Epsom and St. Helier NHS Trust

Use of Resources assessment report

St Helier Hospital
Wrythe Lane
Carshalton
Surrey
SM5 1AA

Tel: 02082962000
www.epsom-sthelier.nhs.uk

Date of publication:
19 September 2019

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/RF4/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 safe as requires improvement; and effective, caring, responsive and well-led as good;
- we took into account the current ratings of the four core and two additional services across the two locations not inspected at this time. Hence, seven services across the trust are rated overall as good, one as outstanding and one as requires improvement;
- the overall ratings for each of the trust's acute locations improved to good; and
- the trust was rated good for Use of Resources.

Epsom and St. Helier NHS Trust

Use of Resources assessment report

Dorking Rd,
Epsom
KT18 7EG
Tel: 01372 735735

https://www.epsom-sthelier.nhs.uk

Date of site visit:
10 April 2019

Date of publication:
[ ]

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?	**Good**

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 10 April 2019 and met the trust's executive team (including the chief executive), non-executive directors (in this case, the chair and the chair of the finance committee) 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?	Good

We rated use of resources as good because the trust takes a proactive and innovative approach to managing its financial and non-financial resources, which supports the delivery of high quality and sustainable care.

The trust's headline cost per weighted activity unit (WAU) is £3,418 against a national median of £3,486 and a London median of £3,534; which suggests that the trust delivers good overall efficiency. Operational performance has improved, particularly in Accident & Emergency (A&E); the trust delivers better performance than peers but with further work to deliver against national standards. The trust's workforce metrics suggest that costs are well controlled, but further improvements will be required to improve areas such as retention and sickness absence. The trust also delivers good outcomes on clinical support services; pathology and imaging are delivered efficiently with further schemes planned to increase capacity. The trust's estate requires further investment to deal with a high level of critical infrastructure risk and backlog maintenance; longer term strategies in this regard are being developed by the trust.

- The trust's engagement with and utilisation of the Get IT Right First Time (GIRFT) programme has been good. There is a common trust-wide based approach to utilising the GIRFT recommendations along with Model Hospital and other metrics through the Priority Based Budgeting (PBB) programme and the Cost Improvement Programme (CIP) Board.
- Electronic rostering is embedded across the nursing workforce and there are clear governance processes which provides the information to the executive board to ensure it is sighted on safe staffing. The trust's use of electronic rostering has won the HCA's 2018 Innovative models of workforce planning and deployment award
- Medicines cost per WAU is in the lowest quartile nationally at £239 compared to the national median of £320. The trust has achieved 142% against its savings targets on biosimilars to March 2018.
- Pathology cost per test is £1.25 against a national median of £1.86 in financial year 2017/18, placing it in the lowest (best) cost quartile. On a more granular level, the trust is in the lowest cost quartile for all tests listed (blood sciences, cellular pathology, microbiology).
- The cost of the finance function for financial year 2017/18 is £863,360 per £100 million of turnover, against a national median of £676,480. The Human Resources (HR) function for the same period costs £1,060,000 per £100 million turnover, also above the national median of £898,020. Further transformational change and challenging efficiency targets are required to be met over the next financial year, and the trust will need to continue to deliver against these to justify the high level of cost.
- The trust's estate is relatively old and in need of greater investment, with a Critical Infrastructure Risk per m2 of £823 against a benchmark value of £102m. Similarly, Backlog Maintenance per m2 is £954 against a benchmark value of £254. While the trust explores a longer term strategy to deal with the estate, further short term opportunities, particularly in Soft Facilities Management (FM) remain.

