London North West University Healthcare NHS Trust

Use of Resources assessment report

London North West Healthcare NHS Trust
Northwick Park Hospital
Watford Road
Harrow, HA1 3UJ

Tel: 020 8864 3232
https://www.lnwh.nhs.uk/

Date of publication: 31 August 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?	**Requires improvement**
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/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, effective, responsive, and well-led as requires improvement; and caring as good;
- we took into account the current ratings of the four core services across the two locations not inspected at this time. Hence, six services across the trust are rated overall as requires improvement, and the remaining two services are rated good;
- the overall ratings for each of the trusts acute locations remained the same; and
- the trust was rated requires improvement for Use of Resources.

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Northwick Park Hospital
Watford Road
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Tel: 020 8864 3232
https://www.lnwh.nhs.uk/

Date of site visit:
28 June 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. A summary of the Use of Resources report is also included in CQC's inspection report for this trust.

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 28 June 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 does not consistently manage its resources to allow it to meet its financial obligations on a sustainable basis and to deliver high quality care.

- The trust spends more on pay and other goods and services per Weighted Activity Unit (WAU) than most other trusts nationally. This indicates that the trust is less productive at delivering services than other trusts by showing that, on average, the trust spends more to deliver the same number of services.
- At the time of the assessment, the trust was not meeting the constitutional operational performance standards around Referral to Treatment (RTT) and Accident & Emergency (A&E). The trust was also not meeting its agreed trajectory to compliance for these two performance standards.
- Individual areas where the trust's productivity compared well included delivery of savings on medicines, sickness rates and pre-procedure non-elective bed days, while opportunities for improvement were identified in nursing staff, non-pay and did not attend (DNA) rates.
- The trust failed to balance its budget in financial year 2017/18, reporting a deficit of £39.1 million, although this was better than the trust's control total of £49.5m deficit. As of the first three months of financial year 2018/19 (April – June), the trust is on track to achieve its planned deficit of £31.4 million.
- The trust delivered £50 million of efficiency savings in 2017/18, which equated to 6.6% of operating expenditure. 81% of these savings were delivered recurrently.
- The trust is reliant on external loans to meet its financial obligations and deliver its services. As at 31 March 2018 the trust had £205.4 million of revenue support loans from the Department of Health and Social Care (DHSC) that it was yet to repay.

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 in June 2018, the trust was not meeting the constitutional operational performance standards around RTT and A&E. The trust was also not meeting its agreed trajectory to compliance for these two performance standards.
- The trust has shown an improvement in A&E performance from 82.3% at December 2017 to 87.6% in May 2018 which the trust attributes to a number of initiatives, including the introduction of a frailty ward, a revised acute care model and expanded ambulatory care capacity. The trust recognises the need to improve its RTT position, which was 81.8% in May 2018, and has invited NHS Improvement's Intensive Support Team to provide expert support.
- At 6.72%, emergency readmission rates are slightly below the national median for the quarter to March 2018. This means patients are less likely to require additional medical

treatment for the same condition at this trust compared to other trusts. The trust credits the establishment of its rapid response teams with integrated community services with helping drive an improvement in performance over the last 12 months.

