Guy's and St. Thomas' NHS Foundation Trust

Use of Resources assessment report

St Thomas' Hospital
Westminster Bridge Road
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Date of publication: 23 July 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?	**Outstanding**
Are services responsive?	**Good**
Are services well-led?	**Outstanding**

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 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 trust's acute locations remained the same; and
- the trust was rated good for Use of Resources.

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Date of site visit:
29 March 2019

Date of publication:
23 July 2019

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 29 March 2019 and met the trust's executive team (including the chief executive), non-executive directors (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?

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 reports financial surpluses on an underlying basis (excluding Provider Sustainability Funding (PSF)) and can articulate a robust approach to delivering financial savings and very good workforce outcomes. However, operational performance across the trust remains challenged and there are a number of opportunities for improvement in these areas, many of which are recognised and currently being addressed by the trust. The trust's headline cost per weighted activity unit (WAU) is £3,778 against a national median of £3,486 and a London median of £3,534; which suggests that further productivity gains are possible.

- The trust's workforce costs are generally well controlled and the approach to people development, job planning, and rostering helps to deliver better outcomes for patients.
- The trust's corporate services are delivered efficiently with positive outcomes. The Human Resources (HR) function benchmarks well but also delivers the good outcomes such as a robust programme in place managed by the trust's occupational health (OH) department to support physical health, mental health and wellbeing. The trust is in the lowest (best) quartile nationally for staff sickness levels at 3.4%. Similarly, both finance and procurement costs benchmark favourably to the peer and national median. The procurement function deliver value to the trust through automated inventory management, catalogue management systems and good business partnering to Directorates.
- The trust has some challenges in relation to operational performance driven by greater than expected growth in activity levels in 2018/19. The trust fails against all four of the key constitutional standards (Accident & Emergency (A&E), Referral to Treatment (RTT), Cancer and Diagnostics) with particularly challenged performance in diagnostics.
- The trust's performance in pathology benchmarks unfavourably against peers and nationally. Reasons for these are understood by the trust and actions to improve performance in these areas are underway; including a retender of services delivered under the trust's existing pathology collaborative.
- The trust has a number of significant issues in radiology, including high costs, Did Not Attend (DNA) rates and a weak performance against the diagnostic standards. The trust will be required to focus on delivering improvements in this area.

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

- The trust has experienced challenges across all the major constitutional standards especially with diagnostics. Much of the performance is due to increased attendances across specialities particularly (in the case of RTT and Cancer) from out of area. Accordingly, the trust has begun to undertake further actions working across the system to avoid increased referrals where appropriate, increase internal capacity and streamline internal processes. Outpatients remains an area where further actions and focus will be required to improve performance.
- A&E performance has fluctuated in financial year 2018/19. The trust's A&E performance of 85.38% as at March 2019 remains in the third (best) quartile and is comparable with London peer median of 85.74% and is better than national median of 84.15%, however it remains below the standard of 95%. Over the last year, performance has fluctuated between 85% and 89%. We note that the trust has seen increases in attendances and has put in place a number of processes to deal with this including investment in paediatric emergency medicine capacity, implementation of medical ambulatory pathways and altering staff rotas to provide additional capacity to evenings where demand shows greatest increases.
- Flow and discharge remain areas where further actions are required. As at September 2019 Emergency length of stay (LoS) was in the highest (worst) quartile nationally in at 9.6 against a national median of 9.3. On pre-procedure non-elective bed days, at 0.70 days, the trust is performing around the national median of 0.66 days. This suggests that patients are waiting slightly more time in hospital prior to emergency treatment compared to most other hospitals in England. Delayed Transfers of Care (DTOC) accounts to 3.9% of patients in March 2019 which is up from 2.1% in April 2018. The trust's proposed actions include better and more timely access to diagnostics and reducing in-hospital delays between the Emergency Department (ED) and wards.
- Emergency readmission rates at 4.51% are significantly better than the national median of 7.86% in September 2018. This is the 7th best performance for this metric nationally. This means patients are less likely to require additional medical treatment for the same condition at this trust compared to other trusts nationally.
- Performance against the Referral-To-Treatment (RTT) standard of seeing 92% of patients within 18 weeks of referral is 86.2% as at March 2019. This is below both the national standard and the London median. Diagnostic performance for March 2019 is 94.85% against a benchmark of 99%.
- Performance on Cancer waits for March 2019 is 75.19% against a national standard of 85%. The trust has not complied with the Cancer standard in both financial year 2018/19 and financial year 2019/20. Some of this performance is due to the trust being a tertiary referral centre but is also a function of delayed diagnostic performance noted above. The trust has completed a number of actions including investing in the Cancer Data team who have been embedded in clinical teams and have created a new post of Chief of Cancer Services. Given the increase in referrals from out of area, the trust has also jointly established a new Director of Cancer Operations to work across all providers to improve the delivery of timed pathways in South East London.
- The average elective rolling length of stay over the 6 months (March 2018 to September 2018) is 3.9 days which is worse than the national median of 3.0 days and the London median of 3.8 days. It also appears that patients are waiting more time in hospital before their procedures compared to other trusts, however, much of this is due to how pre-procedure time in sleep studies is categorised. Adjusting for this, the trust's pre-procedure bed days is 0.36 which is still significantly higher than the national median of 0.13. Having conducted a deep dive of the data to understand the underlying metrics, the trust has identified that pre-operative length of stay is an issue within Cardiovascular

