NHS

Quarterly scorecard for West Hertfordshire Hospitals NHS Trust

Given the additional investment in the health service, NHS organisations need to ensure that they are providing the best quality care in the most efficient and cost effective way. A number of NHS indicators are set out here to enable trusts to track their performance regularly and benchmark themselves against other organisations in order to improve.

How have these indicators been devised?
The NHS Institute for Innovation and Improvement has worked with a number of partner organisations, including the Department of Health, the Health and Social Care Information Centre and others, to develop a set of indicators which will help NHS trusts identify potential efficiency savings. The indicators fall into four areas: finance, clinical productivity, workforce and procurement, as outlined below.

How should the data be used?
The next page shows an overall scorecard of your trust's performance against a number of indicators. By clicking through to one of the PDFs listed in the box below you will find tables showing how all trusts performed on that measure and a ranking.

The NHS Institute has also developed a series of guidance notes for each indicator, which include potential methods of targeting savings.

How has the data been calculated?
All the data used for the indicators is derived from centrally collected data, including NWCS, financial returns and procurement data. Methodology for each indicator is outlined in the guidance notes.

What happens next?
These PDFs will be updated on a quarterly basis in order for your trust to be able to track performance and to target improvement. Information will also be made publicly available in line with principles of transparency.

To download one of the NHS indicators on the right, click on the title.

1 Finance:

- **1.1 Achieving financial balance** Percentage variance in income and expenditure from plan
- **1.2 Cash position** Percentage variance in cash drawings from plan
- **1.3 Monthly run rate** Income and expenditure over previous month

2 Clinical productivity:

- 2.1 Reducing length of stay Potential bed days saved
- 2.2 Increasing day case surgery rates Day case rate
- 2.3 Reducing pre-operative bed days Pre-operative bed days

3 Workforce:

- 3.1 Staff turnover Full time equivalent leavers as a percentage of staff
- 3.2 Sickness absence Percentage of time lost due to sickness absence
- 3.3 Agency costs Percentage of paybill spent on agency staff
- 3.4 FCEs per consultant

4 Procurement:

- 4.1 Uptake of nationally negotiated contracts

For further information go to www.institute.nhs.uk

Where indicators appear in grey this information will be available at a later date

Overall scorecard results for West Hertfordshire Hospitals NHS Trust

The table below shows how your trust scores against the indicators

Your financial position:	National position (out of 172)	Surplus (+) or deficit (-) (£000s)	Improvement (%)
1 Finance:			
1.1 **Achieving financial balance** Percentage variance in I&E from plan	127	-18,000	*
1.2 **Cash position** Percentage variance in cash drawings from plan	18	N/A	*
1.3 **Monthly run rate** Income and expenditure over previous month	48	N/A	*

Your opportunity to increase productivity:	National position (out of 172)	Indicator score	Productivity opportunity
2 Clinical productivity:			
2.1 Reducing length of stay Potential bed days saved	35	12%	£5,766,798
2.2 Increasing day case surgery rates Day case rates for 25 procedures	118	66%	£175,344
2.3 Reducing pre-operative bed days Pre-operative bed days	165	30%	£4,795,966
3 Workforce:			
3.1 Staff turnover Full time equivalent leavers as a percentage of staff	999,999	0	*
3.2 Sickness absence Percentage of time lost due to sickness absence	999,999	0	*
3.3 Agency costs Percentage of paybill spent on agency staff	999,999	0	*

* Data for these columns will be included from Q2 2006-2007

Definitions

1.1 **Income and expenditure:** This shows the forecast outturn difference between income and expenditure for the full year for NHS trusts, as forecast at the last month of the quarter in question. The number is given as an absolute figure so there will be a tendency for larger organisations to show larger variances. The figure given is total forecast operating income for the year minus the total forecast net expenditure for the year.

1.2 **Cash flow:** This indicator shows the percentage variance between actual cash drawings from, or cash repayments made to, the Department of Health, compared to those in the plan, shown as a percentage variance from plan. This is calculated using year to date figures as follows. Cash drawings are calculated as Temporary PDC Received minus Temporary PDC Repaid, plus Permanent PDC Received minus Permanent PDC Repaid, plus Loans Received from DH minus Loans Repaid to DH. From this is subtracted the planned cash drawings, and the remaining variance is divided by the planned figures for each of the above and expressed as a percentage. Since trusts can be net drawers, or net repayers, of cash, there are footnotes applicable to some trusts. The data is for the quarter shown at the top of the page.