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 generally delivers good outcomes across all operational standards. While performance in A&E and Referral-To-Treatment (RTT) has been below national standards over the past year, this has been better than both London and national median performance. Cancer performance has mostly been compliant with standards, but the trust has seen some challenges in certain months on delivery of the diagnostic standard.
- A&E performance has fluctuated in financial year 2018/19. The trust's A&E performance of 87.49% as at April 2019 and remains in the third (best) quartile which is better than the London peer median of 84.52% and better than national median of 82.61%. While it remains below the standard of 95%, the trust has consistently delivered A&E performance better than both the London and national median levels.
- The trust's performance in flow and discharge are areas where performance has improved due to a number of actions taken by the trust, including:
    - integrated care delivered by Epsom Health and Care and Sutton Health and Care
    - opening a Surgical Assessment Unit at St Helier Hospital
    - expanding the use of the medical Ambulatory Care Unit
    - adjusting the use of the Medical Assessment Unit to ensure more consistent clerking and reception of admitted patients
- On pre-procedure non-elective bed days, at 0.56 days, the trust is performing better than the national median of 0.66 days. This suggests that patients are waiting slightly less time in hospital prior to emergency treatment compared to most other hospitals in England.
- Emergency readmission rates at 8.27% are worse than the national median of 7.73% in March 2019. This means patients are more likely to require additional medical treatment for the same condition at this trust compared to other trusts nationally. The trust is aware of the issues and has set out plans to benchmark against particular specialities to improve in this area.
- Performance against the RTT standard of seeing 92% of patients within 18 weeks of referral is 87.43% as at March 2019. Performance on Cancer waits is 95.35% in March 2019, which is better than the national standard of 85%. The trust has complied with the Cancer standard in all but one month in the financial year 2018/19.
- The average rolling length of stay over the 6 months (March 2018 to September 2018) for elective admissions is 3.3 days which is worse than the national median of 3.0 days but better than the London median of 3.8 days. Pre-procedure elective bed days as at March 2019 are 0.19 which is higher (worse) than the national median of 0.12, but comparable to the London median of 0.18.
- The Did Not Attend (DNA) rate is 6.02% as at March 2019 compared to the national median of 6.96%. The trust also performs better than London peers (9.74%), although this may be due to a slightly different demographic as an outer-London trust compared to more central peers. The trust has seen increases in activity in Outpatients, but increased staffing levels have resulted in the trust being able to maintain elective activity across the winter period.
- Diagnostic performance however, is 97.65% against a benchmark of 99% for the same month. The trust's performance against this metric has fluctuated, but it has plans to increase Magnetic Resonance Imaging (MRI) and Computerized Tomography (CT) capacity over 2019/20 to improve in this area.

- The trust's engagement with and utilisation of the Get IT Right First Time (GIRFT) programme has been good. There is a common trust-wide based approach to utilising the GIRFT recommendations along with Model Hospital and other metrics through the Priority Based Budgeting (PBB) programme and the CIP Programme Board (CIPPB). These forums include finance and HR staff, but the programmes are clinically led, drawing on the available benchmarking data.

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

- In financial year 2017/18 the trust had an overall pay cost per Weighted Activity Unit (WAU) of £2,080, slightly lower than the national median of £2,180. This means that it spends less on staff per unit of activity than most trusts in total. The trust's pay cost per WAU is better than the national median for both the medical and nursing professional staff groups. Medical pay costs per WAU are £516 against a national median of £533. Nursing pay costs per WAU are £662 against a national median of £710.
- The trust's pay costs appear well controlled. Temporary medical spend has reduced from October 2018 onwards due to increased recruitment to vacant posts and robust monitoring. The medical and Emergency Department (ED) workforce has increased over financial year 2018/19, while the vacancy factor has decreased from 31% to 16% in the same financial year. The trust was overspent against their agency ceiling (£11.5m against a ceiling and plan of £10.7m), due to pressures relating to A&E and winter in 2019.
- The staff retention rate as at October 2018 was 81.7% against a national median of 85.9%. This metric is comparable with other London trusts faced with a mobile local workforce; the London median is 80.9%. However, the trust's sickness absence rate at 4.62% is higher than national median for the same period.
- The trust has a number of innovative models around workforce, including the setup of the Advanced Nurse Practitioner (ANP) academy, being an active participant in the South West London Acute Provider Collaborative shared bank and use of Physicians Assistants in the Urgent Care Centre. The trust is also in the process of setting up a Clinical Academy for international fellows to ensure that they enter the local workforce by means of a structured programme focusing on quality assurance and sustainability.
- Electronic rostering is embedded across the nursing workforce and there are clear governance processes which provides the information to the executive board to ensure it is sighted on safe staffing. All relevant trust managers and ward staff have access to real time staffing reports, providing greater visibility on shifts. The trust has also set out how use of agency and bank is reviewed daily against the staffing requirements based on the acuity of patients. The trust plans to increase the scope of electronic rostering to including Allied Health Professionals (AHP's) and other staff groups in the future. The trust's use of electronic rostering has won the HCA's 2018 Innovative models of workforce planning and deployment award.
- 98% of trust consultants (excluding locums and new starters) have a job plan in progress, of which 80% have been signed off. The trust's job planning data is captured electronically through the Allocate system. The process for the current financial year includes reducing duplication in tasks across teams, adjusting for service changes and with a clear focus on team job planning.