services. The trust has implemented initiatives to deal with this including opening additional critical care capacity and amending standard admissions protocols.

- The trust has further room for improvement is in Outpatients. The Did Not Attend (DNA) rate is 12.33% as at September 2018 compared to the national median of 7.32%. The trust also performs worse than London peers (10.23%). The trust recognises that this is an area where improvement is required and has a number of ongoing actions including setting out a robust access policy, standardising bookings and follow ups through an "invite-to-book" process, use of digital letters and rationalising appointment letters. The trust also proposes to undertake further assurance work to ensure the 'DrDoctor' reminder service is working as originally proposed and intended.
- The trust's engagement with and utilisation of the Get IT Right First Time (GIRFT) programme has been very good. There is a Quality Improvement (QI) based approach to utilising the GIRFT recommendations along with Model Hospital and other metrics.

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 £2,193, slightly higher than the national median of £2,180. While this means that it spends more 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 nursing professional staff group of £643, compared to the national median of £710. The trust's pay cost per WAU for the medical professional staff group is £519 which benchmarks favourably to the national median of £533. The trust "hosts" a number of services on behalf of the wider NHS and Department of Health and Social Care (DHSC), which has some impact on the total. However, the trust's non-clinical workforce costs benchmark higher than peers.
- The trust's pay costs as at January 2019 are £22m higher than planned, mainly due to the increased AfC pay award agreed after plans were submitted and also because of higher activity, which is offset by higher income in the period. The trust's total agency spend for financial year 2018/19 is forecast to be £19.7m which is well below the agency ceiling of £27.4m.
- The staff retention rate as at October 2018 was 82.1% against a national median of 85.9%. This metric has remained relatively constant over time and is comparable with other London trusts faced with a mobile local workforce; the London median is 80.9%. The trust has implemented a number of actions to aid retention, particularly for nursing staff and has been shortlisted in the Best Employer category of the Nursing Times awards for its work on retention.
- The trust has a number of innovative models around workforce, particularly in nursing, including developing the nursing associate model, which has resulted in 40 trainees being recruited. The trust is currently participating in a pilot scheme called 'neighbourhood nursing' to improve care across community services. The model was in response to the rising demand for district nursing services and to improve retention amongst district nurses. Shift start times have been standardised across wards to improve how staff can be deployed across wards and improve agency staff usage. In addition the Trust has rolled out the Nightingale Project which standardises the way all shifts work; the first hour, mid shift huddle and last hour. This has helped and supported all staff, including temporary staff as all wards now work in the same way.
- Electronic rostering is embedded across the nursing workforce and has clear governance processes which provides the information to the executive board to ensure it is sighted on safe staffing. Several key metrics including roster approvals and finalisation metrics, weekly authorised leave analysis by type and sickness absence reasons are monitored by divisional

teams. The outcomes of these processes are evidenced through the reduction in temporary staffing and low sickness rates. However, the trust is yet to implement electronic rostering across the Allied Health Professionals (AHP) workforce to ensure effective deployment of this staff group.

