The Hillingdon Hospital

Use of Resources assessment report

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Date of publication: 24/07/2018

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?	**Inadequate** 🔴
Are services effective?	**Requires improvement** 🟡
Are services caring?	**Good** 🟢
Are services responsive?	**Requires improvement** 🟡
Are services well-led?	**Requires improvement** 🟡

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

Are resources used productively?	**Requires improvement** 🟡

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

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

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

Use of Resources assessment and rating

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

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

Combined rating for Quality and Use of Resources

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

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

- We rated safe and well-led at Hillingdon Hospital as inadequate; effective and responsive as requires improvement, and caring as good. We rated three of the trust's 12 core services as good, three as requires improvement and two service as inadequate. In rating the trust, we took into account the current ratings of the four services at Mount Vernon Hospital not inspected this time.
- the trust was rated Requires Improvement for Use of Resources.

The Hillingdon Hospitals NHS Foundation Trust

Use of Resources assessment report

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Tel: 01895 238 282
www.thh.nhs.uk

Date of site visit:
2 May 2018

Date of publication:
<xx.MONTH.201x>

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

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

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

How we carried out this assessment

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

We visited the trust on 2 May 2018 and met the trust's executive team (including the chief executive), a non-executive director (in this case, 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?	Requires improvement

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

- The trust does not consistently manage its resources to allow it to meet its financial obligations on a sustainable basis and to deliver high quality care. Though the trust reported a surplus of £5.9 million for financial year 2016/17, this included the benefit of one-off funding, as the trust had an underlying deficit in 2016/17 of £19.2 million.
- In financial year 2017/18, the trust reported a £7.9 million deficit on £254 million operating income (3.1% deficit margin); it did not accept its control total for the financial year 2017/18.
- The trust has been reliant on short-term loans to meet its financial obligations. This reliance increased in financial year 2017/18 compared to 2016/17; the trust required £18 million in loans from the Department of Health and Social Care in 2017/18 which was £13.4 million more than what was required in 2016/17.
- The trust has very serious issues with its estates. The trusts clinical infrastructure risk per square metre is the third highest (worst) in the country. The national benchmarking is £285 but the trust reported £1,292 and the total backlog maintenance per square metre is the fourth highest (worst) in the country.
- The cost of running its Finance department is higher than the national average, although the trust believes that it delivers good value for money; evidence provided by the trust included a minimal level of overpayment by its payroll function.
- The trust is not meeting the constitutional operational performance standard for Accident and Emergency (A&E), having failed the standard throughout 2017/18. A&E performance was worse than the national median in March 2018, and deteriorated month-on-month over the final three months of financial year 2017/18.
- Theatre touchtime utilisation was 77% in December 2017, below the national benchmark of 85% and worse than the national median of 79%.
- On pre-procedure non-elective bed days, at 1.19 days, the trust is performing in the highest (worst) quartile compared to the national median which is 0.78. This means patients are waiting longer for interventions having been admitted as emergencies.
- In 2016/17, the trust spent more than the national average on agency as a proportion of total pay spend (£178 agency staff cost per Weighted Activity Unit (WAU) compared to national median £137). It has however achieved significant reductions in the cost of agency and locum staff in 2017/18 (£1.4 million reduction year-on-year) through a comprehensive workforce plan that covers agency controls, recruitment, communication with temporary staff members, and collaborative working with other providers in North West London.

