London North West University Healthcare NHS Trust

Use of Resources assessment report

Watford Road
Harrow
Middlesex
HA1 3UJ
Tel: 02088643232
www.lnwh.nhs.uk

Date of publication: 06 November 06/11/2019

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
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;
- the overall ratings for each of the trust's acute locations remained the same; and
- the trust was rated requires improvement for Use of Resources.

London North West University Healthcare NHS Trust

Use of Resources assessment report

Watford Road
Harrow
Middlesex
HA1 3UJ
Tel: 02088643232
www.lnwh.nhs.uk

Date of inspection visit: 02 July to 15 August 2019
Date of publication: 06/11/2019

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.

Proposed rating for this trust?	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 . We visited the trust on 25 June 2019 and met the trust's executive team (including the chief executive), non-executive directors (in this case, the chair) and relevant senior management responsible for the areas under this assessment's KLOEs.

Findings

Requires improvement

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

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. The approach to identifying and realising efficiency opportunities is not embedded across the organisation.

- The trust has made significant gains in operational performance over the previous 12 months, but these improvements are not mirrored in financial performance. In financial year 2018/19 the trust met its Control Total (before Provider Sustainability Funding), but this was largely due to non-recurrent profits on disposals. Improvements made in financial year 2017/18 to the underlying deficit position have not been sustained in financial year 2018/19. The underlying deficit position has worsened from £82.9m in financial year 2017/18 to £88.9m in financial year 2018/19 driven by failure to deliver recurrently the efficiency plan. While some of the deficit is structural in nature and not entirely within the trust's control, a significant area of challenge for the trust is control of costs such as premium staffing.
- The trust's medical, nursing and allied health professional (AHP) staff costs benchmark higher than national median. Pay costs have been higher in financial year 2018/19 due to agency costs relating to additional capacity for winter and increased spending on Referral-to-Treatment (RTT) to manage backlogs.
- Given the continuing financial challenges the trust has not signed up to its Control Total in financial year 2019/20 and is undertaking a series of recovery measures to deliver what remains a challenging plan.
- While the trust continues to have challenges relating to operational pressures, particularly in areas such Did Not Attend (DNA) rates and emergency admissions, they have seen improved performance in a number of key areas. They have delivered against the constitutional standards for Cancer, and benchmark better than national median for Accident & Emergency (A&E) delivery (91% in April 2019 against a national median of 85.1%). RTT performance benchmarks slightly worse than the national median but the trust has made significant improvements to their backlog and the 52-week wait position.
- These improvements have been driven by the continued focus of the trust leadership and staff. The trust has made significant improvements in flow and discharge through good use of ambulatory pathways, better use of the frailty unit and measures to use community and step-down capacity. Length of stay (LoS) across both the elective and non-elective pathways have improved and is better than peers.
- They key challenge for the trust is to maintain and continue to improve operational performance while meeting its financial plan.

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 experienced challenges across all the major constitutional standards. The trust has seen increased attendances across specialities and has put in place additional capacity including staff, beds and waiting list initiatives across both elective and non-elective pathways to manage pressures and continue to deliver against the standards.
- Accident & Emergency (A&E) performance has improved over the financial year 2018/19. The trust's A&E performance of 91.0% as at April 2019 remains in the best quartile and is better than national median of 85.1%, however it remains below the standard of 95%. We note that the trust has seen increases in attendances (in particular ambulance conveyances) and has put in place a number of processes to deal with this including additional beds and staffing over the winter months. Ambulance handovers continue to be a challenge due to the numbers of arrivals, but 30-minute handover breaches have improved from 19.2% in financial year 2017/18 to 10.5% in financial year 2018/19.
- The trust has made significant improvements in flow and discharge through good use of ambulatory pathways, better use of frailty unit and measures to use community and step down capacity. On pre-procedure non-elective bed days, at 0.44 days, the trust is performing significantly better than the national median of 0.66 days. This suggests that patients are waiting less time in hospital prior to emergency treatment compared to most other hospitals in England. Development of an older people's short stay unit to improve the frailty pathway has improved use of community and step-down bed capacity and therefore improved overall LoS. The trust further notes that use of both Discharge to Assess (D2A) and "Home First" schemes has increased over the previous year.
- Emergency readmission rates are 8.08% as at March 2019. This is worse than the national median of 7.73%. However, the trust usually performed better than the national median in all but this quarter over the previous 2 years. The trust's observations suggest that some of the increase in this quarter is related to agency and locum staffed winter escalation wards (the capacity the trust opened to deal with the increased activity over this period), but further investigations are being conducted and an audit led by the trust's deputy Medical Director is due in mid-July 2019. The trust will need to ensure that any significant factors are dealt with in time for winter in financial year 2019/20.
- Performance against the Referral-To-Treatment (RTT) standard of seeing 92% of patients within 18 weeks of referral is 83.4% as at March 2019. This is below both the national standard and the London median. Performance has

improved from 81.6% over the 2017/18 financial year. The trust's backlog of patients waiting over 52 weeks for treatment has similarly improved, with 18 patients waiting 52 weeks at March 2019, down from 47 in the previous month. This forms part of a broader recovery plan for RTT, and the trust is working with system partners to manage demand pressures and is working to ensure adequate capacity is in place to manage the total waiting list.

