NHS Improvement

Chelsea and Westminster Hospital NHS Foundation Trust

Use of Resources assessment report

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18th January 2018

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13th February 2018

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

Proposed rating for this trust	**Outstanding** ☆

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 on 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 18th January 2018 and met the trust's executive team including the Chief Executive, the Chair and relevant senior management responsible for the areas under this assessment's KLOEs.

Findings

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

We rated use of resources as outstanding because the trust is achieving excellent use of resources, enabling it to provide high quality, efficient and sustainable care for patients:

- The trust is in surplus and has an excellent track record of managing spend within available resources and in line with plan. The trust is on track, after the first eight months of the year, to achieve its planned surplus of £7.2m and meet its control total in 2017/18, having reported a £10.5 million surplus in 2016/17.
- The trust is able to meet its financial obligations and pay its staff and suppliers in the immediate term and meets capital service and liquidity metrics. The trust is maintaining positive cash balances without the need for interim support in the last 12 months.
- The trust is in receipt of £10.9m transitional funding in 2017/18 to meet its financial obligations and integrate services with the West Middlesex University Hospital (WMUH), following its acquisition in September 2015. The trust will continue to receive the acquisition-related funding until March 2020, investing in new systems and standardisation to realise its economies of scale, post integration.
- The trust has an ambitious £25.9 million Cost Improvement Programme (CIP) in 2017/18 (which equates to 4.3% of operating expense) which is currently delivering to plan. In 2016/17 the trust delivered £20.8m recurrent savings (96% of its planned savings target). At the time of assessment, the trust noted that it expects its CIP requirement to be approximately £19m in 2018/19, subject to planning guidance; 100% of the 18/19 CIP plan is being reported as recurrent.
- The trust has an excellent understanding of the practical, evidence-driven approach that is required to balance continuous improvement in clinical quality, operational performance and financial sustainability. The trust has Use of Resources as one of its three strategic priorities for improvement, and executives and managers were able to confidently demonstrate the drivers of performance across the three domains.
- Despite a 50% increase in cancer referrals in the last 12 months the trust has managed to improve its operational performance in Accident and Emergency (A&E), Referral to Treatment (RTT) and Cancer waiting times whilst maintaining its quality of care (as measured by the Summary-level Mortality Indicator which reduced from 86 to 83 during 2016/17) and lowering its costs of service delivery per patient (Reference Cost Index reduced from 93 to 92 during 2016/17).
- The trust spends less on pay and other goods and services per Weighted Activity Unit (WAU) than most other trusts nationally. For 2016/17 the trust had an overall cost per WAU of £3,224, compared with a national median of £3,375, placing it in the lowest (best) cost quartile nationally.
- The trust has made significant reductions in agency spend from £27.1m in 2016/17 to £18.4m in 2017/18. The introduction of new tax arrangements along with the trust developed FlexiStaff+ and LocumTap platforms (applications to enable staff to work more flexibly) have supported a reduction in medical agency costs.

However the trust has further opportunities for improvement:

- The trust recognises the need to improve its staff retention rate from 77.2% (October 2017), to the national median (85.5%). The trust is engaged in the NHS Improvement

Retention Support programme, and understands the need to invest in training and career development opportunities. The latest monthly Trust Gross Turnover rates (December 2017) demonstrate a 2% improvement over six months. The trust has developed a workforce strategy plan with some innovative workforce models to underpin this improvement.

- The outpatients DNA rate of 10% is in the 4th (worst) quartile of performance nationally, and the national median is 7.47% (Q1 2017/18). The trust has ambitious plans to reduce DNA rates to this level and save 30,000 outpatient appointments, using improved planning, standardisation of processes and technological solutions.
- The trust stated that it needs to increase its medical job planning completion rate from 85% to 100%, and ensure that each medical Programmed Activity (PA) is electronically rostered.