However we also noted areas of good practice, including:

- The trust spends less on pay and other goods and services per WAU than most other trusts nationally. This indicates that the trust is more productive at delivering services than other trusts by showing that, on average, the trust spends less to treat the same number of patients.
- There is a holistic approach to planning patient discharge, transfer or transition to other services that are more appropriate for the delivery of their care or rehabilitation. 1.0% of beds were occupied by patients with a delayed transfer of care between January and March 2018 compared to the 3.5% national target.
- The trust took a number of actions to improve patient flow in 2017/18, including reconfiguring its wards and introducing a range of assessment units. These actions resulted in a 0.3 day and 1.6 day improvement in elective length of stay and non-elective length of stay respectively from October to November 2017 compared to the same period in 2016. Despite this progress, the trust did not have sufficient bed capacity to meet demand, which impacted on the trust's A&E performance and efforts to reduce temporary staffing.
- Clinical productivity improvements have been achieved by engaging with good practice identified by the Getting It Right First Time (GIRFT) programme. This includes making changes to how elective orthopaedic services were delivered following a GIRFT review which resulted in a 1.8 day improvement in the length of stay for elective orthopaedic patients (from 5.6 days to 3.8 day).
- The trust uses technology in some areas to improve productivity and effectiveness of its workforce, including good utilisation of digital systems for e-rostering which was used for all staff groups except doctors in 2017/18; the trust plan to adopt the same system for doctors in 2018/19. The trust uses the 'SafeCare' app to better communicate with temporary staff members.
- The cost of running its Human Resources (HR) department was lower in 2016/17 than the national average (£903,110 compared to £1,000,566 per £100m turnover). In addition, the trust provided evidence of the quality of this service including reducing the time from advertising a new role to recruitment from 79 days to 43 days.
- There is evidence of a systematic approach to identifying and realising efficiency opportunities, but it has required external support to do this. The trust delivered £10.5 million of recurrent savings in 2017/18, improving its underlying position by £1.9 million. The trust spent £1.6 million on external consultancy support in 2017/18.

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

- At the time of the assessment, the trust was not meeting the constitutional operational performance standards around Accident & Emergency (A&E) and Referral to Treatment (RTT). A&E performance was worse than the national median in February 2018, and had deteriorated month on month since January 2018. RTT performance was better than the national median and improved in February 2018 compared to January 2018. The trust was meeting the constitutional operational performance standard for Cancer.
- The trust reports a delayed transfer of care (DTOC) rate that is lower than average and lower than the trust's national target rate of 3.5%. DTOC rates have been improved from 2.8% of occupied beds in January 2017 to 1.0% March 2018. The trust works closely with system partners Hillingdon CCG, Care4you and Metrohealth GP Networks, CNWL NHS Foundation Trust and Hillingdon4All (a collaborative of voluntary and community sector providers) to transform the way health and social care is commissioned and provided to better integrate services.

- Clinical productivity improvements have been achieved by engaging with good practice identified by the Getting It Right First Time (GIRFT) programme. The trust consolidated its elective orthopaedic services on its Mount Vernon Hospital site in response to recommendations from a GIRFT review. The trust has provided evidence that shows this has delivered a range of benefits including a 1.8 day improvement in the length of stay for elective orthopaedic patients (from 5.6 days to 3.8 day) and a 0.4 day improvement in the length of stay for non-elective patients (from 10.4 to 10.0 days). The trust intends to implement recommendations from GIRFT on how urology services are provided.
- The trust is proactively managing its resources in the face of operational demands. Capacity modelling undertaken by the trust identified that available beds would not be sufficient to meet the expected increase in non-elective demand. The trust estimated it would either need an additional 60 beds, to improve overall length of stay by 1 day. The trust enacted a programme of work focused on improved process across the hospital (including the creation of assessment units) and enhanced discharge processes. This resulted in a 0.8 day reduction in length of stay.
- Fewer patients are coming into hospital unnecessarily prior to planned treatment compared to most other hospitals in England. However more patients are coming into hospital prior to emergency treatment.
    - On pre-procedure elective bed days, at 0.33 days, the trust is performing in the highest (worst) quartile when compared nationally – the national median is 0.13 days. The trust provided data that demonstrated that this position had been distorted by a single complex patient; excluding this patient the trust is better than the national median. This was further substantiated by the trust's surgery on day of admission rate for elective admissions, which is in the best quartile nationally (95.8%, compared to national median 91.5%).
    - On pre-procedure non-elective bed days, at 1.19 days, the trust is performing in the highest (worst) quartile when compared nationally – the national median is 0.78. The trust recognised this as an area for improvement.
- At 7.6%, emergency readmission rates are above the national median of 7.4% from October to December 2017. This means patients are slightly more likely to require additional medical treatment for the same condition at this trust compared to other trusts.
- The Did Not Attend (DNA) rate for the trust has improved from 10.1% in quarter 3 (October – December) of financial year 2016 to 8.3% for the same period of financial year 2017/18. This improvement has been achieved through better communication with patients (including the use of text reminders) and the ability for patients to amend bookings via email. However, this is still above the national average DNA rate of 7.4%.
- Theatre touchtime utilisation was 77% in December 2017, below the national benchmark of 85% and worse than the national median of 79%.