1.3 **Monthly run rate:** This indicator shows the extent of the variance in income and expenditure in the last month of the quarter. The variance is expressed as a percentage of total operating income. This is calculated by taking the total actual operating income for the month and subtracting first the total actual net expenditure for the month and then any planned surplus or deficit. This is divided by the total actual operating income for the month to give the indicator. A negative figure shows that the organisation has failed to achieve its financial plan for the month. The calculation excludes any non-recurrent impact of RAB carry forward and the reversal of previous years' financial support, in order to establish the true underlying recurrent position.

2.1 **Potential bed days saved:** This is calculated by working out the number of bed days that would have been saved if there had been a 25% reduction in the amount of time spent by patients in excess of the median length of stay for patients with the same age, sex, diagnosis, method of admission and social deprivation. This is expressed as a percentage of all bed days in the trust. The 25% figure has been chosen as representing an achievable reduction in above average bed days. In general, the lower the percentage, the better the performance in terms of avoiding above average hospital stays. The data is for the quarter shown at the top of the page.

2.2 **Day case rates:** The day case rate is the percentage of all operations from the Audit Commission basket of 25 procedures performed as a day case. Note that the indicator is expressed as a percentage of all activity so trusts that perform well on the indicator may still have scope for significant potential improvement. In general, the higher the day case rate, the better. Data is for the quarter shown at the top of the page.

2.3 **Pre-operative bed days:** The pre-operative bed days indicator is the percentage of all bed days for patients undergoing a procedure in hospital between date of admission and date of operation where valid data were available. Note that trusts that perform well on this indicator may have scope for larger improvement than trusts that perform less well if they have significantly more activity. In general, the lower the percentage of pre-operative bed days, the better. The data is for the quarter shown at the top of the page.

3.1 **Staff turnover:** This indicator shows the number of full-time equivalent leavers from an individual organisation over one quarter, multiplied by four to give an annualised figure. The turnover rate is expressed as a percentage of the average number of staff in post. The data is for the quarter shown at the top of the page.

3.2 **Sickness absence:** This indicator shows the number of full-time equivalent staff days lost to sickness absence. It is expressed as a percentage of staff in post for the time period. Low values in general indicate good performance. The data is for the quarter shown at the top of the page.

3.3 **Agency costs:** This indicator shows the amount spent on agency staff, expressed as a percentage of paybill plus agency spend. A low value in general indicates good performance. The data is for the quarter shown at the top of the page.

NHS

Overall scorecard results for West Hertfordshire Hospitals NHS Trust

The table below shows how your trust scores against the indicators

Your financial position:	National position (out of 172)	Indicator score	Change from last period
1 Finance:			
1.1 Achieving financial balance Forecast outturn surplus(+) or deficit(-)	109	-11,500,000	6.500
1.2 Cash position Percentage variance in cash drawings from plan	43	-34%	-34
1.3 Monthly run rate Percentage variance from plan	76	-1%	-1

Your opportunity to increase productivity:	National position (out of 172)	Indicator score	Change from last period	Productivity opportunity
2 Clinical productivity:				
2.1 Reducing length of stay Potential bed days saved	31	11.2%	▲ -0.6%	£5,509,000
2.2 Increasing day case surgery rates Day case rates for 25 procedures	132	63.4%	▼ -3.0%	£172,000
2.3 Reducing pre-operative bed days Pre-operative bed days	153	28.0%	▲ -1.5%	£4,724,000
3 Workforce:				
3.1 Staff turnover Full time equivalent leavers as a percentage of staff	-	0.00%	0.00%	*
3.2 Sickness absence Percentage of time lost due to sickness absence	-	0.00%	0.00%	*
3.3 Agency costs Percentage of paybill spent on agency staff	-	0.00%	0.00%	*

