George Eliot Hospital NHS Trust

Use of Resources assessment report

Lewes House
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Date of publication: 19/05/2020

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

CQC temporarily suspended all routine inspections on 16 March 2020 to support and reduce the pressure on health and social care services during the COVID-19 pandemic. CQC, as well as providers, want to be able to prioritise keeping people safe during this time. This inspection was already underway at the time of the suspension and therefore couldn't be completed in the usual way.

This report includes the findings from the completed service level inspections, but the well-led inspection was not completed. CQC is only able to update findings on well-led at the overall trust level or update the other trust-level ratings when we have inspected the well-led component. As a result, the ratings for the overall trust and five key questions included in this report are from a previous inspection.

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

NHS Trust

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Date of inspection visit: 03 Mar to 05 Mar 2020
Date of publication: 19/05/2020

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 NHS trust's performance against a set of initial metrics alongside local intelligence from NHS Improvement's day-to-day interactions with the NHS trust, and the NHS 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 NHS trust on 12th February 2020 and met the NHS trust's leadership team including the chief executive and the chair, as well as relevant senior management responsible for the areas under this assessment's KLOEs.

Findings

Requires improvement

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

We rated Use of Resources as requires improvement because the NHS trust is not consistently making best use of its resources to enable it to provide high quality, efficient and sustainable care for patients:

The NHS trust's performance against the clinical services productivity metrics, such as pre-procedure non-elective bed days, long length of stay and 30-day emergency readmissions rates is worse than most other NHS trusts. This indicates that there remain opportunities to improve emergency care pathways to support better utilisation of emergency care beds and facilities.
The NHS trust is not meeting most of the national constitutional operational standards, and its performance is below (worse than) national medians. When compared to the previous year, there has been a deterioration in performance against the Cancer and 18-week Referral to Treatment standards and at the time of the assessment, the NHS trust was not meeting the improvement targets in this respect.
The pay costs of delivering the same units of activity are higher than other NHS trusts, and the proportional use of temporary staffing, in particular agency staffing, also remains higher than most other NHS trusts (the main drivers being vacancy cover). Whilst the NHS trust has achieved some success in recruitment to nursing staff vacancies, medical staff recruitment continues to be a challenge. There remain opportunities to optimise substantive workforce through better utilisation of workforce deployment solutions.
The cost of corporate services relative to turnover remain high compared to other NHS trusts. Previous assessments have recommended that the NHS trust pursues back office collaborative working opportunities to reduce corporate overhead costs. Although there has been progress in developing some back-office collaboration with other NHS trusts, the pace of change remains slow and the NHS trust was not able to demonstrate productivity improvements achieved since the last assessment. Significant opportunities also remain to improve procurement processes and drive down cost of purchases.
The NHS trust achieved its 2018/19 financial plan and control total of £18.5 million deficit before PSF (12.3% of turnover), however this was with the support of non-recurrent income and cost improvement initiatives. At the time of the assessment, the NHS trust was reporting a year to date deficit of £18.7 million (14.67% of income). This was £5.3 million adverse to plan (pre PSF, FRF, MRET) and although still forecasting to achieve its control total, the NHS trust had not yet finalised the recovery and risk mitigation plans to secure this.
The overall Cost per Weighted Activity Unit (WAU) is £ £3,752 compared to a national median of £3,486 for 2017/18. This place the NHS trust in the highest (worst) cost quartile nationally.
However, it should be noted that:

- The NHS trust's maintenance backlog and the overall cost of running the estate remain low compared to other NHS trusts.
- The NHS trust continues to compare well against some clinical services metrics such as, pre-procedure elective bed days and day case rates, which indicates better utilisation of elective beds.
- Sickness absence management also compares well nationally.

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

The NHS trust's performance against the clinical services productivity metrics indicates that there remain opportunities to improve utilisation of emergency beds and services. The NHS trust is not meeting most of the national constitutional operational standards, with a performance below national median and a deterioration in some.