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

- Medicines cost per WAU is in the lowest quartile nationally at £262 compared to the national median of £309. The trust has achieved 142% against its savings targets on biosimilars to March 2018. The trust notes that this was delivered through gain-share arrangements with Clinical Commissioning Groups (CCGs). The trust's pharmacy function has introduced waste management technicians on the wards. The technicians follow up on medicines that would be wasted to either follow the patient or reuse the medicine.
- The trust's radiology cost per report is £50.49, which is comparable to the national median of £50.49. The trust currently meets the Diagnostic operational standard and has further plans to improve in this area. Diagnostic capacity will increase in 2019/20 through an additional MRI scanner, replacement of CT scanner, upgrading gynaecology urodynamics test machines and replacing cardiac echo machines. The trust has plans for further collaboration with the other local acute providers under the south west London imaging network. Areas where collaboration is planned for imaging are in Picture Archiving Communications System (PACS) reporting, demand and capacity tool, recruitment of radiographers and doctors, training for sonographers and radiographers, and collective bidding and contracting.
- Pathology cost per test is £1.25 against a national median of £1.86 in financial year 2017/18, placing it in the lowest (best) cost quartile. On a more granular level, the trust is in the lowest cost quartile for all tests listed (blood sciences, cellular pathology, microbiology). The trust currently delivers its pathology in-house but is planning to join a collaborative network. The South West London pathology network was established in 2014. This network will expand to include the trust and a full business case is to be presented to partner boards in quarter one (April – June) of financial year 2019/20.

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

- For financial year 2017/18 the trust had an overall non-pay cost per WAU of £1,338, which is marginally higher than the national median of £1,307. Drivers of the higher cost include the trust's estate and corporate services as set out below.
- The cost of the finance function for financial year 2017/18 is £863,360 per £100 million of turnover, against a national median of £676,480. This is in the highest cost quartile, but the trust maintains that the higher spend is required to drive large scale efficiencies and effective business partnering. Examples of this include the PBB programme and the CIP boards that have been key to delivering greater financial grip and the trust's financial control total. Further transformational change and challenging efficiency targets are required to be met over the next financial year, and the trust will need to continue to deliver against these to justify the high level of cost.
- The HR function for the same period costs £1,060,000 per £100m turnover, also above the national median of £898,020. The trust can evidence better cost control, excellent use of e-roster and innovative workforce models such as the Advanced Nurse Practitioner (ANP) academy and international fellows programme as outcomes for the higher cost of the function. There are areas for improvement relating to sickness rates and some wider staff satisfaction metrics which the trust is focused on for the next financial year.
- The trust's Procurement Process Efficiency and Price Performance Score of 65 is comparable to the national median of 66, which suggests that procurement processes are largely efficient and that the trust has is succeeding in driving down costs on the things it buys.
- The trust's estates and facilities (E&F) cost per m2 is £311 which is lower (better) than national median of £342. However, the trust's estate is relatively old and in need of greater

investment, with a Critical Infrastructure Risk per m2 of £823 against a benchmark value of £102. Similarly, Backlog Maintenance per m2 is £954 against a benchmark value of £254.