- Diagnostic performance for March 2019 is 99.2% and delivers against the benchmark of 99%. The trust continues to deliver against the Cancer performance standards of treating 85% of patients within 62 days of referral. Performance on Cancer waits for March 2019 is 86.3%.
- Pre-procedures elective bed days are 0.13 as at March 2019 having improved from 0.24 in March 2018. The national median is 0.12 (London median 0.18). This means than patients are spending broadly the same time before their procedures at the trust compared to other trusts nationally and less time compared to trusts in London. The improvement has been achieved particularly through the introduction of Enhanced Recovery After Surgery (ERAS) for complex colorectal patients. The overall length of stay reduction has been quantified by the trust as a saving of 6.3 beds per quarter.
- The trust has further room for improvement in Outpatients. The Did Not Attend (DNA) rate is 11.68% as at March 2019 compared to the national median of 6.96%. The trust also performs worse than London peers (9.74%). This continues to be an area of challenge for the trust, and improvement has been limited over the previous 12 months. However, the trust notes that clinic utilisation has improved despite the performance on DNA rates. The trust also notes that a new text reminder system is due to be rolled out from July 2019, which should further improve performance against this metric. The trust has also undertaken a number of measures including a standardised approach to cancellation and data collection, improved non face-to-face translation services (via telephone) and plans to introduce video interpreting.
- The trust's engagement with and utilisation of the Get IT Right First Time (GIRFT) programme has been good. The trust is starting to put in place a Quality Improvement (QI) based approach to utilising the GIRFT recommendations along with Model Hospital and other metrics. Given the financial and operational challenges facing the trust, further time and investment will be required in this area.

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 £2,243, slightly higher than the national median of £2,180. This means that it spends more on staff per unit of activity than most trusts in total. The trust's pay cost per WAU is worse than the national median for nursing professional staff group; at £758 compared to the national median of £710. The trust's pay cost per WAU for the medical professional staff group is £537 which benchmarks broadly in line with the national median of £533.
- The trust's pay costs for the 2018/19 financial year have been £31.1m higher than planned, mainly due to the reliance on agency and locums to manage increased demand over winter and to deliver improved Referral-to-Treatment (RTT) performance through waiting list initiatives. The trust's total agency spend for financial year 2018/19 was £30.2m, above a ceiling of £21.9m. This is also reflected in the proportion of temporary staff as a percentage of the total staff which showed an increase from 5.16% in May 2018 to 5.38% as at May 2019. During this period the proportion of temporary staff peaked at 6.28% in March 2019 for the reasons outlined above.
- The trust demonstrates good performance in the management of sickness absence. The trust sickness rate is recorded at 3.31% as at February 2019, which is lower than the peer median of 3.66% and the national median rate of 4.50%
- The trust notes that workstream reviews are underway by speciality, a key component of which is to actively explore alternative roles to doctors, given the trusts high pay costs (including on medical pay).
- The staff retention rate as at December 2018 was 79.5% against a national median of 85.6%. This metric has remained relatively constant over time and is comparable with other London trusts faced with a mobile local workforce; the London median is 80.9%. The trust can evidence a comprehensive engagement and Organisational Development (OD) plan setting out a number of discrete initiatives including "Conversations for Action" for senior leaders and staff to engage and "HEART ambassadors" and "HEART heroes" to reward and recognise staff who demonstrate the trust's values. These are reflected in the top 5 scores and most improved areas in the trust's staff survey. However, the survey also suggests that further work is required relating to career development and promotion, which the trust expects to tackle through the ongoing OD work.
- Electronic rostering is embedded across the nursing workforce and has clear governance processes which provides the information to the executive board to ensure it is sighted on safe staffing. Several key metrics including roster approvals and finalisation metrics are monitored by divisional teams and escalated to executives as appropriate. Nursing establishment is reviewed in line with the SafeCare tool.

- The trust has an electronic job planning tool (SARD) and at the time of the assessment, there were 172 signed off job plans out of 567. The trust has plans for a more innovative workforce model (which are planned to be reflected in future job plans), this forms part of the service line reviews noted above. Accordingly, this is an area for further improvement.

