Mid Cheshire Hospitals NHS Foundation Trust

Use of Resources assessment report

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

Ratings

Overall quality rating for this trust	**Good**
Are services safe?	**Requires improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Good**

Our overall quality rating combines our five trust-level quality ratings of safe, effective, caring, responsive and well-led. These ratings are based on what we found when we inspected, and other information available to us. You can find information about these ratings in our inspection report for this trust and in the related evidence appendix. (See www.cqc.org.uk/provider/reports)

Are resources used productively?	**Good**

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

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

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

Use of Resources assessment and rating

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

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

Combined rating for Quality and Use of Resources

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

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

- We rated one of the three services we inspected at Leighton Hospital as requires improvement and the other two as good. Combined with the ratings from the previous inspection Leighton Hospital had an aggregated rating of requires improvement overall. However, it was agreed that the responsive rating of requires improvement in medicine should not be aggregated as it referred to a small area within the service. This location was rated as good overall.
- Urgent care services at Victoria Hospital were rated as requires improvement. However, we did not inspect the outpatients service at this location and at the last inspection the service was not rated separately. Therefore, it was agreed that this location rating would not be aggregated into the trust overall rating.
- We inspected both community adults' services, rated good overall and community services for children and young people, rated requires improvement overall. We did not inspect Elmhurst Intermediate Care Centre at this inspection so it remains good from the last inspection. However, as these services have been delivered by this trust for less than two years it was agreed that these ratings would not be aggregated into the trust overall ratings.
- Therefore, overall, we rated effective, caring, responsive and well led within the trust as good. We rated safe as requires improvement. In rating the trust, we took into account the current ratings of the six services not inspected this time.
- We rated well-led for the trust overall as good.
- The trust reported a surplus of £1.5m for 2016/17, which included £8.6m Sustainability and Transformation Funding (STF). For 2017/18, the trust is forecasting to deliver its planned surplus of £1.3m, which includes £5.7m STF. The trust has accepted the 2018/19 control total of a surplus of £5.2m, which includes £8.4m STF.

- The trust's overall cost per weighted activity unit (WAU) of £3,426 (2016/17) is below average and places it in the second quartile. This indicates that the trust is more productive at delivering services than other trusts by showing that, on average, the trust spends less to deliver the same number of services.
- Whilst the trust's pay cost per WAU is £2,338 for 2016/17 (worse than £2,157 national median), placing the trust in the bottom quartile, the trust has provided a clear explanation for this, in particular: low agency spend; strong retention rates putting staff at the top of pay scales; and the number of collaborative arrangements in place which mean pay costs are held on its books but activity is recorded for others.
- The trust's non-pay cost per WAU is £1,088 for 2016/17, placing it in the top (best) quartile.
- At the time of the assessment in March 2018, the trust is forecasting to deliver cost savings of £10.6m (4.3% of expenditure) against a target of £5.8m, the over-performance being due to participation in the mandated Capped Expenditure Programme.
- As at January 2018, the trust has consistently spent below the agency ceiling year-to-date (YTD). The trust's agency spend is 25.9% below its ceiling and it has spent £2.5m less in 2017/18 than in the same period for 2016/17. The trust's agency cost per WAU of £88 for 2016/17 is lower than the national median of £137 and its total agency spend (£3.5m YTD as of January 2018) is lower than its peers (small district general hospitals (DGHs)).
- Staff retention, at 89.7% is strong, with the trust in the highest (best) quartile nationally.
- The trust has significantly improved delayed transfers of care (DTOC) over the past six months and has been below the national target of 3.5% since October 2017. The trust gave examples of joint working with the local economy health partners and local authorities to achieve this. This has led to a reduction of sixteen inpatient beds.
- Following a transformation project, the trust has reduced the rate of Did Not Attends (DNA) to 6% in July 2017 against a national average of 7.5%.
- The trust is better than the national median for pre-procedure elective bed days (0.09 versus 0.14 as at June 2017).
- The overall cost per test for the trust is £1.90 against a national median of £1.91. The trust is in the second quartile and has further plans to reduce cost per test.