- At the time of the assessment in February 2020, the NHS trust was not meeting most of the constitutional operating standards and there has been a deterioration in some. Performance for the 18-week Referral to Treatment (RTT), 62- day wait for urgent GP Cancer referrals, and 4-hour wait in Accident and Emergency, were all below national standards and national medians. However, the NHS trust was meeting the 6-week Diagnostic standard, with an improved performance compared to the previous inspection. The NHS trust was also meeting the 62-day standard for cancer screening referrals.
- A&E performance has been impacted by an increase in attendances, partly due to high numbers of ambulance conveyances from neighbouring regions such as Leicester. The NHS trust continues to focus on improving its minor's pathway and Same Day Emergency Care services. An Emergency Department Frailty service is now in place and is co-located with both the Ambulatory care and the GP assessment service in a purpose-built unit.
- Fewer patients were coming into hospital unnecessarily prior to their elective treatment compared with other hospitals in England. As at September 2019, the NHS trust's pre-procedure elective bed days at 0.04 remain in the lowest (best) quartile compared to national median of 0.12 bed days. This is an improved position compared to the previous assessment. The NHS trust continues to perform well on day case rates, benchmarking in the best quartile nationally during July 2019 to September 2019.

- More emergency patients continue to wait in hospital prior to their procedures when compared with other NHS trusts. As at September 2019, the NHS trust's performance for pre-procedure non-elective bed days was 1.74 bed days compared to a national median of 0.64 bed days, placing the NHS trust in the worst performing quartile. This was also a deterioration against the position at the last assessment. The NHS trust attributes this performance to continuing theatre and bed capacity constraints, and inefficiencies in the emergency patient pathways. The NHS trust plans to address this through a review of theatre capacity and investment in beds. There has been a reconfiguration of beds on some wards to optimise the available capacity. The NHS trust is scoping the opportunity for 30 additional beds onsite to increase the bed base for electives and emergency services.
- The NHS trust's 30-day emergency readmissions rate at 9.54% against a national median of 9.34% as at September 2019 remains worse than other NHS trusts, and has deteriorated form previous assessments. The NHS trust has reported that there are no audits of readmissions and it has not identified any concerning themes from patient complaints.
- There has been a slight improvement in the Did Not Attend rate (7.61%), although this remains above the national median of 7.13% (September 2019). At the last assessment, performance was 7.80% compared to the national median of 7.29% as at September 2018.
- The NHS trust's performance for Long Length of Stay (LLOS) over 21 days, was 34 patients as at 3rd February 2020, and although this is below the NHS trust's baseline of 43, it does not meet the target of 26 patients. The NHS trust has identified the limitations to improvements as; unavailability of non-weight bearing pathways and community intravenous antibiotics services. The NHS trust is working with system partners to address these issues. The NHS trust has introduced systems to track flow of patients with long length of stay, for instance, review meetings are conducted three times a week for LLOS patients, and each ward has a current length of stay target set at 10 days with dashboard to track performance.
- The NHS trust's Delayed Transfers of Care (DTOC) rate has been variable, and in December 2019 at 3.9%, was higher than the national target rate of 3.5%.
- 'Getting IT Right First Time' (GIRFT) programme is well received in the NHS trust. GIRFT review meetings are held each quarter, and programme led by the Medical Director. There have been seven visits since the last assessment, however the NHS trust has not provided evidence of productivity benefits realised from implementation of GIRFT recommendations from the visits.

How effectively is the NHS trust using its workforce to maximise patient benefit and provide high quality care?
The NHS Workforce productivity does not compare well. Workforce costs remain high, with the use of temporary medical agency staff benchmarking worse than other NHS trusts. Although the NHS trust has achieved some success in recruitment to nursing staff vacancies, medical staff recruitment continues to be a challenge. There remain opportunities to expand and improve the use of existing workforce deployment solutions, to optimise the substantive workforce and reduce costs.

- For 2017/18, the NHS trust had an overall pay cost per WAU of £2,421 compared to the national median of £2,180, placing it in the worst quartile nationally. This means that it continues to spend more on staff per unit of activity than most other NHS trusts. The refreshed cost information for 2018/19, also places the NHS trust's medical, nursing and AHP costs of delivering activity in the highest cost quartile nationally.
- The NHS trust's expenditure on agency staffing exceeded the 2018/19 agency ceiling (set by NHS England and NHS Improvement) by 14%, and at 7.8% of overall pay cost, the agency expenditure was higher than most other NHS trusts. For 2019/20, the NHS trust's agency spend as at January 2020, had already reached ceiling, indicating that the ceiling will be breached again.
- Use of medical agency staffing, particularly in the Emergency Department, continues to be the main contributor to the high agency costs (70%). The NHS trust has commissioned a new contract with NHS Professionals (a bank and agency collaborative) to provide medical agency cover. The NHS trust expects this will support tighter processes and controls to manage spend. Accountability for agency spend has been devolved to directorates and clinical directors are now accountable for their agency spend.
- Although overseas recruitment initiatives have achieved success in recruitment of nurses, recruitment of medical staff continues to be a challenge. Emergency department and Paediatric medical staffing are particularly fragile. Collaboration with a neighbouring NHS trust is being explored in respect to the latter.