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

- Medicines cost per WAU for financial year 2017/18 is in the third quartile nationally at £326 compared to the national median of £320. The trust's medicines are however more comparable to the trust type peer median of £388 which is based on clinical output which considers the higher proportion of specialist work undertaken by the trust. The trust has achieved 128% against its savings targets on biosimilars to March 2018.
- The trust's radiology cost per report is £52 as at March 2018, which is comparable to the national median of £50. The trust can evidence a number of innovative practices across the trust and the wider system to increase efficiency in this area. These include the launch of the Ultrasound academy for trainee sonographers which will enable them to qualify as sonographers with a post graduate certificate or diploma, joint appointments of radiologists with The Hillingdon Hospital NHS Foundation Trust for interventional radiology and continue to be a proactive partner in the North West London radiology reporting network which aims to create shared reporting expertise across the trust. Radiographer reporting is in the poorest performing quartile nationally and is acknowledged by the trust as an area for improvement. There is a significant risk in the imaging asset base with 67% of the MRI machines being over 10 years old and similar challenges on X-ray and ultrasound systems at 46% and 22% respectively.
- The number of pharmacists actively prescribing has improved from the prior year and remains low at 21% compared to the national median which is at 28%, however this is being addressed by the Trust and ten pharmacists are awaiting registration with the General Pharmaceutical Council (GPhC). In addition to this a limited number of prescribing pharmacists have been recruited with a further number of pharmacists undergoing prescribing training. Pharmacists time spent on clinical pharmacy activity is 79% and is considered good progress in comparison to the national median which is currently at 70% and the national target set at 80%.
- Pathology cost per test is £2.99 against a national median of £1.92 as at September 2018. The trust outsources its laboratory services. The trust expects that some of the higher cost is a data issue given the nature of the arrangement, but it is investigating this. The trust is in the process of retendering its pathology services and expects it will be able to reduce costs further through a competitive tender process.

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 £1,331 compared with a national median of £1,307. This places it in the third (worst) cost quartile nationally. The trust's key opportunities in non-pay relate to estates and procurement.
- The cost of the finance function for financial year 2017/18 is £615,870 per £100m of turnover, below the national median of £676,480. Within this cost, the Transformation and Project Management Office (PMO) team costs are higher than national median, due to the trust's investment in this area to drive longer term efficiency gains. The impact of these investments on the trust's overall productivity and financial performance will need to be monitored over the next year.
- The Human Resources (HR) function costs £931,080 per £100m turnover, above the national median of £898,020. This is higher than median and partly due to the inclusion of the interpretation function within this area. The trust also notes that this cost has subsequently reduced in financial year 2018/19 through a full restructure of the function. While there is value delivered terms of the staff engagement and OD initiatives currently underway there are opportunities for efficiencies within all professional staff groups which are yet to be tackled. Additionally, the high costs and extensive use of agency and locums in financial year 2018/19 year suggest opportunities for savings through more robust planning for financial year 2019/20 could be achieved.
- The trust's Procurement Process Efficiency and Price Performance Score of 81 as at September 2018 is comparable to the upper benchmark score of 79 (and better than the national median of 66). This suggests that procurement processes have been very efficient and that it has historically succeeded in driving down costs on the things it buys. The trust has continued to focus on standardisation across the trust through engagement with clinicians. As part of this, a new Clinical Nurse Specialist (CNS) role was created within the procurement function. The procurement team won an Health Service Journal (HSJ) award in 2019 for their work on standardisation of wound care.

- The trust's estates and facilities (E&F) cost per m2 is £355. While this isis higher than national median of £342, the trust performs better than peers in this metric (peer median of £454). We also note that the trust's estate is relatively old with a very high backlog maintenance (£807 against a benchmark of £254) and critical infrastructure risk of £179 (benchmark £102). While internal trust capital funding is limited to tackle much of this, developing systemwide strategies and plan to deal with this backlog, must be a key focus of the trust.