However:

- Staff sickness levels, at 4.15%, are above the national median of 3.92%, although better than the trust's small DGH peer group (4.4%). The trust acknowledges the need to undertake work to ensure the trust approach to sickness absence is consistent and is aware of the impact of a differing shift pattern within surgery and cancer, where sickness absence is higher.
- The trust acknowledges that it is faced with a number of inefficiencies and additional costs in respect of staff time due to its dated IT infrastructure that requires investment.
- The trust acknowledges a shortage in x-ray and imaging reporting capacity and is using resource across Cheshire to support as well as outsourcing. The recruitment to address the shortfall is a theme in the early adopter project (Cheshire and Merseyside Imaging Collaborative).

- The trust has a higher than the median benchmark for backlog maintenance, at £435 per m^2, with the trust's estates strategy identifying the priority in addressing the high category risks relating to fire safety concerns. The residences on site are a significant contributor to the high backlog maintenance which the trust understands and is actively exploring options to ameliorate the exposure.

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 significantly improved delayed transfers of care (DTOC) over the past six months and has been below the national target of 3.5% since October 2017. The trust gave examples of joint working with the local economy health partners and local authorities to achieve this. This has led to a reduction of sixteen inpatient beds as well as improving care for patients who are not treated in the wrong setting or having an unnecessarily extended stay in hospital. The trust has maintained relatively good performance against the 4 hour standard and has delivered against both the Cancer 62 day access standard and Referral to Treatment (RTT) standard.
- Following a transformation project, the trust has reduced the rate of Did Not Attends (DNA) to 6% in July 2017, against a national average of 7.5%. The trust gave examples of the initiatives that they had introduced to enable this to happen, including text messaging and telephone contact with patients.
- The trust has reduced the length of stay for patients aged 75 and over by working closely with local health economy partners to focus on Patient Access and Flow. The number of patients staying in hospital for more than 7 days has reduced, whilst the number of patients staying 0-3 days has increased.
- The trust has a 30 day emergency readmission rate of 10.12% against a national average of 8.55%. This puts the trust in the highest (worst) quartile for the second quarter of 2017-18 when compared to other organisations. The trust links this to the ambulatory care pathway and the layout of the A&E department. A clinical audit has been undertaken to assure the trust that quality of care was not affected by this. When patients who are admitted through the ambulatory care pathway are excluded from the calculation, readmissions drop to 8.3%. The trust stated this had been discussed with the CCGs to confirm that the issue relates to activity counting rather than to the quality of patient care.
- Elective pre- procedure bed days were 0.09 days for the trust against a national median of 0.13 days. The trust provided a number of examples of the initiatives they had introduced to support this, such as a focus on scheduling processes and the introduction of a surgical lounge allowing the trust to stagger the arrivals of patients into the hospital.
- Non-elective pre- procedure bed days were higher than the national median of 0.77 days, at 0.91 days. The trust has identified its intermediate care facility as contributing towards this; however, it also acknowledges that there is scope for improvement and provided examples of how this will be achieved.