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

- Staff costs are generally well-controlled, demonstrated by pay cost per WAU and sickness levels. Staff turnover is improving and is close to the national median. The trust is operating around its agency cap. There are some examples of staffing innovation replacing traditional models of care delivery (including the use of physician associates).
- For 2016/17 the trust had an overall pay cost per WAU of £2,138, compared with a national median of £2,157, placing it in the second lowest (best) cost quartile nationally. This means that it spends less on staff per unit of activity than most trusts. The trust pay cost per WAU

is better than the national median for medical, nursing and allied health professional staff groups.

- The trust did not meet its agency ceiling as set by NHS Improvement for 2017/18; however, it is operating around its ceiling; its variance from ceiling scored 2 (the second best rating) against the criteria of NHS Improvement's Single Oversight Framework.
- Staff retention at the trust has improved and is close to the national median. The retention rate improved from 80% in January 2017 to 82.8% in January 2018 (national median is 86.2%). The trust is engaged in the NHS Improvement Retention Support programme to identify further opportunities to improve retention.
- At 4.1% in October 2017, staff sickness rates are better than the national average of 4.6%.

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

- The trust's medicines cost per WAU is low when compared nationally. As part of the Top Ten Medicines programme, it is making good progress in delivering on nationally identified savings opportunities, achieving 107% of the savings target against a national median of 100%. The trust has made good progress in implementing switching opportunities, but there are more opportunities to pursue for Etanercept and Adalimumab; the trust has visited other trusts that have been successful in switching to these drugs to identify good practice it can adopt.
- The trust is a member of North West London Pathology, a joint venture with Chelsea and Westminster NHS Foundation Trust and Imperial College Healthcare NHS Trust. North West London Pathology consolidates pathology services to deliver efficiencies of scale, and plans to save £92m over eight years. The overall cost per test of £1.97 at North West London Pathology is above but similar to the national median £1.91, whilst the overall cost per full-time equivalent is in the lowest (best) cost quartile nationally.
- The trust has taken internal measures and has worked with partner organisations to improve the productivity of its Radiology service. The trust has changed the role and grade of its radiographers, which has helped reduce its reliance on agency staff and outsourcing in Radiology. The trust is also part of the North West London Imaging Network collaboration, which is in the process of procuring a new IT solution to enable better cross-network working and networked multidisciplinary team meetings.

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 £1,260 compared with a national median of £1,301. This places it in the second lowest (best) cost quartile nationally.
- The trust's procurement processes are efficient and successfully drive down costs on the things it buys. The trust's Procurement department cost per £100m turnover is £384, which is more expensive than the national median (£375); the evidence supports that they are using this resource well. This is reflected in the trust's Procurement Process Efficiency and Price Performance Score of 70.3, which placed it in the highest quartile nationally. The trust makes good use of the Purchase Price Index and Benchmark (PPIB) tool, and its indicative PPIB usage score in Quarter 3 (October to December) of financial year 2017/18 was 70.3 compared to the national median of 62.9. The trust was an early adopter of electronic procurement systems, which is well embedded within the organisation. 100% of non-pay spend is on a purchase order, compared to 84.5% national median. The trust was the first in London to achieve level 1 National Standards of Procurement accreditation.