- Patients are on average spending less time inhospital prior to emergency treatment compared to most other hospitals in England. However, the data suggests that patients are on average spending more time in hospital prior to planned treatment.
    - Pre-procedure elective bed days were at 0.24 for the last three months of the financial year 2017/18 (January - March 2018). The trust is performing in the highest (worst) quartile when compared nationally (national median is 0.13). The trust attributes the primary driver of this performance to be St Mark's Hospital, a specialist centre for colorectal disease, where the complex surgery performed requires a greater prevalence of pre-assessment bed days. Trust data demonstrates that stripping out St Mark's Hospital would result in an improved performance of around 31% which would reduce bed days to c.0.17, putting the trust in the second highest (worst) quartile.
    - Pre-procedure non-elective bed days, at 0.63, the trust is performing in the lowest (best) quartile when compared nationally (national median is 0.81).
- The Did Not Attend (DNA) rate for the trust was high at 12% from January - March 2018 compared to a national median of 7.3%, although trust figures show it dropped to 10.4% for the period April – June 2018. The trust attributes part of its poor performance to the transfer of services to a centralised access centre. The trust has seen subsequent improvements in its DNA rates, driven by the implementation of a new text messaging reminder service.
- The trust reports a delayed transfers of care (DTOC) rate of 2.41% in May 2018, lower than the national average, although higher than the trust's own target rate. The trust attributes its low DTOC rates to collaborative working. The trust held regular multi-agency discharge events over winter, has implemented a new discharge policy formalising its approach to criteria led discharge and has daily reviews of delayed discharges. The trust has also received expert support from NHS Improvement's Emergency Care Improvement Programme.
- In the last 6 months the trust has improved the number of beds occupied by patients who have been in hospital 7 days or more (stranded patients), from an average of 66% to an average of 53% but acknowledges this is an area where more progress is needed. The trust conducts a weekly stranded patients meeting, including a full ward by ward review.
- The trust has seen improvements in its length of stay (LoS) arising from the consolidation of elective services at Central Middlesex Hospital. However, for the six-month period to 31 March 2018 the trust average LoS (excluding short stays) is in the highest (worst) quartile at 4.0 days.
- Theatre productivity has been a recent area of focus for the trust. The latest theatre productivity analysis for 2017/18, produced by an external consultancy, shows a potential productivity opportunity for the trust of 12%. This compares to 19.3% nationally, which means the trust is more productive than the national average.
- A number of the trust's surgical specialties have been subject to Get It Right First Time (GIRFT) reviews. The trust is taking action to address the recommendations raised from these reviews. The Urology review noted that for patients who are admitted as an

emergency with a diagnosis of a urinary tract stone, the intervention rate at the trust is significantly lower than the national average.

- In addition, LoS for urology patients who are admitted as an emergency are good, with respect to the proportion of patients who are staying for more than four days. This is likely to reflect the high level of Consultant input into on-call work.

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

- During 2017/18 the trust undertook a large-scale organisational development approach to co-designing its organisational values with staff which are HEART (Honesty, Equality, Accountability, Respect and Teamwork). These values are being further embedded across the trust through HEART ambassadors, with an aim of improving both staff and patient experience. The trust values are also central to its appraisal process and recruitment.
- For financial year 2016/17 the trust had an overall pay cost per WAU of £2,203, compared with a national median of £2,157, placing it in the second highest (worst) cost quartile nationally. This means that it spends more on staff per unit of activity than most trusts. The trust is in the highest quartile for allied health professionals (AHP) cost per WAU and the second highest for nursing cost per WAU, although it benchmarks in the second lowest (best) quartile for medical cost per WAU. The trust notes that a number of its services, such as its Short Term Assessment Rehabilitation & Reablement Service, have planned high use of AHPs which allows the trust to minimise its medical staffing costs.
- The trust undertook a nursing establishment review at the start of 2017/18 and reworked its ward rotas to save £1.2 million compared to 2016/17.
- The trust has achieved significant reductions in agency spend over the last few years, from £59 million in financial year 2015/16 to £22.8 million in 2017/18. The trust bettered its agency ceiling of £32.6 million, as set by NHS Improvement for 2017/18, by £9.8 million and is forecasting to meet its £21.9 million ceiling in 2018/19. The significant reduction in the cost of agency staff has been achieved through a number of workstreams, including more effective rota management and increased use of bank rather than agency. In partnership with the local mental health trust, the trust has developed a more cost effective and better quality service for patients who require one to one support by mental health care assistants. This was previously virtually all agency staff and is now a recruited team who receive enhanced training.
- The trust has reduced vacancies amongst junior doctors and middle grades by attracting and training trust doctors from overseas in key shortage specialties such as medicine. In addition, the trust has reviewed and redesigned its rotations to make them more attractive to junior doctors whilst ensuring cover in less popular areas such a care of the elderly.
- In November 2017 the trust opened a new, state of the art ultrasound training academy at Central Middlesex Hospital – the first of its kind in the UK. This is aimed at addressing the short supply nationally of sonographers and helping the trust reduce agency costs. The trust is working with other NHS organisations to help train staff from across the region.