- The hard facilities management (FM) cost per m2 as at March 2017/18 financial year is £57 against a benchmark value of £88. However, the soft FM cost per m2 for the same period is £157 against a benchmark value of £133, suggesting some further opportunities for savings are available while the trust explores a longer term strategy to deal with the age of their estate.

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

- The trust reported a deficit (including Provider Sustainability Funding - PSF) of £2.9m in the financial year 2018/19. Excluding, PSF the deficit position of the trust was £26.2m. However, this exceeded the trust's Control Total (CT) favourably by £1.9m. The trust has significant opportunities for improvement, including dealing with operational factors, estates and workforce. These are understood by the trust executive and actions to deal with these factors form part of the trust's PBB and CIP plans and governance. This must continue to be a focus of the trust. The trust has accepted its Control Total for 2019/20 and as at M2, is on plan to deliver their financial outturn.
- The trust planned a recurrent CIP programme of £17m (3.7% of operating expenditure), but only delivered £9m (52% against plan). In addition, the trust was able to deliver unplanned non-recurrent schemes of £5m, taking the total CIP delivery to £13.9m (82% of plan). The trust has similarly fallen short of CIP delivery in previous years; delivering £12.8m (86% against plan) and £13.2m (85%) in financial year 2017/18 and 2016/17.
- In each of the previous financial years, the trust's initial CIP plans included up to £3m of schemes which were considered "unidentified" which were not delivered against. Other areas of under-delivery included medical workforce, procurement and new care models. The trust's plan for 2019/20 is a realistic 12.8m (2.6% of expenditure). Utilising the PBB and CIP Programme Boards to identify, plan and deliver efficiencies must remain a focus for the next financial year.
- The trust is in receipt of revenue funding from the Department of Health and Social Care due to the size of its deficit. However, the trust can evidence robust cash management system and can evidence that working capital is well managed.

Areas of outstanding practice

- The trust has a number of innovative models around workforce, including the setup of the Advanced Nurse Practitioner (ANP) academy, being an active participant in the South West London Acute Provider Collaborative shared bank and use of Physicians Assistants in the Urgent Care Centre. The trust is also in the process of setting up a Clinical Academy for international fellows to ensure that they enter the local workforce by means of a structured programme focusing on quality assurance and sustainability.
- Electronic rostering is embedded across the nursing workforce and there are clear governance processes which provides the information to the executive board to ensure it is sighted on safe staffing. All relevant trust managers and ward staff have access to real time staffing reports, providing greater visibility on shifts. The trust has also set out how use of