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

- The trust's overall pay cost per WAU is £2,338 for 2016/17, worse than the national median of £2,157 and placing the trust in the bottom quartile. The trust has provided explanation for this performance, noting in particular:
    - The trust has low agency spend (see below for further detail) and thus has higher pay costs than trusts with high agency spend. This is supported by its below average overall cost per WAU;
    - The trust does not currently have any significant outsourcing arrangements in place;
    - The trust's strong retention rates (see below) mean that many staff are at the top of their pay scales; and
    - The trust has a number of collaborative arrangements in place which mean pay costs are held on its books but activity is recorded for others. These include its pathology partnership with East Cheshire NHS Trust and its laundry collaborative.
- Whilst the trust's WAU cost for allied health professionals (AHPs) and nurses is higher than others (respectively £131 and £832 for 2016/17), the cost per WAU for medical staff is lower than most at £419 for 2016/17, compared to the national median of £526 (placing the trust in the top quartile). The trust noted that this is consistent with other small district general hospitals (DGHs) and is partly a result of junior doctor gaps being met through use of alternative roles.
- The trust provided examples of new staffing models, such as the use of Advanced Practitioner roles in Histopathology and Radiology; the development of joint posts with University Hospital of North Midlands NHS Trust (UHNM) in cardiology and vascular; and a strong return to practice course for nurses.
- As at January 2018, the trust has consistently spent below the agency ceiling year-to-date. The trust's agency spend is 25.9% below its ceiling and it has spent £2.5m less in 2017/18 than in the same period for 2016/17. The trust has robust procedures in place to control agency expenditure, including an expanding nurse bank; medical workforce policies to cover gaps in medical rotas; and a clear escalation process for agency bookings.
- Staff retention, at 89.7%, is strong, with the trust in the highest quartile nationally compared to the national median of 85.53%. The trust is working with both older nurses in areas such as Retire and Return and Return to Practice and with its younger cohort of nurses. The trust's overall staff engagement score of 3.85 per the 2017 NHS Staff Survey is above average.
- Staff sickness levels, at 4.15%, are above the national median of 3.92%, although better than the trust's small DGH peer group (4.4%). The trust gave evidence of a number of schemes in place to support staff wellbeing, in particular, its Resilience Training programme. The trust has acknowledged it needs to undertake more work to ensure the trust approach to sickness absence is consistent and is aware of the impact of a differing shift pattern within surgery and cancer, where sickness absence is higher.
- The trust has put in place job plans for all its consultants, recorded electronically via Allocate and gave examples of how annualised planning is being used.
- The trust does not currently have an e-rostering system, although procurement is planned for 2018/19. The trust believes a number of additional efficiencies could be driven through e-rostering.

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

- The overall cost per test for the trust is £1.90 against a national median of £1.91. The trust is in the second lowest (best) quartile and has further plans to reduce cost per test. The trust advised that it will do this through implementing a single on-call model across the Blood Sciences service and reviewing the send away tests to seek better value.
- The trust is below the median for test per FTE; at 36,747 against a national median of 46,635 tests per FTE. The trust advised that it utilises an eRequesting tool with embedded rules to assist with demand management and appropriate requesting. It also advised of the current limitation to the reduction of further staffing due to the multi-site model operated.
- The trust is working collaboratively with University Hospital of North Midlands NHS Trust to implement the recommendations from the Carter Review into operational productivity in the NHS of a hub and spoke delivery model at scale. The trust is very actively engaged in this programme and provided evidence of good practice from their exiting collaboration with East Cheshire NHS Trust.
- The trust is collaborating in the Cheshire & Merseyside Imaging Collaborative which has been selected and supported as an early adopter project. There is an established history of working together and an active project to implement a shared Picture Archiving and Communication System (PACS) across the collaborative.
- The trust acknowledged a shortage in reporting capacity and is using resource across Cheshire to support as well as outsourcing. The recruitment to address the shortfall is a theme in the early adopter project.
- Medicines cost per WAU, at £244, is below the national median of £320 and the trust is performing well against the other medicines management key performance indicators (KPIs) and YTD, indicates an underspend against the planned expenditure with the trust noting that it had started this work early with the commissioners and had strong engagement with its clinicians.
- The stockholding days reported by the trust for January and February 2018 were 24 and 25 days respectively against a national median of 18 days.
- The trust is delivering cost improvement programme (CIP) levels in excess of the plan for pharmacy, with £549k to date against a plan of £225k.
- The trust provided some good examples of use of technology with the virtual fracture clinic and use of Skype, but acknowledged that there is more that could be done. There is a plan to implement further opportunities through developing the business case for an electronic patient record (EPR).

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

- The trust is actively engaged in exploring collaborations for payroll, procurement, IT and occupational health services and is working with Countess of Chester NHS FT, Wirral University Teaching Hospital NHS FT, East Cheshire NHS Trust and Liverpool Heart & Chest NHS Foundation Trust.
- With costs per £100m turnover of £660,640 (national median £685,219) in finances the trust is not yet able to make the case for change to a collaborative model. The trust has a higher than national median cost per £100m turnover in payroll of £121,279 (national median £95,569), however, the business for collaboration with partners indicates a higher cost for the trust with the proposed model and so the trust acknowledges that further work is needed to develop a viable model.