- The trust notes that job planning is driven by business planning requirements and future requirements, including strategic requirements up to 2023. The trust has set out a number of areas where changes have been made as a result of this approach, including for example Orthopaedics.

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 highest quartile nationally at £417 compared to the national median of £309. The trust's medicines are however more comparable to the type peer median of £396 which is based on clinical output which considers the higher proportion of specialist work undertaken by the trust. The trust has achieved 133% against its savings targets on biosimilars to March 2018. The trust notes that this is part of its overall Medicines Optimisation (MO) savings programme and was delivered through gain-share arrangements with Clinical Commissioning Groups (CCGs).
- A number of the other efficiency metrics relating to pharmacy including stockholding and pharmacy prescribers are not comparable to peers as the trust had not previously provided this data to the Model Hospital.
- The trust has 61 Pharmacist Independent Prescribers (PIP) deployed across the trust. In addition to their work in inpatient and outpatient settings they have an increasing role in delivering teaching to undergraduate medical students . Extended weekend services were introduced in 2013, focussing on acute medical and surgical admissions and pharmacy services at weekends continue to develop in response to capacity demands and patient need.
- The trust's radiology cost per report is £116, which is significantly higher than the national median of £50. The trust has confirmed that the costs submitted in the financial year 2017/18 annual NHS Improvement Imaging Return were incorrect and restating these costs suggests a value of £84, which still places the trust in the lower (worst) quartile nationally. Additionally, as noted above, the trust's diagnostic performance is poor and among the worst nationally. Did Not Attend (DNA) rates, are particularly high in imaging at the trust. The DNA issues are being tackled as part of the overall DNA rates work currently underway at the trust.
- The trust recognises efficiency in radiology as an area for further work and is working with an external partner on transformation in radiology that expects to deliver significant savings over a four-year period from 2019/20 financial year onwards.
- Pathology cost per test is £4.61 against a national median of £1.99. The trust's pathology service is provided by Viapath (a joint venture between the trust, King's College Hospital NHS Trust and Serco). The trust is currently in the process of re-tendering pathology services and expects to be able to significantly reduce costs as a result. However, the overall cost per test is still likely to be higher than national median, given the complexity and case mix at 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 2017/18 the trust had an overall non-pay cost per WAU of £1,585 compared with a national median of £1,307. This places it in the fourth (worst) cost quartile

nationally. The trust notes that the overall non-pay costs are higher than peers due the cost of the trust's estate and the types of cost reported in this area.

- The cost of the Finance function is £536,230 per £100m of turnover, against a national median of £676,480. The HR function costs £699,230 per £100m turnover, below the national median of £898,020. Both functions deliver excellent value to the trust as evidenced by both the workforce processes, innovations and outcomes and the strong financial performance. A high degree of business partnering within the trust was apparent.
- The trust's Procurement Process Efficiency and Price Performance Score of 99 is significantly better than the upper benchmark score of 79. This suggests that procurement processes have been very efficient and that it has historically succeeded in driving down costs on the things it buys. The trust has achieved a high degree of process control with automated inventory management across multiple sites and can evidence good catalogue management and business partnering to the clinical divisions.
- The trust's estates and facilities (E&F) cost per m2 is £415, which is significantly higher than national median of £342, placing the trust in the fourth (worst) quartile. The trust's estate is relatively new, with low Critical Infrastructure Risk per m2 (£23 against a benchmark value of £57) and low Backlog Maintenance per m2 (£50 against a benchmark value of £186). The hard facilities management (FM) cost per m2 as at March 2017/18 financial year is £84 against a benchmark value of £93. However, the soft FM cost per m2 for the same period is £126 against a benchmark value of £122, suggesting further opportunities for savings are available. The maximum opportunities for efficiencies across both Hard and Soft FM is £13.4m.