- 52% of job plans had been agreed at the time of the assessment. This has not improved since the last assessment undertaken in November 2018 (51.5%). The use of demand and capacity planning to inform consultant job planning processes has not progressed since the last assessment. The NHS trust indicated that there is a job planning process in place for Associate Specialist and Specialty (SAS) doctors which mirrors the process in place for consultants.
- E-rostering is in place and has been rolled out for deployment of all nursing staff and some non-clinical staff. Key Performance Indicators (KPI) have recently been implemented to ensure efficient staff deployment. The KPIs are reviewed and discussed at a monthly Nursing and Midwifery E-roster and NHSP meeting. A staffing review has been undertaken with changes being made to shift patterns, moving to long day shifts. This has resulted in better staff coverage and the NHS trust is reporting financial efficiencies of £1.5 million from this initiative. The NHS trust uses an electronic tool to track patient acuity, however more work is required to embed its use in the subsequent deployment of staff. E-rostering has not been implemented for medical staff.
- As reported in previous assessments, the NHS trust has established some alternative roles in its workforce to provide support and resilience to their medical teams. They include emergency nurse practitioners, advanced clinical practitioners and an antibiotic prescribing pharmacist. There have been no further developments in this respect since the last assessment.
- There has been a slight deterioration in the overall Staff Retention rate, which at 84.7% (December 2019) remains below the national median 86.2% and in the second worst quartile nationally. At the last Use of Resources assessment, staff retention rate was 85.1% compared to the national median of 85.9% (September 2018). The NHS trust highlighted that this was driven by high turnover in corporate areas.
- The overall Sickness absence rate performance has been variable since the last assessment, however at 4.23% for December 2019, it remains better than the national median of 4.77% and in the best performing quartile nationally. The NHS trust has an HR business partnership model in place to support and empower operational managers to actively manage sickness absences. Other initiatives include; a health and wellbeing programmes, a robust clinical supervision model for nurses and a local employee assistance programme that is available to staff 24-hours, 7 days a week.

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

Pathology service costs have remained in the best quartile for the last three years, however volume of tests cannot be tracked, and service delays continue to impact on performance. Savings from switching to best value biosimilars (a national initiative) remain very low, and there are significant opportunities to improve antimicrobial stewardship. There has been progress in recruitment of radiologists, which the NHS trusts expect will positively impact on imaging service costs and improve turnaround times.

- The NHS trust's performance on the Top 10 Medicines initiative (switching to best value biosimilars) remains lower than most other NHS trusts, with the additional savings delivered in 2018/19 (£0.4 million) being the lowest in the country. For 2019/20 the additional savings as at December 2019 were £0.34 million. This is the 4th lowest in the country.
- The NHS trust's antibiotic prescribing has remained in the highest (worst) quartile for the last 2 years, as indicated by the high-level antibiotic prescribing rate per 1,000 admissions. For 2018/19, this was reported at 5,510 antibiotic Defined Daily Doses per 1,000 admissions compared to the national median of 4,756. The NHS trust recognises that it needs to improve antimicrobial stewardship and is reviewing governance structures to check antibiotics prescribing. There are dedicated resources in the form of a clinical lead and pharmacists to drive this work. At the time of the assessment the improvement initiatives had not yet had an impact.
- The NHS trust is reviewing the longer-term model of its aseptic services unit, including options of joint working with other local NHS trusts. This is currently at the financial planning stage with associated estates considerations. The pace of change on this has been slow to date.
- As reported in previous assessments, the NHS trust is part of a well-established pathology network, and the overall cost per test in pathology remains better than other NHS trusts at £1.21 for 2018/19 (national median is £1.94). The NHS trust highlighted some improvements that have been made by the lead provider since the last assessment, for instance investment in more modern equipment (analysers).