- At £350 per square metre in 2016/17, the trust's estates and facilities costs benchmark is equal to the benchmark for this type of trust. Hard facilities management (FM) costs are, at £130 per square metre, higher than other trusts of its type (benchmark cost is £82 per square metre). Soft FM costs are in line with the relevant benchmark (both £127 per square metre). Food cost per meal, laundry and linen cost per item and water and sewage cost per square metre are all better than the relevant benchmark. Total waste cost is £26 per tonne, the lowest in the country.
- The board cites quality and safety risks due to its estate as its key risk. The trust has the third highest (worst) clinical infrastructure risk per square metre in the country (£1,292 compared to relevant benchmark £285). Total backlog maintenance per square metre is the fourth highest (worst) in the country. Addressing the quality of the estate at Hillingdon Hospital formed part of the North West London long-term health strategy "Shaping a Healthier Future". The trust is in the process of identifying alternative strategic solutions, following delays to the implementation of this strategy. As a shorter-term measure, the trust has created a ring-fenced planned maintenance team to proactively manage its estate.

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

- The trust does not consistently manage its resources to allow it to meet its financial obligations on a sustainable basis and to deliver high quality care. In 2017/18, the trust reported a £7.9 million deficit on £254.1 million operating income (3.1% deficit margin).
- The Trust did not accept its control total of a £7.4m surplus for 2017/18.
- The trust delivered a surplus of £5.9m in 2016/17. However, this included the benefit of one-off funding and the trust had an underlying deficit in 2016/17 of £19.2m. The trust planned a deficit of £8.5 million in 2017/18, and finally reported a deficit of £7.9 million (£0.6 million better than plan).
- The trust's long-term financial model for the past five years included assumptions regarding the impact of 'Shaping a Healthier Future', the North West London health strategy. The expected impact of this was a short term reduction in income that would be recovered once services had been reconfigured across North West London. The trust was given revenue funding to support it during implementation of the strategy. However, delays to implementation means the trust has still not seen the expected benefit but is no longer receiving transitional support. Given the ongoing delays to 'Shaping a Healthier Future', the trust has commissioned an analysis of the drivers of its deficit to inform an alternative strategy to return to financial balance.
- The trust has improved its underlying financial position over the past twelve months and there is evidence of a systematic approach to identifying and realising efficiency opportunities. The trust delivered £10.5 million of recurrent savings in 2017/18 which reduced its underlying deficit by £1.9 million. The trust has accepted its 2018/19 financial control total.
- The trust had an ambitious cost improvement plan (CIP) of £12.5m (or 4.9% of its expenditure) and delivered £10.5 million (80%). All reported CIP was delivered recurrently and this was more than double the level of non-recurrent savings made in 2016/17 (£4.2 million). The trust realised a £10.4 million non-recurrent benefit from revaluing its investment property portfolio, which was not reported as a CIP but allowed it to outperform its financial plan for 2017/18.
- The trust is reliant on short-term loans to maintain positive cash balances and to meet its financial obligations and pay its staff and suppliers in the immediate term. This is reflected

in its capital service and liquidity metrics (-0.24 times, and -15.75 days respectively), which both score 4 (the worst rating) against the criteria of the single oversight framework.

- The trust uses costing data to generate Service Line Reporting (SLR) information for each specialty and has a good understanding of the contribution that different services generate. This information is used, in conjunction with national benchmarking data from the Model Hospital, to support financially sound decision making about service changes. Where services have been identified as potentially unsustainable, the trust works with partners to address these concerns at system-level.
- The trust spent £1.6 million on external consultancy support in 2017/18. The trust has been working with an external consultancy as part of the national Financial Improvement Programme, to identify and deliver financial efficiencies. This support has enabled the trust to increase the level of recurrent savings delivered from £4.2 million in 2016/17 (without support) to £10.5m in 2017/18.