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 takes a proactive, and often innovative, approach to managing its financial and non-financial resources, which supports the delivery of high quality, sustainable care and achieves excellent use of its resources.
- At the time of the assessment, as at quarter 3, the trust was meeting the constitutional operational performance standards on RTT, Cancer and Accident & Emergency. The trust has made improvements in both RTT performance and A&E performance since quarter 2.
- In quarter 3 there was a material deterioration in diagnostic waiting time performance to 93.5%, which is below the 99% standard for patients being tested within 6 weeks. The trust understands the primary driver of this underperformance in non-obstetric ultrasound (88%), and has a recovery plan in place to fill vacancies using agency staff in the short term, with a view to recruit to the posts substantively and reduce pay costs in the longer term.
- Patients are less likely to require additional medical treatment for the same condition at this trust compared to other trusts. At 8.4%, emergency readmission rates are slightly below the national median of 8.9% as at March 2017. The greatest area for improvement is at the West Middlesex site which has a rate of 9.5-10.5% during 2017/18, compared to 3-3.5% at the Chelsea site.
- Patients are likely to require a shorter inpatient stay at this trust compared to other trusts. The trust's Average Length of Stay (ALOS) is 3.66 days compared to the national mean of 4.17 days. The trust has a Non-Elective ALOS of 3.67 days and the Elective ALOS is 3.55 days. The trust has made significant investments in implementing improvements to reduce length of stay, support early discharge for medically fit patients (HomeFirst pathway) and improve patient flow (Pre-12 noon discharges, 24% increase in Ambulatory & Emergency Care, Red:Green days embedded trust wide). The trust's continuing performance against the A&E four hour target is testament to the impact of this work.
- The trust reports a Delayed Transfers of Care (DTOC) rate that has been improving between April 2017, when DTOCs occupied 10 beds, and November 2017 when they reduced to 3 beds. This is due to the trust's work with partners across its local health system, driven by a new Integrated Discharge Team (implemented in September 2017) on both acute sites.
- Marginally more patients are coming into hospital unnecessarily prior to elective treatment compared to most other hospitals in England.
    - On pre-procedure elective bed days, at 0.17 days, the trust is performing in the second highest quartile when compared nationally – the national median is 0.14 days (Q1 2017/18)

    - On pre-procedure non-elective bed days, at 0.42 days, the trust is performing in the lowest (best) quartile below the median when compared nationally – the national median is 0.69.

- The Did Not Attend (DNA) rate for the trust is relatively high at 10% for Q1 2017/18 compared to the national median of 7.47%. The trust mitigates the impact of these DNAs by over-booking clinic templates to DNA rates by specialty, but could further improve engagement and performance by over-booking clinics using clinic level DNA rates.
- The trust has an ambitious DNA reduction plan in place, with the aim of achieving the national median and saving around 30,000 outpatient appointments. Using specialty deep dives, the trust is looking to implement a number of operational improvements to lower the DNA rate and reduce the First to Follow Up Ratio, including the relaunch of text reminder services, virtual clinics, improvement in outpatient letters/emails and more rigorous implementation of the discharge policy. It is too soon to evaluate the impact of these initiatives.
- The trust was not able to demonstrate the utilisation of scheduled clinics (clinic uptake rate, cancellation rates, slot utilisation etc.) but did provide assurances that it could manually reconcile Consultant PAs to the clinic schedules to understand capacity variances. The trust was confident that its managers were able to act on this information and subsequently schedule clinics to maximise the deployment of capacity agreed in job plans.
- The trust has engaged with the Getting It Right First Time (GIRFT) programme, having reviewed five specialties to date, with a further three specialties scheduled for early 2018. The trust monitors the implementation of the specialty reports through a fortnightly implementation board and is able to outline tangible improvements to date, e.g. increasing the number of cataracts operations per list from 2-3 to 6-7 during Q3 2017/18.
- The trust has more opportunity to realise improvements from GIRFT and recognised this would be a major component of its 2018/19 CIP plan, e.g. a continued shift from uncemented hips (15%) to cemented hips, lowering procedure costs and revision rates.
- The trust utilises its theatre sessions (touch time) at 81%, placing it in the 3rd quartile just above (better than) the median (77%), but just below the target benchmark of 85%. Optimising the trust's theatre capacity would allow it to undertake an additional 4,000 cases per year within current capacity. The trust could therefore cut the number of planned theatre sessions and reduce costs or undertake further income-generating activity. The trust recognises that it needs to increase list uptake and the numbers of cases booked per list increasing its use of the 6-4-2 booking process.

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

- There is effective control over staff costs with expenditure on staffing not exceeding initial staffing budget, low pay bill growth and low pay cost per weighted activity unit (WAU). Innovative and efficient staffing models and roles are used to deliver high quality and sustainable care, including by ensuring there is an appropriate skill mix for the work being undertaken.
- For 2016/17 the trust had an overall pay cost per WAU of £1,800, compared with a national median of £2,157, placing it in the lowest cost quartile nationally. This means that it spends less on staff per unit of activity than most trusts, however the trust acknowledged that due to the high proportion of contracted out services (e.g. payroll) pay costs would benchmark low, with non-pay costs benchmarking high.
- The trust is in the 1st (best) quartile for Allied Health Professionals (AHPs), Medical and Nursing costs per WAU, and is still able to achieve a lower ALOS than peers, suggesting it

has a very productive and well-managed workforce.