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

- The trust reported a surplus, including incentive payments such as Sustainability and Transformation Funding (STF) and Provider Sustainability Funding (PSF), of £40.8m in financial year 2017/18. The trust has also reported a surplus on this basis of £31.4m for the financial year 2018/19. In each year, the trust has met its Control Total (CT).
- On an underlying basis, without the benefit of incentive payments or other one-off benefits, the 2018/19 financial year position is a surplus of £7.8m. This is an improvement from the underlying deficit of £28m in financial year 2017/18. The trust has a good understanding of the causes of the deficit including operational factors and productivity.
- The trust has delivered a large-scale CIP in each of the previous two years; £90.6m in financial year 2017/18 and £84.8m in financial year 2018/19. Of the 2018/19 CIP programme, the trust has delivered £53.4m recurrently (against a recurrent CIP plan of £46.6m).
- The trust can describe robust cash management and is not in receipt of working capital financing from DHSC.

Areas of outstanding practice

- The trust has implemented a number of actions to improve staff retention, particularly for nursing staff and has been shortlisted in the Best Employer category of the Nursing Times awards for its work in this area. The trust has also standardised shift starts across wards, which has improved how well staff can be deployed across wards and led to better agency

staff utilisation. The trust has a number of innovative models around workforce, particularly in nursing, including developing the nursing associate model in the trust (which has resulted in 40 trainees being recruited). The trust is currently participating in a pilot scheme called 'neighbourhood nursing' to improve care across community services. The model was in response to the rising demand for district nursing services and to improve retention amongst district nurses.