- The trust confirmed that the Occupational Health Service costs are incorporated in HR and as this is a service provided wider than the trust, it lends to the understanding of the higher than median cost per £100m turnover in HR of £796,245 (national median £761,285).
- The trust provided evidence of increased use of the purchase price index and benchmarking tool (PPIB) reporting 49.9 in line with the benchmark of 50.0 and has a reported supplies and service cost per WAU below the national median. The trust keeps informed of the added value to the procurement team through the use of a data analyst within the department.
- The trust provides the laundry service for itself and for the Shropshire Laundry Consortium which contributes to the higher cost per £100m turnover in estates & facilities.
- The trust has a higher than the median benchmark for backlog maintenance (at £435 per m2 against a national median of £149 per m2) with the trust estates strategy identifying the priority in addressing the high category risks relating to fire safety concerns. The residences on site are a significant contributor to the high backlog maintenance which the trust understands and is actively exploring options to ameliorate the exposure.

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

- The trust reported a surplus of £1.5 m for 2016/17, which included £8.6m STF.
- For 2017/8, the trust is forecasting to deliver its planned surplus of £1.3m, which includes £5.7m STF.
- The trust reported 2016/17 cost savings of £3.3m (1.5% expenditure), with a further £2.3m delivered through income generation schemes with 100% classified as recurrent. At the time of the assessment in March 2018 the trust was forecasting to deliver cost savings of £10.6m (4.3% of expenditure) against a target of £5.8m, the over-performance being due to participating in the mandated Capped Expenditure Programme.
- The trust has accepted the 2018/19 control total of a surplus of £5.2m, which includes £8.4m STF.
- The trust's cash balance at the end of 2016/17 was £5.6m and it is forecasting a closing cash balance of £7.7m at the end of 2017/18.
- The trust produces costing information by division and clinical area (service line reporting) and Patient Level Costing (PLICS) monthly and uses this when making services decisions.

The trust provides occupational health services to other providers, CCGs and local business, which provides a source of commercial income. In addition, the trust has successfully secured an orthopaedic contract with a Welsh Health Board in 2017/18 and this contract will be extended to cover ophthalmology in 2018/19.