- The trust has used an AHP-led community musculoskeletal service to reduce secondary care referrals, with only 20% of initial referrals sent onwards.
- The trust has job plans in place for 90% of consultants, although does not yet have an electronic planning system in place to help achieve efficiencies.
- The trust uses 'Allocate' electronic rostering for nursing, with a six week 'in advance' sign off target for all rosters.
- Staff retention at the trust shows room for improvement, with a retention rate of 80.3% in March 2018 against a national median of 85.6%. The trust has in place a recruitment and retention plan which includes the launch of the HEART values but has not yet seen this translate to a step up in retention rates.
- At 3.5% in February 2018, staff sickness rates are better than the national median of 4.38%.

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

- From July - September 2017 the overall pathology cost per test at the trust benchmarks in the highest (worst) quartile nationally. A major driver for this is the size of the trust's genetics laboratory, with cost per test for genetics being significantly higher than for other pathology tests nationally. However, the trust also benchmarks in the highest (worst) quartile nationally for genetics cost per test.
- The trust has outsourced pathology to The Doctors Laboratory (TDL) for both urgent and non-urgent services. In May 2018, 97.35% of tests were reported within target turnaround time. The trust has set out that they will be re-tendering for pathology services at the end of the TDL contract and expect to reduce overall pathology costs.
- The trust's medicines cost per WAU is slightly high when compared nationally, being £329 compared to a national median of £320 for financial year 2016/17. As part of the Top Ten Medicines programme, the trust is making good progress in delivering on nationally identified savings opportunities, achieving 128% of the savings target against a national median of 100%.
- The trust reports that having pharmacists in clinics as part of the biosimilar switching programme has been extremely effective to provide consistent messages to patients. The trust has undertaken evaluations to demonstrate that there has been no impact of the switch to biosimilars on outcomes for patients, for example with etanercept for rheumatology patients.
- The trust approved a hospital pharmacy transformation plan in March 2017. Under this plan the trust has implemented a pharmacy transcribing service, reducing LoS by over 3 hours, and put in place a bi-lingual labelling system across the trust.

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

- For financial year 2016/17 the trust had an overall non-pay cost per WAU of £1,430 compared with a national median of £1,301, placing it in the second highest (worst) cost quartile nationally. This suggests that the trust may be able to reduce its spending on supplies and services.

- The cost of running its Finance and Human Resources departments are higher than the national average although the trust believes that they deliver good value for money.
- The trust's procurement processes are fairly efficient and tend to successfully drive down costs on the things it buys. This is reflected in the trust's Procurement Process Efficiency and Price Performance Score of 56.5 in the last 3 months of financial year 2016/17 (January – March 2017), which is classified as 'meets expectation'.
- From January to March 2018 the trust was in the second lowest (best) quartile on the percentage variance for top 100 products and the lowest (best) quartile on the percentage variance from median price metrics.
- The trust is in the second highest quartile for use of the purchase price index and benchmarking (PPIB) tool and reports 100% of non-pay spend as being on purchase order.
- The trust received Procurement Skills Development Network Standards Accreditation in May 2018. They are only the third acute in London to obtain this accreditation.
- At £393 per square metre in financial year 2016/17, the trust's estates and facilities costs benchmark significantly above the national average of £368, although the trust reports delivering £4.8 million in estates and facilities efficiencies in 2017/18 and expects to see an improvement in this metric when 2017/18 figures are available. The trust notes that the Central Middlesex Hospital, which is a private finance initiative, is a partial driver of above median cost, along with a number of costly local community locations.
- The trust's backlog maintenance of £709 per square metre as at 2016/17 is in the highest quartile nationally. High and significant risks (£158 per square metre) are managed and monitored through estates risk workshops, with a current focus on fire compliance.