* Data for these columns will be included from Q3 2006-2007

Productivity Metrics

National top quartile
Poorer than average performance

⇑ Productivity improvement
⇓ Productivity decline

	Trust	2.1 Potential Bed Days Quarter 1			2.1 Potential Bed Days Quarter 2			% Change in Potential Bed Days		Change in National Position	
		National Position	Potential Bed Days %	Productivity Opportunity £	National Position	Potential Bed Days %	Productivity Opportunity £				
RC1	Bedford Hospitals NHST	28	11.5	2,017,000	40	11.6	3,141,000	+0.1	⇓	+12	⇓
RWH	East & North Hertfordshire NHST	99	12.7	6,581,000	122	12.9	7,340,000	-0.2	⇑	+23	⇓
RDE	Essex Rivers Healthcare NHST	25	11.3	4,498,000	19	10.8	4,386,000	-0.5	⇑	-6	⇑
RQQ	Hinchingbrooke Health Care NHST	41	12.0	2,194,000	37	11.5	1,985,000	-0.5	⇑	-4	⇑
RGQ	Ipswich Hospital NHST	57	12.1	5,555,000	46	11.7	5,104,000	-0.4	⇑	-11	⇑
RQ8	Mid Essex Hospitals NHST	34	11.8	4,756,000	32	11.3	4,672,000	-0.5	⇑	-2	⇑
RM1	Norfolk & Norwich University Hospital NHST	6	10.1	6,144,000	7	10.0	6,350,000	-0.1	⇑	+1	⇓
RQW	Princess Alexandra NHST	116	12.9	4,698,000	64	12	3,914,000	-0.9	⇑	-52	⇑
RCX	Queen Elizabeth Hospital Kings Lynn NHST	43	12.0	3,702,000	26	11.1	3,098,000	-0.9	⇑	-17	⇑
RWG	West Hertfordshire Hospitals NHST	35	11.9	5,766,000	31	11.2	5,509,000	-0.7	⇑	-4	⇑
RGR	West Suffolk Hospital NHST	50	12.1	2,231,000	89	12.3	3,516,000	+0.2	⇓	+39	⇓
				48,142,000			**49,015,000**				

Nb James Paget and Luton Trusts figures available for quarter 1 only:

		2.1 Potential Bed Days Quarter 1		
		National Position	Potential Bed Days Saved %	Productivity Opportunity £
	James Paget Healthcare NHST	24	11.3	3,040,000
	Luton & Dunstable Hosptial NHST	44	12.0	4,671,000
				7,711,000

Productivity Metrics

	Trust	2.2 Day Case Rates Quarter 1			2.2 Day Case Rates Quarter 2			% Change in Day Case Rate		Change in National Position	
		National Position	Day Case Rate %	Productivity Opportunity £	National Position	Day Case Rate %	Productivity Opportunity £				
RC1	Bedford Hospitals NHST	59	73.9	29,000	59	73.5	56,000	-0.4	⇓	+0	–
RWH	East & North Hertfordshire NHST	102	69.1	68,000	124	64.2	130,000	-4.9	⇓	+22	⇓
RDE	Essex Rivers Healthcare NHST	57	74.4	66,000	81	70.9	113,000	-3.5	⇓	+24	⇓
RQQ	Hinchingbrooke Health Care NHST	107	68.6	52,000	49	74.3	48,000	+5.7	⇑	-58	⇑
RGQ	Ipswich Hospital NHST	64	73.6	52,000	31	76.3	32,000	+2.7	⇑	-33	⇑
RQ8	Mid Essex Hospitals NHST	109	68.5	163,000	83	70.6	126,000	+2.1	⇑	-26	⇑
RM1	Norfolk & Norwich University Hospital NHST	29	78.7	115,000	36	76	178,000	-2.7	⇓	+7	⇓
RQW	Princess Alexandra NHST	143	62.4	117,000	126	63.9	104,000	+1.5	⇑	-17	⇑
RCX	Queen Elizabeth Hospital Kings Lynn NHST	10	83.2	21,000	8	81.3	19,000	-1.9	⇓	-2	⇑
RWG	West Hertfordshire Hospitals NHST	118	66.4	175,000	132	63.4	172,000	-3.0	⇓	+14	⇓
RGR	West Suffolk Hospital NHST	27	79.0	42,000	17	78.8	80,000	-0.2	⇓	-10	⇑
				900,000			**1,058,000**				

Nb James Paget and Luton Trusts figures available for quarter 1 only:

		2.2 Day Case Rates Quarter 1		
		National Position	Day Case Rate %	Productivity Opportunity £
	James Paget Healthcare NHST	19	79.8	27,000
	Luton & Dunstable Hosptial NHST	83	71.4	57,000
				84,000