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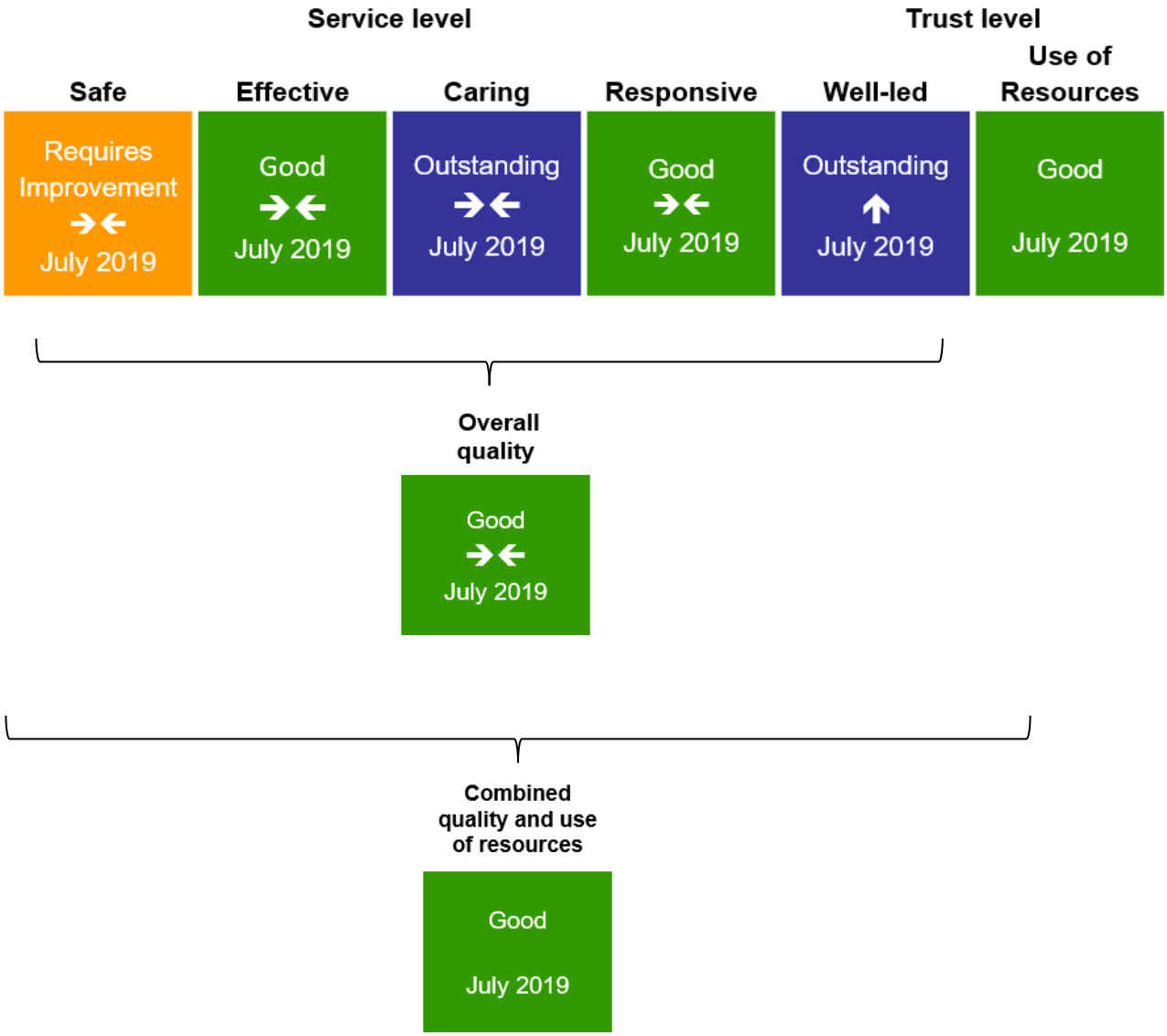
- The cost of the Finance function is £536,230 per £100m of turnover, against a national median of £676,480. The Human Resources (HR) function costs £699,230 per £100m turnover and similarly compares below the national median of £898,020. Both functions deliver excellent value to the trust, as evidenced by both the workforce processes, innovations and outcomes and the processes whereby CIPs, and financial outcomes have been delivered. A high degree of business partnering with the wider trust was apparent.
- The trust has delivered a large-scale CIP in each of the previous two years; £90.6m in financial year 2017/18 and £84.8m in financial year 2018/19. Of the 2018/19 CIP programme, the trust has delivered 53.4m recurrently (against a recurrent CIP plan of 46.6m).

Areas for improvement

- Operational performance has been variable and in some cases below standards. The trust has experienced challenges across all the major constitutional standards, with particular issues in diagnostics and RTT. Much of the performance is due to increased attendances particularly (in the case of RTT and Cancer) from out of area. Accordingly, the trust has begun to undertake further actions working across the system to avoid increased referrals where appropriate, increase internal capacity and streamline internal processes. In particular, Outpatients remains an area where further actions and focus will be required to improve performance.
- The trust's radiology cost per report is £116, which is significantly higher than the national median of £50, and the trust type (by clinical output) of £56. The Trust has confirmed that the costs submitted in the 2017/18 annual NHSI Imaging Return were incorrect, and restating these costs suggests a value of £84, which is still in the fourth (worst) quartile nationally. Additionally, as noted above, the trust's diagnostic performance is poor and among the worst nationally and DNA rates are particularly high in imaging at the trust. The trust recognises efficiency in radiology as an area for further work and is working with an external partner on transformation in radiology that expects to deliver significant savings over a four-year period.
- The trust's overall pathology cost per test is £4.61 against a national median of £1.99. The trust's pathology service is provided by Viapath (a joint venture between the trust, King's College Hospital NHS Trust and Serco). The trust is currently in the process of re-tendering pathology services and expects to be able to significantly reduce costs as a result. However, the overall cost per test is still likely to be higher than national median, given the complexity and case mix at the trust.

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.