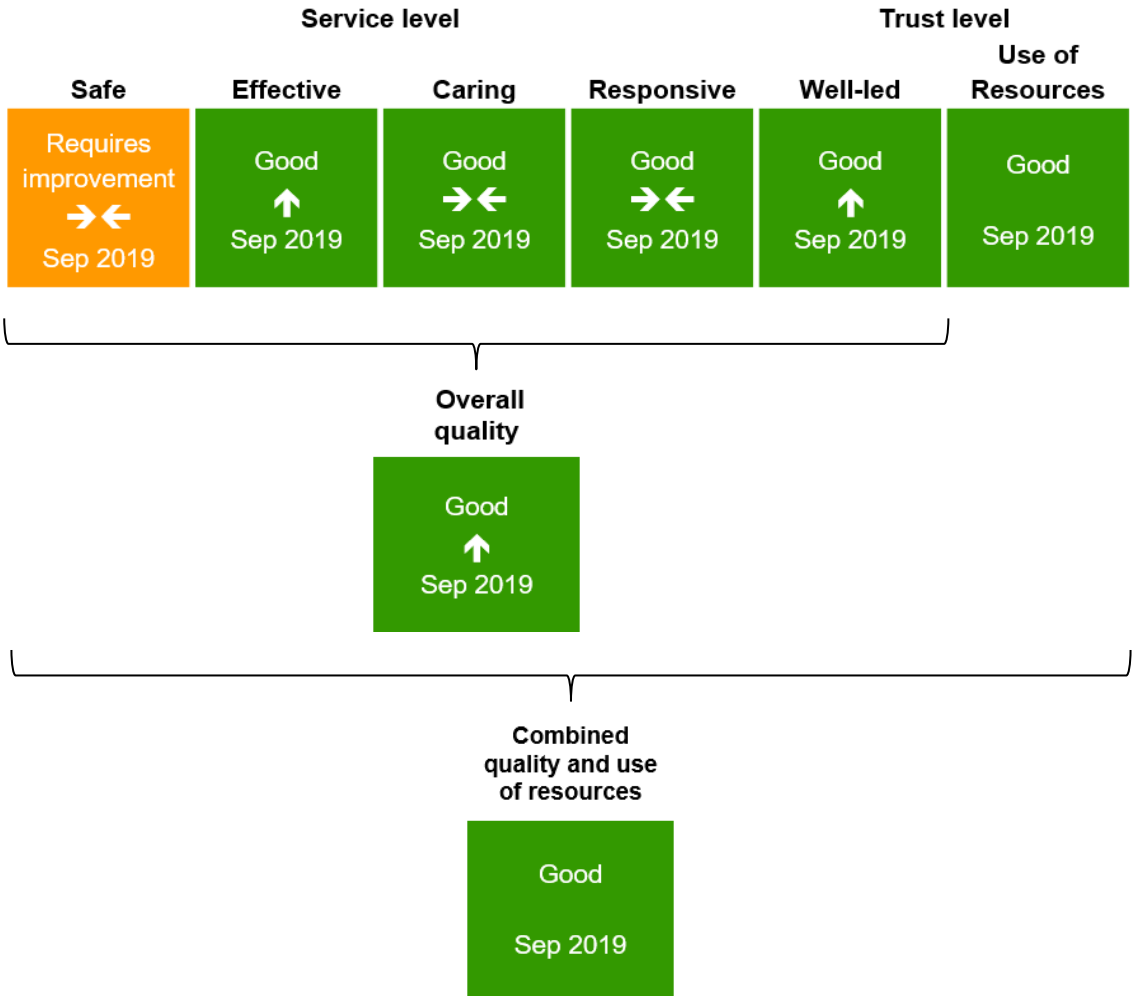
agency and bank is reviewed daily against the staffing requirements based on the acuity of patients. The trust plans to increase the scope of e-roster to including Allied Health Professionals and other staff groups in the future. The trust's use of electronic rostering has won the HCA's 2018 Innovative models of workforce planning and deployment award.

- Pathology cost per test is £1.25 against a national median of £1.86 in financial year 2017/18, placing it in the lowest (best) cost quartile. On a more granular level, the trust is in the lowest cost quartile for all tests listed (blood sciences, cellular pathology, microbiology).

Areas for improvement

- In each of the previous financial years, the trust's initial CIP plans included up to £3m of schemes which were considered "unidentified" which were not delivered against. Other areas of under-delivery included medical workforce, procurement and new care models. The trust's plan for 2019/20 is a realistic 12.8m (2.6% of expenditure). Utilising the PBB and CIP Programme Boards to identify, plan and deliver efficiencies must remain a focus for the next financial year.
- The trust's estates and facilities (E&F) cost per m2 is £311 which is lower (better) than national median of £342. However, the trust's estate is relatively old and in need of greater investment, with a Critical Infrastructure Risk per m2 of £823 against a benchmark value of £102m. Similarly, Backlog Maintenance per m2 is £954 against a benchmark value of £254. The hard facilities management (FM) cost per m2 as at March 2017/18 financial year is £57 against a benchmark value of £88. However, the soft FM cost per m2 for the same period is £157 against a benchmark value of £133, suggesting some further opportunities for savings are available while the trust explores a longer term strategy to deal with the age of their estate.

Ratings tables



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.