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

- In financial year 2017/18 the trust reported a deficit of £39.1million against a control total and plan of £49.5 million deficit. For 2018/19 the trust has a control total and plan of £31.4 million, which it is on target to meet as at the first three months of financial year 2018/19.
- The trust is able to analyse its 2017/18, £77.6m underlying deficit by trust site and point of delivery. However, the trust was not able to provide analysis to demonstrate the extent to which the drivers of the deficit are operational, strategic or structural.[1]
- In 2018/19 the trust has a stretching cost improvement programme (CIP) of £34 million (or 4.5% of its expenditure) and is currently forecasting to deliver against its plans. The trust delivered 100% of its £50 million planned savings in the previous financial year, of which 81% were recurrent. As at May 2018, 38.6% of the 2018/19 CIP was high risk, including 16.9% unidentified.
- The trust has relatively low cash reserves and is not able to consistently meet its financial obligations and pay its staff and suppliers in the immediate term without working

[1] Operational drivers: considered broadly within the control of the trust
Strategic drivers: issues that the trust may be able to influence but not control
Structural drivers: issues not considered within the control of the trust

capital loans, as reflected by its capital service and liquidity metrics. The trust is reliant on short-term loans to maintain positive cash balances.

- The trust has implemented a patient level costing system from which it reports monthly service line data. This costing data has been presented to various clinicians and is a fundamental part of specialty deep dives, a recently launched clinically led improvement process to develop excellent, sustainable services built from specialty level plans.
- The trust works with clinicians to ensure that all chargeable work is paid for. Following an income review carried out by an external consultant, the trust secured agreement from its local commissioners for £7m additional income in 2017/18 for services that the trust was not reimbursed for previously.
- The trust spent £1.9m on management consultancy fees in 2017/18, with Kingsgate, a firm of turnaround, transformation and transition specialists, providing CIP support. Having launched an internal transformation process the trust has significantly reduced management consultancy spend, with only £18k incurred in the first 2 months of financial year 2018/19.
- The trust's better payment practice performance has improved considerably over the last 18 months. In 2017/18 the trust paid 95.24% of its non-NHS suppliers within 30 days. This compares to 73.6% in 2016/17 and 27.16% in 2015/16.

Outstanding practice

- In November 2017 the trust opened a new, state of the art ultrasound training academy at Central Middlesex Hospital – the first of its kind in the UK. This is aimed at addressing the short supply nationally of sonographers and helping the trust reduce agency costs. The trust is working with other NHS organisations to help train staff from across the region.
- Theatre productivity has been a recent area of focus for the trust. The latest theatre productivity analysis for 2017/18, produced by an external consultancy, shows a potential productivity opportunity for the trust of 12%. This compares to 19.3% nationally, which means the trust is more productive than the national average.
- A number of the trust's surgical specialties have been subject to Get It Right First Time (GIRFT) reviews. The Urology review noted that for patients who are admitted as an emergency with a diagnosis of a urinary tract stone, the intervention rate at the trust is significantly lower than the national average. In addition, LoS for urology patients who are admitted as an emergency are good, with respect to the proportion of patients who are staying for more than four days. This is likely to reflect the high level of Consultant input into on-call work.