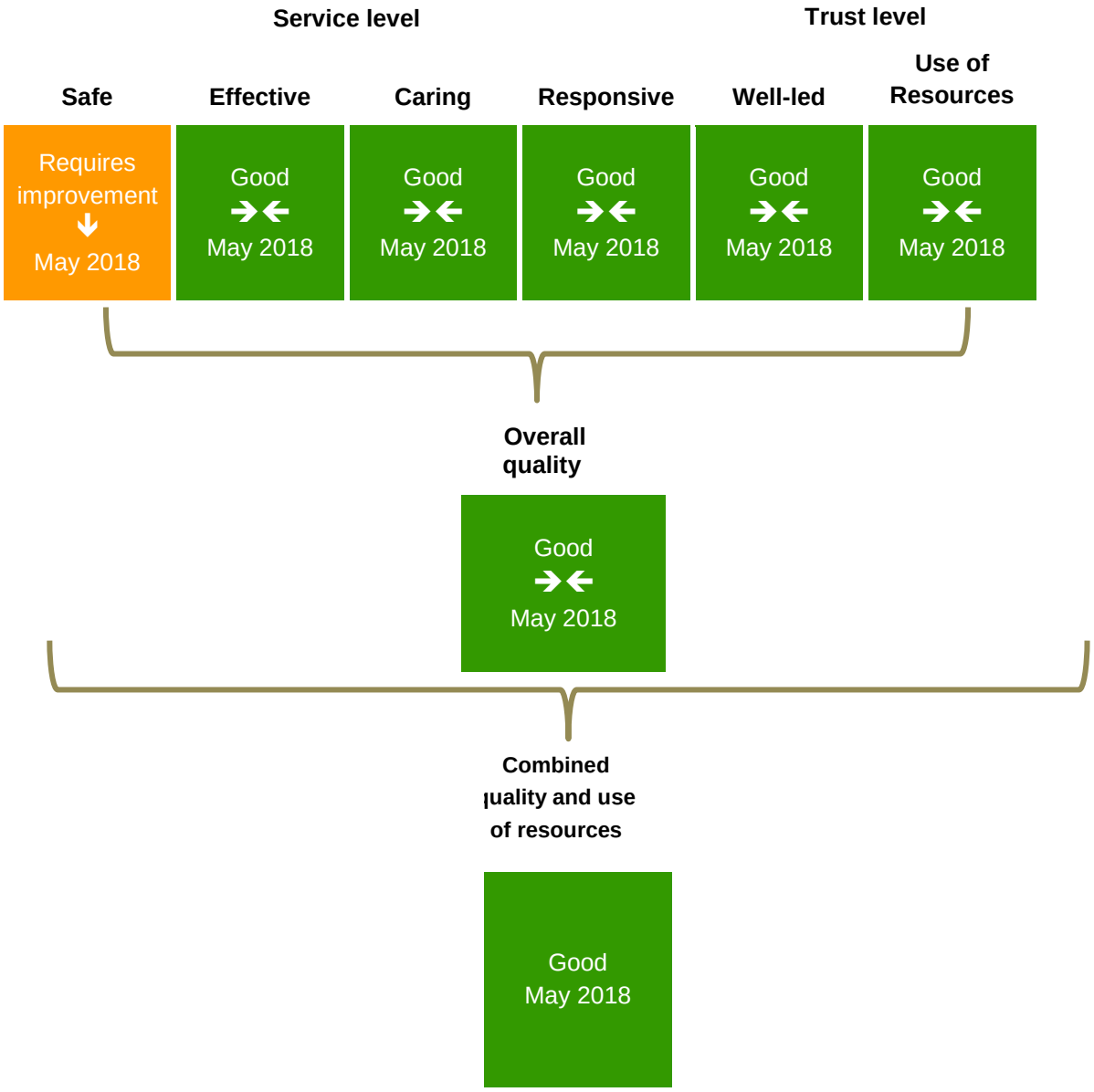
Ratings tables

Key to tables					
Ratings	Inadequate	Requires improvement	Good	Outstanding	
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓
Month Year = date key question inspected					

***** Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust



Use of Resources report glossary

Term	Definition
18-week referral to treatment target	According to this national target, over 92% of patients should wait no longer than 18 weeks from GP referral to treatment.
4-hour A&E target	According to this national target, over 95% of patients should spend four hours or less in A&E from arrival to transfer, admission or discharge.
Agency spend	Over reliance on agency staff can significantly increase costs without increasing productivity. Organisations should aim to reduce the proportion of their pay bill spent on agency staff.
Allied health professional (AHP)	The term 'allied health professional' encompasses practitioners from 12 diverse groups, including podiatrists, dietitians, osteopaths, physiotherapists, diagnostic radiographers, and speech and language therapists.
AHP cost per WAU	This is an AHP specific version of the pay cost per WAU metric. This allows trusts to query why their AHP pay is higher or lower than national peers. Consideration should be given to clinical staff mix and clinical staff skill mix when using this metric.
Biosimilar medicine	A biosimilar medicine is a biological medicine which has been shown not to have any clinically meaningful differences from the originator medicine in terms of quality, safety and efficacy.
Cancer 62-day wait target	According to this national target, 85% of patients should begin their first definitive treatment for cancer within 62 days following an urgent GP referral for suspected cancer. The target is 90% for NHS cancer screening service referrals.
Capital service capacity	This metric assesses the degree to which the organisation's generated income covers its financing obligations.
Care hours per patient day (CHPPD)	CHPPD measures the combined number of hours of care provided to a patient over a 24 hour period by both nurses and healthcare support workers. It can be used to identify unwarranted variation in productivity between wards that have similar speciality, length of stay, layout and patient acuity and dependency.
Cost improvement programme (CIP)	CIPs are identified schemes to increase efficiency or reduce expenditure. These can include recurrent (year on year) and non-recurrent (one-off) savings. CIPs are integral to all trusts' financial planning and require good, sustained performance to be achieved.
Control total	Control totals represent the minimum level of financial performance required for the year, against which trust boards, governing bodies and chief executives of trusts are held accountable.
Diagnostic 6-week wait target	According to this national target, at least 99% of patients should wait no longer than 6 weeks for a diagnostic procedure.

