in financial year 2018/19 this improved to £52.0 million. The underlying deficit has also not improved over this period. In financial year 2017/18 the underlying deficit was £55.0 million, in financial year 2018/19 this was £56.4 million (6.9% of turnover).
- RTT – although significant progress has been made to commence the reporting of their patient tracking list status, the trust needs to continue to identify and implement processes to improve access to patients and reduce their waiting lists.

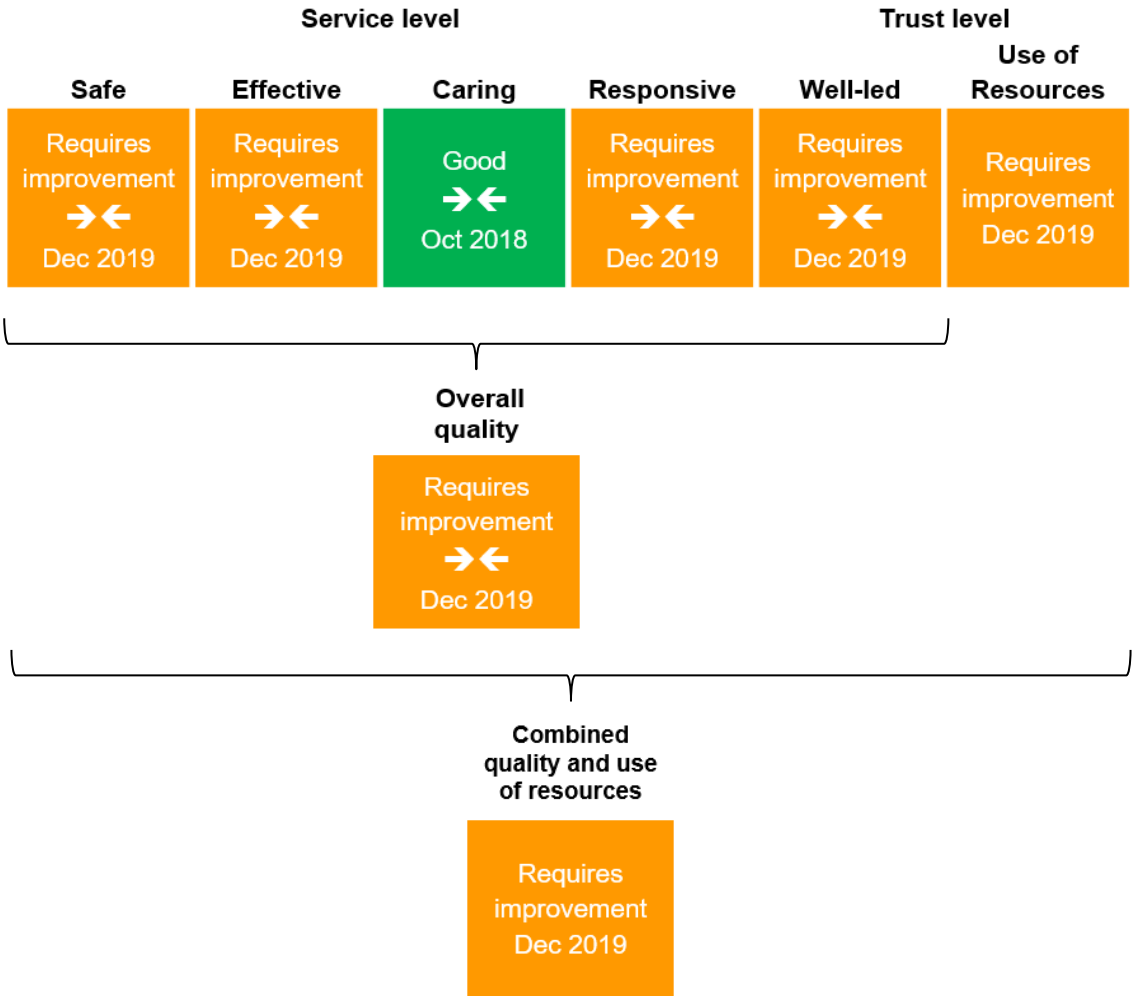
Ratings tables

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 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.