Areas for improvement

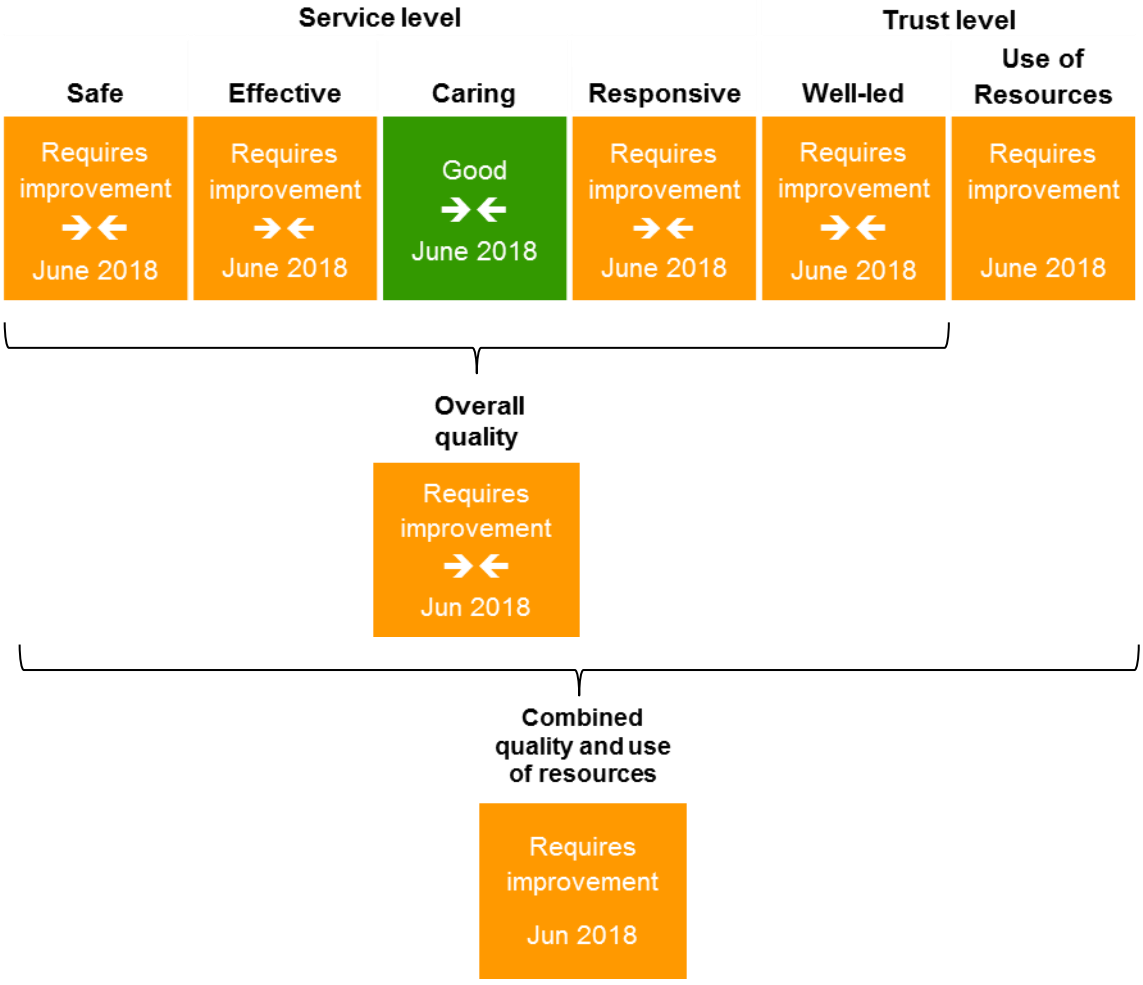
- At the time of the assessment in, the trust was not meeting the constitutional operational performance standards around RTT and A&E. The trust was also not meeting its agreed trajectory to compliance for these two performance standards.
- The DNA rate for the trust, although improving, remains higher than national median.
- The number of stranded patients, at an average of 55% remains high, although has improved in the last 6 months.
- The trust's overall pay cost per WAU is in the second highest (worst) cost quartile nationally, as is the non-pay cost per WAU.
- The overall pathology cost per test at the trust benchmarks in the highest (worst) quartile nationally. The trust has set out that they plan to join a pathology network to reduce overall pathology costs.
- At £393 per square metre in 2016/17, the trust's estates and facilities costs benchmark significantly above the national average.
- The trust's backlog maintenance of £709 per square metre as at 2016/17 is in the highest quartile nationally.
- The trust has made limited progress in the digitisation field: whilst a Chief Information Officer has been recently recruited, the trust is yet to put in place electronic care records, electronic prescribing or electronic job planning for consultants.
- The trust is able to analyse its 2017/18, £77.6m underlying deficit by trust site and point of delivery. However, the trust was not able to provide analysis to demonstrate the extent to which the drivers of the deficit are operational, strategic or structural.

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.