- Although the NHS trust has a service level agreement in place to manage the outsourced pathology service, there is no robust method of enforcing compliance, and delays are impacting on operational performance, for instance, delays in Histopathology have adversely impacted on Cancer pathways. The NHS trust also has no mechanism in place to track and manage demand levels. This was the case at the last assessment.
- The overall cost per report in imaging services at £37.64 (2018/19) is lower than the national median and in best quartile nationally. This has reduced since the last assessment, when the NHS trust reported an overall cost per report of £53.01 (2016/17).
- The NHS trust invested in its radiology workforce increasing the number of consultant radiologists posts from 8 FTE to 12.5 FTE and has introduced some remote working to support recruitment. The NHS trust currently has one reporting radiographer and overnight reporting is outsourced to an independent Radiology service provider, to ensure more timely imaging reports for patients.
- The NHS trust highlighted that the increased capacity had had a positive impact on reporting turnaround times for CT, which were previously higher than most other NHS trusts, however supporting evidence of this was not provided.
- DNA rates remain high for non-obstetric ultrasound at 8.5% which is in worst quartile nationally. The NHS trust is implementing a two-way text messaging service to improve this.
- Examples of technology investments made since the last assessment to improve workforce productivity include; implementation of electronic VTE assessments to drive compliance in inpatient areas, and implementation of employee and manager self-services for electronic staff record (ESR) updates.

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

The maintenance backlog and the overall cost of running the estate remain low compared to other NHS trusts, however there are opportunities to further reduce some of the soft facilities management costs for areas such as food, Linen and Laundry. Although the NHS trust has made some progress in developing back office collaboration with other NHS trusts, the pace of change remains slow and the NHS trust was not able to demonstrate productivity improvements made in this area since the last assessment. Significant opportunities also remain to improve procurement processes and drive down cost of purchases.

- The total non-pay cost per WAU is £1332 compared to a national median of £1307 (2017/18).
- The cost of Corporate services functions relative to turnover remains higher than other NHS trusts. As highlighted in previous assessments, the NHS trust attributes this to its relatively small size, when measured by turnover. Finance function costs per £100 million of turnover was £1.01 million for 2018/19 compared to national median of £0.65 million. HR function costs per £100 million of turnover were £1.38 million compared to a national median of £0.9 million, and the cost of the IMT function per £100 million of turnover was £2.78 million compared to a national median of £2.52 million.
- Previous assessments have recommended that the NHS trust pursues back office collaborative working opportunities which could support reduction in corporate overhead costs. Since the last assessment there has been some progress in working towards back office collaboration with other NHS trusts, however at a slower pace than expected.
- The NHS trust moved to a shared finance system with other local STP partners in June 2019, however a review of business processes and workforce requirements had not yet been finalised at the time of the assessment, and therefore the impact of the technology investment on the cost of services is yet to be realised.
- The NHS trust will also have a shared Director of HR within its foundation group from 1st April 2020, which it expects will support further collaborative working in the HR operations. The NHS trust has implemented some technology solutions to support productivity improvements, for instance enabling ESR Employee and manager self-service, and plans are in place to start using electronic payslips by April 2020.
- In the Procurement League Table, the NHS trust's ranking remains low at 131 out of 133 NHS trusts (July to September 2019). This indicate there remain significant opportunities to improve the effectiveness of its procurement processes and to work with other NHS trusts to drive benefits of scale in procurement operations. This remains an area of concern for the NHS trust, and was highlighted in the last assessment but little progress has been made.
- The Estates cost per m2 at £260 for 2018/19 remains lower than the benchmark value of £354, and is an improvement on the costs per square metre for 2017/18 which was £293. The NHS trust's backlog maintenance is currently estimated as £140 per m2 compared to a benchmark of £213 per m2. This remains in the best quartile nationally.

- Food costs per meal appear to be high at £5.43 for 2018/19 (national median is £4.07). The NHS trust attributes this partly to inaccuracies in data returns which included costs from the restaurant and café. A review has also been undertaken at ward level to identify wards that are driving the higher meal costs, and there are ongoing focused efforts to reduce wastage.
- Linen costs are also high with the Laundry and Linen cost per item at £0.55 compared to a national median of £0.34 (2018/19). The NHS trust has a new provider for Laundry and Linen services, that is working with wards on demand management.