Outstanding practice

- The trust's procurement processes are efficient and help the trust to successfully drive down cost of the things it buys. Whilst the cost of procurement is higher than other trusts, the evidence supports that this is a good use of its resource. In terms of process, the trust is the first in London to achieve level 1 National Standards of Procurement accreditation, is above national median in terms of use of the PPIB tool, and 100% of non-pay spend is on a purchase order. The trust is procuring items at a lower price than the national median as a result; for example, the trust is buying its most important products at good prices as demonstrated by the percentage variance for top 100 products which is better than national median.

Areas for improvement

- The trust reduced its underlying financial deficit over the course of 2017/18. However, it remains in deficit and reliant on external loans to meet financial obligations.
- The trust is not meeting the national operational performance standards for A&E or RTT.
- Agency staff costs per WAU are higher (worse) than the national median, and the trust is not meeting its agency ceiling.
- Theatre touchtime utilisation is below the national benchmark and below the national median.
- More inpatients are waiting unnecessarily prior to emergency treatment compared to most other hospitals in England.
- The trust has among the highest (worst) critical infrastructure risk per square metre and backlog maintenance per square metres in the country.

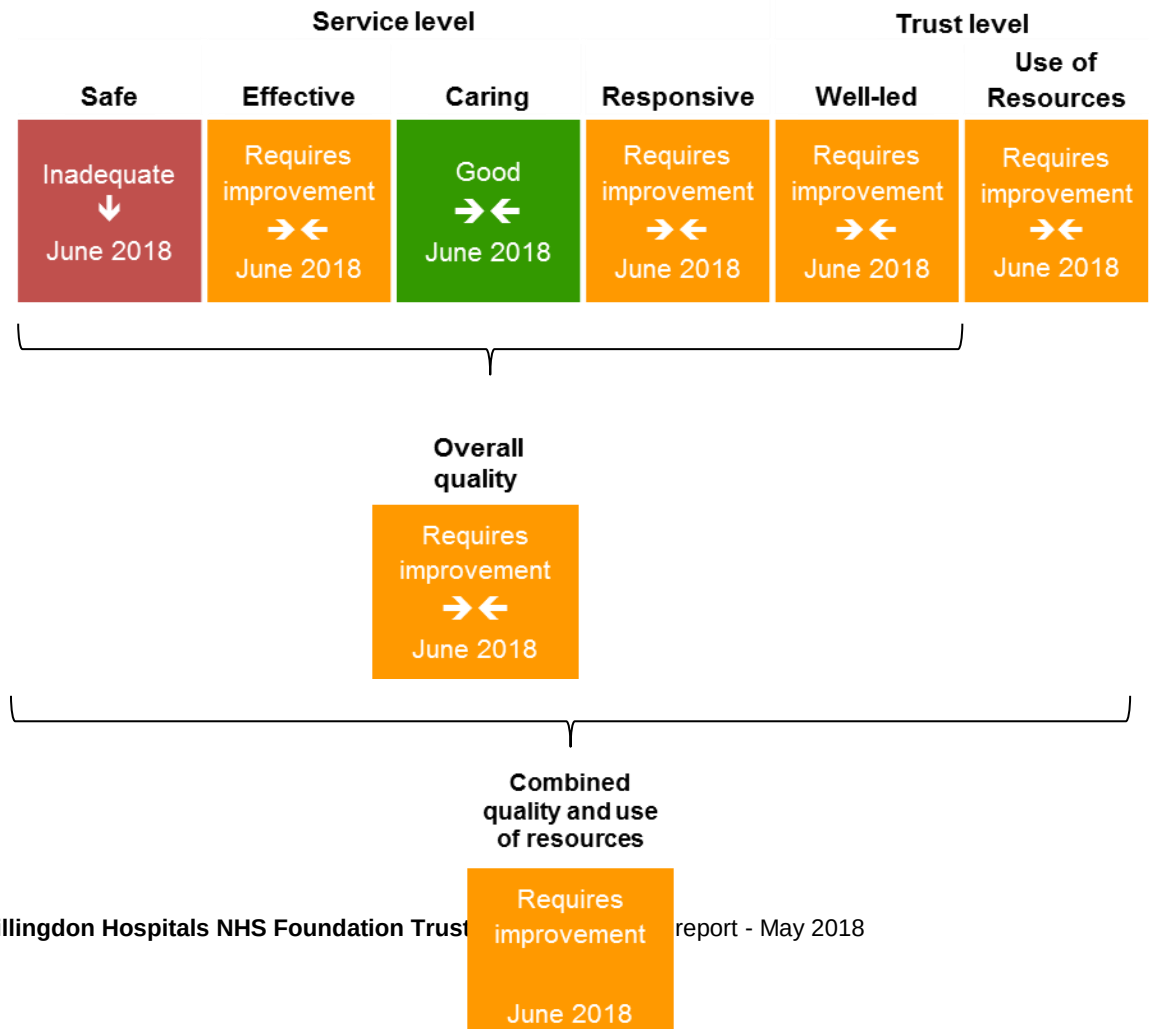
Ratings tables

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

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

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

Ratings for the whole trust



Use of Resources report glossary

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

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

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

Pre-procedure non-elective bed days	This metric looks at the length of stay between admission and an emergency procedure being carried out – the aim being to minimise it – and the associated financial productivity opportunity of reducing this. Better performers will have a lower number of bed days.
Procurement Process Efficiency and Price Performance Score	This metric provides an indication of the operational efficiency and price performance of the trust's procurement process. It provides a combined score of 5 individual metrics which assess both engagement with price benchmarking (the process element) and the prices secured for the goods purchased compared to other trusts (the performance element). A high score indicates that the procurement function of the trust is efficient and is performing well in securing the best prices.