- Care Hours Per Patient Day (CHPPD) are monitored at the trust Board and each ward meets or exceeds the national benchmark, despite the low nursing costs per WAU.
- The trust recognises that it has a high cost theatre staffing model (£37,126/Full Time Equivalent (FTE) in the 4th quartile nationally). The trust is planning a theatre nursing skill mix and agency review with clearer grade progression to promote retention.
- The trust did not meet its agency ceiling set by NHS Improvement for 2016/17 (£27.2m spent compared to plan of £18.0m, 51% variance) and is forecasting to marginally miss (by 2%) its ceiling in 2017/18. However, the trust has achieved significant reductions in the cost of agency and locum staff through the use of a collaborative staff bank for doctors and using strict controls to minimise cost per hour cap rate breaches.
- The trust uses an electronic system to roster nurses, and it is currently being extended to AHPs. The trust can demonstrate a reduction of 9% in unallocated hours; a 13% reduction in unavailable hours and 92% of rosters are agreed 6 weeks in advance – in line with good practice. The trust undertakes daily acuity scoring and is able to flexibly deploy its nursing establishment based on patient need. The trust is exploring software options to e-roster doctors, given the poor interoperability of its current system.
- 85% of Consultants have an up-to-date job plan, but the trust acknowledge they have found it challenging to exceed this level, given variable clinical engagement. The trust does follow best practice by using service level job plans, linked to demand and capacity plans, to set Direct Clinical Care (DCC) allocations and standardise Supporting Professional Activities (SPA) and Additional Professional Activities (APA) as per the job planning policy.
- The trust has developed an innovative workforce model to recruit junior doctors to support improvement work across the trust, employing up to 8 “Clinical Education Fellows” at any one time, to combine clinical knowledge with improvement techniques and productivity improvements.
- Staff retention at the trust shows room for improvement, with a retention rate of 77.2% in October 2017 against a national median of 85.5%. The trust recognises the need to invest in training and career development opportunities, and has a detailed retention improvement plan including increased recognition and reward for staff (through the PROUD programme). The latest monthly Trust Gross Turnover rates (December 2017) suggest a 2% improvement over six months.
- At 3.16% in September 2017, staff sickness rates are better than the national average of 3.92%.

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

- The overall cost per pathology test at the trust benchmarks in the second highest quartile nationally. The trust has not fully realised the benefits of scale at the West Middlesex site, from which the Chelsea site has benefited for several years. The pathology joint venture, North West London Pathology, managed by the trust, is now benefiting the West Middlesex site. The trust believes that significant benefits in the form of reduced cost per test should be realised in 2018/19 and over the next 8 years.
- The trust conducts spot audits of imaging reporting activity and is broadly within Royal College of Radiologists guidelines. The trust has extended the roles of radiographers to release radiologist time and pools capacity across its two sites to maximise throughput. However there appears to be significant variability in reporting productivity between radiologists. Reducing unwarranted variation and interruptions could improve the trust’s

costs of reporting. The trust has recognised the need to reduce its current reliance on the outsourcing of reports, create more uninterrupted sessions and continue its work to increase capacity across the North West London area, e.g. PET-CT.

- The trust's spending on medicines is relatively low when compared nationally. When comparing in-tariff drugs the trust spends £126/WAU against the national median of £202/WAU. As part of NHS Improvement's Top Ten Medicines programme, it is making good progress in delivering on nationally identified savings opportunities, achieving 125% of the savings target against a national median of 110%.
- The trust is using technology in innovative ways to increase the availability of junior doctors in its emergency department through the use of FlexiStaff+ and LocumTap, a temporary staffing community and mobile app developed by the trust. The trust has seen significant growth in shift fill rates from 35% to over 90%, particularly in the emergency department, where fill rates are 97%, saving the trust at least £500k per year in premium pay costs.

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

- For 2016/17 the trust had an overall non-pay cost per WAU of £1,423, compared with a national median of £1,301, placing it in the second highest cost quartile nationally. This represents a reduction in last year's non-pay cost per WAU of £1,756. As previously noted, the trust's high proportion of contracted out services, e.g. IT, drives a higher non-pay cost, and a lower pay cost per WAU.
- The cost of running its Human Resources departments, £656k per £100m turnover, is lower than the national average of £761k per £100m turnover (Model Hospital 2015/16). The trust recognises that given its low retention rates, it will likely need to increase HR capabilities, which will be offset by the resulting reduction in recruitment costs.
- The cost of running its Finance departments, £1,010k per £100m turnover, is higher than the national average £658k per £100m turnover (Model Hospital 15/16). In 2016/17 this reduced to £870k per £100m and the trust expect this to continue to fall (10% in 2017/18 and 2018/19), benefiting from a single ledger and a unified organisational structure across both sites.
- The trust's procurement processes are relatively efficient and tend to successfully drive down costs on the things it buys. However, this is not reflected in the trust's Procurement Process Efficiency and Price Performance (PEPPA) score of 14, which placed it in the lowest quartile when compared with a lower benchmark of 50. When PEPPA is adjusted for pass-through drugs and Public Dividend Capital (PDC), the trusts ranking improves from 134th of 136 trusts to 38th, placing the trust in the top quartile. The trust also exceeds a number of metrics on the use of e-catalogues.
- At £310 per square metre in 2016/17, the trust's estates and facilities costs benchmark slightly below the national benchmark of £334, putting it in the 2nd quartile. The trust recognises that in 2015/16 it made an erroneous submission of the Estates Return Information Collection (ERIC), understating its estates costs (£117/sqm) and for the 2016/17 submission, it is confident the data is correct.
- The trust has a low backlog maintenance cost of £85/sqm compared to a national median of £183/sqm (the trust locally validated 2016/17 costs). The trust has invested in backlog maintenance, particularly since its acquisition of the West Middlesex site which has a mixture of new and old estate.