Did not attend (DNA) rate	A high level of DNAs indicates a system that might be making unnecessary outpatient appointments or failing to communicate clearly with patients. It also might mean the hospital has made appointments at inappropriate times, eg school closing hour. Patients might not be clear how to rearrange an appointment. Lowering this rate would help the trust save costs on unconfirmed appointments and increase system efficiency.
Distance from financial plan	This metric measures the variance between the trust's annual financial plan and its actual performance. Trusts are expected to be on, or ahead, of financial plan, to ensure the sector achieves, or exceeds, its annual forecast. Being behind plan may be the result of poor financial management, poor financial planning or both.
Doctors cost per WAU	This is a doctor specific version of the pay cost per WAU metric. This allows trusts to query why their doctor pay is higher or lower than national peers. Consideration should be given to clinical staff mix and clinical staff skill mix when using this metric.
Delayed transfers of care (DTOC)	A DTOC from acute or non-acute care occurs when a patient is ready to depart from such care is still occupying a bed. This happens for a number of reasons, such as awaiting completion of assessment, public funding, further non-acute NHS care, residential home placement or availability, or care package in own home, or due to patient or family choice.
EBITDA	Earnings Before Interest, Tax, Depreciation and Amortisation divided by total revenue. This is a measurement of an organisation's operating profitability as a percentage of its total revenue.
Emergency readmissions	This metric looks at the number of emergency readmissions within 30 days of the original procedure/stay, and the associated financial opportunity of reducing this number. The percentage of patients readmitted to hospital within 30 days of discharge can be an indicator of the quality of care received during the first admission and how appropriate the original decision made to discharge was.
Electronic staff record (ESR)	ESR is an electronic human resources and payroll database system used by the NHS to manage its staff.
Estates cost per square metre	This metric examines the overall cost-effectiveness of the trust's estates, looking at the cost per square metre. The aim is to reduce property costs relative to those paid by peers over time.
Finance cost per £100 million turnover	This metric shows the annual cost of the finance department for each £100 million of trust turnover. A low value is preferable to a high value but the quality and efficiency of the department's services should also be considered.
Getting It Right First Time (GIRFT) programme	GIRFT is a national programme designed to improve medical care within the NHS by reducing unwarranted variations.
Human Resources (HR)	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.

cost per £100 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 costs	Patient-level costs are calculated by tracing resources actually used by a patient and associated costs

Pre-procedure elective bed days	This metric looks at the length of stay between admission and an elective procedure being carried out – the aim being to minimise it – and the associated financial productivity opportunity of reducing this. Better performers will have a lower number of bed days.
Pre-procedure non-elective bed days	This metric looks at the length of stay between admission and an emergency procedure being carried out – the aim being to minimise it – and the associated financial productivity opportunity of reducing this. Better performers will have a lower number of bed days.
Procurement Process Efficiency and Price Performance Score	This metric provides an indication of the operational efficiency and price performance of the trust's procurement process. It provides a combined score of 5 individual metrics which assess both engagement with price benchmarking (the process element) and the prices secured for the goods purchased compared to other trusts (the performance element). A high score indicates that the procurement function of the trust is efficient and is performing well in securing the best prices.
Sickness absence	High levels of staff sickness absence can have a negative impact on organisational performance and productivity. Organisations should aim to reduce the number of days lost through sickness absence over time.
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.