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

Whilst the NHS trust achieved its financial plan and control total in 2018/19, this was with the support of non-recurrent measures. At the time of the assessment, the NHS trust was reporting an adverse position to its year to date plan and had not finalised its recovery and risk mitigation plan.

- For 2018/19, the NHS trust achieved its financial plan and control total of £18.5 million before PSF (12.3% of turnover), however this was with the support of non-recurrent measures, including income support from commissioners. Achievement of this control total secured the NHS trust additional incentive income (PSF) of £2.7 million and core PSF of £3.0m, which reduced the reported deficit further to £12.8 million (8.2% of turnover), a position that was better than the control total with PSF (£14.3 million) million'.
- At the time of the assessment the NHS trust was reporting a year to date deficit of £18.7 million, that was £5.3 million adverse to plan (pre PSF, FRF, MRET). The main reasons for the adverse position were identified as emergency services cost pressures, under delivery of forecast savings on medical and nurses staff costs, and higher than planned agency expenditure. Although still forecasting to deliver the plan, the NHS trust had not yet fully identified the required recovery actions and mitigations to address the identified future risks.
- Whilst the NHS trust achieved its CIP target for 2018/19 of £7.5 million (4.3% of expenditure), only 37% of this was reported as recurrent (64% in 2017/18). At the time of the assessment CIP delivery was behind target, with the NHS trust forecasting 80% delivery (£8.2 million against the plan of £10.2 million as at January 2020). Weakness in CIP systems and processes, and failure to achieve income generation schemes, remain the key challenges.
- As reported in previous assessments, due to its historical deficit position, the NHS trust continues to rely on revenue and cash support to meet its financial obligations and maintain a positive cash balance. At the time of the assessment, the NHS trust had remained within its planned borrowing limits but highlighted a risk of cash shortfalls in last quarter (Jan-March 20) due to increased pay cost pressures.
- Since the last assessment the NHS trust has developed Patient Level Costing systems and completed its first national submission for 2018/19. The NHS trust score on the cost assessment tool (which helps identify whether and where an NHS trust's costing processes are particularly strong and where it should focus efforts to improve) is 78% compared to a national median of 82%. This indicates scope to further improve the quality of the cost data. The NHS trust is identifying a clinical champion to support development and use of the cost data The NHS trust has invested in a reporting tool, that supports interrogation of cost data and development of service line reporting.
- At the time of the assessment the NHS trust was reporting a shortfall of £7.2 million against its income plan. The NHS trust had agreed an incentive contract with its lead commissioner at the start of the year, to drive system improvements in the quality of care and sustainability of services. However, the NHS trust had not delivered the improvements required to secure £9.5 million of the incentive funding (PSF/FRF) The NHS trust commissioned external consultancy support for its clinical workforce transformation programme earlier on in 2019/20. However, this subsequently been reduced, and a joint transformation team with the main commissioners is being set up to support the transformation Plans. Expenditure on external consultants was reported as 0.38 million as at January 2020.

Areas for improvement

- Clinical services productivity metrics indicate that there remain opportunities to improve utilisation of emergency care resources. The NHS trust should continue making improvements in this respect to optimise available capacity.

- Agency costs and in particular medical staffing agency continue to benchmark higher than most other NHS trusts. The NHS trust should maintain focussed efforts on improving medical staff recruitment rates and optimising its substantive medical workforce.
- The NHS trust has previously made commendable progress in establishing more robust job planning processes. The NHS trusts should ensure that these processes are scaled to all consultants and other relevant medical staff.
- The NHS trust should consider integrating job planning information in the overall operational capacity planning processes.
- The NHS trust should continue working to identify and integrate alternative roles that would create more resilience in its workforce models.
- The NHS trust should increase the pace of securing back office benefit of scale opportunities through collaborative working.
- The NHS trust recognises the improvements required in respect to antimicrobial stewardship, and should ensure that improvement initiatives are implemented.
- Procurement remains an area of poor performance. The NHS trust should work at pace to drive improvements in procurement processes and information.

The NHS trust should focus on improving its recurrent financial deficit.

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
Requires improvement Feb 2019	Requires improvement Feb 2019	Good Feb 2019

Trust level

Responsive	Well-led	Use of Resources
Requires improvement Feb 2019	Requires improvement Feb 2019	Requires improvement ➔➔ May 2020

Overall quality

Requires improvement
Feb 2019

Combined quality and use of resources

Requires improvement
Feb 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.