Sickness absence	High levels of staff sickness absence can have a negative impact on organisational performance and productivity. Organisations should aim to reduce the number of days lost through sickness absence over time.
Single Oversight Framework (SOF)	The Single Oversight Framework (SOF) sets out how NHS Improvement oversees NHS trusts and NHS foundation trusts, using a consistent approach. It helps NHS Improvement to determine the type and level of support that trusts need to meet the requirements in the Framework.
Service line reporting (SLR)	SLR brings together the income generated by services and the costs associated with providing that service to patients for each operational unit. Management of service lines enables trusts to better understand the combined view of resources, costs and income, and hence profit and loss, by service line or speciality rather than at trust or directorate level.
Supporting Professional Activities (SPA)	Activities that underpin direct clinical care, such as training, medical education, continuing professional development, formal teaching, audit, job planning, appraisal, research, clinical management and local clinical governance activities.
Sustainability and Transformation Fund (STF)	The Sustainability and Transformation Fund provides funding to support and incentivise the sustainable provision of efficient, effective and economic NHS services based on financial and operational performance.
Staff retention rate	This metric considers the stability of the workforce. Some turnover in an organisation is acceptable and healthy, but a high level can have a negative impact on organisational performance (eg through loss of capacity, skills and knowledge). In most circumstances organisations should seek to reduce the percentage of leavers over time.
Top Ten Medicines	Top Ten Medicines, linked with the Medicines Value Programme, sets trusts specific monthly savings targets related to their choice of medicines. This includes the uptake of biosimilar medicines, the use of new generic medicines and choice of product for clinical reasons. These metrics report trusts' % achievement against these targets. Trusts can assess their success in pursuing these savings (relative to national peers).
Weighted activity unit (WAU)	The weighted activity unit is a measure of activity where one WAU is a unit of hospital activity equivalent to an average elective inpatient stay.