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

- The trust reported a deficit, including incentive payments such as Sustainability and Transformation Funding (STF) and Provider Sustainability Funding (PSF), of £21m in financial year 2018/19, exceeding its Control Total (a deficit of £31.4m). In the previous financial year the trust similarly exceeded its Control Total (CT), delivering a deficit of £39.1m (CT: £49.5m deficit).
- On an underlying basis, without the benefit of incentive payments or other one-off benefits including land sales and transactional funding from HM Treasury relating to Central Middlesex Hospital, the 2018/19 financial year position is a deficit of £88.9m (12.2% of turnover). This is a slight deterioration from from the underlying deficit of £82.5m in financial year 2017/18. Prior to this the trust's underlying deficit improved from £100.6m in financial year 2015/16. The deterioration in financial year 2018/19 has been attributed by the trust to under-delivery of recurrent Cost Improvement Programmes (CIPs). Cost pressures in year relating to delivery of operational standards has also had some impact on this position.
- The constituent parts of the underlying deficit are well understood by the trust; a drivers of deficit analysis was refreshed in year and notes that £34.9m of opportunity exists in operational areas, some of which is planned to be delivered in financial year 2019/20. The trust is in discussion with system partners on dealing with the strategic and structural elements of the deficit.
- The trust has not signed up to its Control Total in financial year 2019/20. However, a challenging efficiency programme means that the trust plans to deliver an underlying deficit of £76.0m for the year, an improvement of £12.9m. Given the failure to deliver recurrent savings in the previous year, and ongoing pressures relating to RTT and A&E, means that this will require significant grip and control internally and joined up system working. We note that much of this is underway.
- The trust delivered recurrent CIPs of £34.7m in financial year 2016/17 and £40m in financial year 2017/18. However, recurrent CIP delivery was only £21.2m in financial year 2018/19, leading to the increase in the underlying deficit noted above. This was mitigated through non-recurrent means in year. The trust points out that from financial year 2019/20 onwards the focus will be on transformational savings (e.g. through the service line reviews).
- The trust is in receipt of distressed funding from the Department for Health and Social Care (DHSC) given its deficit position and has accumulated £260m of borrowings to DHSC. The trust can demonstrate good policies and processes for managing its cash position on an ongoing basis, including robust 12-week forecasting. For March 2019 the trust's performance against the Better Payment Practice Code was not compliant but was above the national acute trust average for both NHS (92% versus 69% national acute average) and non-NHS payments (90% versus 79% national acute average).

Outstanding practice

- The trust has made significant improvements in flow and discharge, through good use of ambulatory pathways, better use of frailty unit and measures to use community and step down capacity. On pre-procedure non-elective bed days, at 0.44 days, the trust is performing significantly better than the national median of 0.66 days. This suggests that patients are waiting less time in hospital prior to emergency treatment compared to most other hospitals in England. Development of an older people's short stay unit to improve the frailty pathway has improved use of community and step-down bed capacity and therefore improved overall LoS. The trust further notes that use of both Discharge to Assess (D2A) and "Home First" schemes has increased over the previous year.
- The procurement team won a Health Service Journal (HSJ) award in 2019 for their work on standardisation of wound care.
- The trust has launched its two year organisational development and engagement plan which is informed by feedback from the staff survey and patient experience and aligned to planned organisational transformation work. As part of this initiative, the trust co-produced with staff and patients its HEART values which is being embedded within the organisation through its culture and values staff working group.

Areas for improvement

- The trust's pay costs as at for the 2018/19 financial year have been £31.1m higher than planned, mainly due to the reliance on agency and locums to deliver increased activity/attendances over winter and Waiting Lis Initiatives to manage RTT backlog. The trust's total agency spend for financial year 2018/19 was £30.2m, above a ceiling of £21.9m. The trust notes that workstream reviews are underway by speciality, a key component of which is to actively explore alternative roles to doctors, given the trusts high pay costs (including on medical pay).
- The trust has not signed up to its Control Total in financial year 2019/20. However, a challenging efficiency programme means that the trust plans to deliver an underlying deficit of £76.0m for the year, an improvement of £12.9m. Given the failure to deliver recurrent savings in the previous year, and ongoing pressures relating to RTT and A&E, means that this will require significant grip and control internally and joined up system working. We note that much of this is underway.
- The trust has further room for improvement is in Outpatients. The Did Not Attend (DNA) rate is 11.68% as at March 2019 compared to the national median of 6.96%. The trust also performs worse than London peers (9.74%). This continues to be an area of challenge for the trust, and improvement has been limited over the previous 12 months. However, the trust notes that clinic utilisation has improved despite the performance on DNAs. The trust also notes that a new text reminder system is due to be rolled out from July 2019, which should further improve performance against this metric. The trust has also undertaken a number of measures including a standardised approach to cancellation and data collection, improved non face-to-face translation services (via telephone) and plans to introduce video interpreting.

Ratings tables

Key to tables					
Ratings	**Not rated**	**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 last rating published					

***** 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

Service level

Safe	Effective	Caring	Responsive
Requires improvement →← Nov 2019	Requires improvement →← Nov 2019	Good →← Nov 2019	Requires improvement →← Nov 2019

Trust level

Well-led	Use of Resources
Requires improvement →← Nov 2019	Requires improvement →← Nov 2019

Overall quality

Requires improvement →← Nov 2019

Combined quality and use of resources

Requires improvement →← Nov 2019

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.

Term	Definition
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.

Term	Definition
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.

Term	Definition
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.