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

- The trust is in surplus including its Sustainability and Transformation Fund (STF) funding and has a consistent track record of managing spending within available resources and in line with plans.
- In 2016/17 the trust reported a surplus of £10.5m against a control total and plan of £4.4m surplus (including STF). Excluding STF of £18.8m, the trust reported a deficit of £8.3m. For 2017/18 the trust has a control total and plan of £7.2m surplus (margin of 1.16%), which it is on target to meet as at quarter 3.
- The trust has a Cost Improvement Plan (CIP) of £25.9m (or 4.3% of its expenditure) and is currently forecasting to deliver against plans, despite some slippage at month 8. The trust delivered 96% of its planned savings in the previous financial year, all of which were recurrent savings.
- The trust has adequate cash reserves and is able to consistently meet its financial obligations and pay its staff and suppliers in the immediate term, as reflected by its capital service (1.85, 2nd quartile) and liquidity metrics (5.83 days, 1st quartile). The trust is not reliant on short-term loans to maintain positive cash balances.
- The trust uses a well-established Patient-Level Information and Costing System (PLICS) system to generate Service Line Reporting (SLR) information for each specialty. The top 10 lowest Earnings Before Interest, Tax, Depreciation and Amortisation (EBITDA) specialties were targeted in the 17/18 CIP
- The trust has a low consultancy expenditure of £0.98m in 2016/17, compared to £7.7m in 2015/16, making significant reductions by building an internal programme management office, allied with internal Service Improvement and Efficiency Leads.

Outstanding practice

- The trust is outstanding in its ability to continuously improve its performance across quality, operations and finances throughout the organisation. The trust's investment in its operational management workforce, electronic systems (e.g. advanced e-rostering), standardisation of processes (e.g. outpatient booking), capacity planning and tracking (e.g. deep dive reviews), and discipline in enforcing productivity improvements (e.g. specialty job plans) have all contributed to an outstanding level of visibility, planning and rigorous execution of productivity improvements.
- The trust has developed an online community, FlexiStaff+ and a mobile app, Locumtap to increase the availability of medical staff on its rotas. The trust has seen significant growth in shift fill rates from 35% to over 90%, particularly in the emergency department, where fill rates are 97%, saving the trust at least £500k per year in premium pay costs.
- The trust has a low consultancy expenditure of £0.98m in 2016/17, compared to £7.7m in 2015/16, making significant reductions by building an internal improvement capability, allied with internal Service Improvement and Efficiency Leads. The model of using Clinical Fellows, junior clinicians who are employed to lead service improvement programmes, marked the trust out as innovative compared with its peers.

Areas for improvement

- The trust is continuing to pursue its Retention Improvement Plan, with the support of NHS Improvement Retention Support Programme. In particular the trust would benefit from improving its HCA retention rate (73% in October 2017).
- The trust has an opportunity to make improvements in the efficiency of its outpatient services, reducing DNA rates from 10% to the national median of 7.5%, developing greater provision of virtual clinics and electronically scheduling and booking patients, supported by bi-directional booking services and Robotic Process Automation to reduce delivery costs.
- The trust would benefit from increasing its medical job planning completion rate from 85% to 100%, and ensure that each medical PA is electronically rostered to ensure improved clinical session uptake. This would support the trust's ongoing efforts to increase the utilisation of scheduled theatre lists.
- The trust can improve the costs of its theatres workforce, reducing the cost per Full Time Equivalent (FTE) whilst improving retention.
- The trust can make improvements in imaging reporting productivity, focusing on Radiologists that are not meeting the lower Royal College guidelines. The trust could also explore the wider application of reduced plain film reporting and autoreporting.
- Although the trust has identified significant CIPs in facilities and estates costs to date, the quality of the trust's data validation can to be improved to give greater assurance that the trust is maximising its opportunities to reduce costs and effectively manage service levels.

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	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.

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

(PLICS)	
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.