Productivity Metrics

	Trust	2.3 Pre Operative Bed Days Quarter 1			2.3 Pre Operative Bed Days Quarter 2			% Change in Pre Operative Bed Days		Change in National Position	
		National Position	Pre Operative Bed Days %	Productivity Opportunity £	National Position	Pre Operative Bed Days %	Productivity Opportunity £				
RC1	Bedford Hospitals NHST	166	29.7	1,060,000	excluded from exercise- no data						
RWH	East & North Hertfordshire NHST	55	22.4	2,460,000	114	25	3,400,000	+2.6	⇓	+59	⇓
RDE	Essex Rivers Healthcare NHST	98	24.5	3,464,000	122	25.7	3,228,000	+1.2	⇓	+24	⇓
RQQ	Hinchingbrooke Health Care NHST	27	19.4	613,000	37	21.1	689,000	+1.7	⇓	+10	⇓
RGQ	Ipswich Hospital NHST	65	22.9	2,713,000	53	22	2,757,000	-0.9	⇑	-12	⇑
RQ8	Mid Essex Hospitals NHST	70	23.1	2,398,000	81	23.8	2,721,000	+0.7	⇓	+11	⇓
RM1	Norfolk & Norwich University Hospital NHST	143	27.2	5,573,000	113	25.3	5,725,000	-1.9	⇑	-30	⇑
RQW	Princess Alexandra NHST	82	23.8	2,382,000	62	23	2,133,000	-0.8	⇑	-20	⇑
RCX	Queen Elizabeth Hospital Kings Lynn NHST	128	26.2	1,601,000	65	23.3	1,285,000	-2.9	⇑	-63	⇑
RWG	West Hertfordshire Hospitals NHST	165	29.5	4,795,000	153	28	4,724,000	-1.5	⇑	-12	⇑
RGR	West Suffolk Hospital NHST	93	24.2	697,000	85	23.9	911,000	-0.3	⇑	-8	⇑
				27,756,000							
				26,696,000			**27,573,000**				
				NB Bedford Hospitals figure removed from total							

Nb James Paget and Luton Trusts figures available for quarter 1 only:

		2.3 Pre Operative Bed Days Quarter 1		
		National Position	Pre Operative Bed Days %	Productivity Opportunity £
	James Paget Healthcare NHST	49	22.2	755,000
	Luton & Dunstable Hosptial NHST	149	27.6	2,845,000
				3,600,000

Productivity Metrics

	Trust	Quarter 1 Total Productivity Opportunity	Quarter 2 Total Productivity Opportunity	Net Movement	
RC1	Bedford Hospitals NHST	3,106,000	3,197,000	**+91,000**	
RWH	East & North Hertfordshire NHST	9,109,000	10,870,000	**+1,761,000**	⇓
RDE	Essex Rivers Healthcare NHST	8,028,000	7,727,000	**-301,000**	⇑
RQQ	Hinchingbrooke Health Care NHST	2,859,000	2,722,000	**-137,000**	⇑
RGQ	Ipswich Hospital NHST	8,320,000	7,893,000	**-427,000**	⇑
RQ8	Mid Essex Hospitals NHST	7,317,000	7,519,000	**+202,000**	⇓
RM1	Norfolk & Norwich University Hospital NHST	11,832,000	12,253,000	**+421,000**	⇓
RQW	Princess Alexandra NHST	7,197,000	6,151,000	**-1,046,000**	⇑
RCX	Queen Elizabeth Hospital Kings Lynn NHST	5,324,000	4,402,000	**-922,000**	⇑
RWG	West Hertfordshire Hospitals NHST	10,736,000	10,405,000	**-331,000**	⇑
RGR	West Suffolk Hospital NHST	2,970,000	4,507,000	**+1,537,000**	⇓
		76,798,000		**+1,060,000**	
		75,738,000	**77,646,000**	**+1,908,000**	⇓

+1,151,000 ⇓

Net potential savings have increased by 2.5%

NB Bedford Hospitals Pre Op Bed Days Q1 removed from total

Nb James Paget and Luton Trusts figures available for quarter 1 only:

		Quarter 1 Total Productivity Opportunity
	James Paget Healthcare NHST	3,822,000
	Luton & Dunstable Hosptial NHST	7,573,000
		11,395,000

Productivity Metrics
NHS Better Care, Better Value Indicators

Indicator	Steps to Achieving Indicator	Explanation of scoring
1. Finance		
1.1 Achieving Financial Balance	• Demonstrate in financial plans that the organisation will break even and meet its duty to break even annually. • Reflect in financial plans (budgets) all current and future commitments to expenditure and any that arise from new investments and developments. • Update suitably profiled budgets monthly to reflect agreed revisions to planned budgets. There must be a clearly defined set of rules that allow for any such changes to the initial budget. • Agree to finance any new developments only where there is a clear indication of the source of income required to support it. Equally reductions in demand for services that may arise from, for example, changes in referral patterns or demand management, should be linked to reductions in expenditure budgets. • Give equal weight to income and expenditure streams. Plans must show reasonable profiling of both income and expenditure streams. Plans must show reasonable profiling of both income and expenditure throughout the year. Spreading income or expenditure over each month is not sufficient. • Account for all income and expenditure I the relevant period, and make provisions where necessary. This is especially important as the financial risks associated with	Income and expenditure. This shows the forecast outturn difference between income and expenditure for the full year for NHS Trust, as forecast at the last month of the quarter in question. The number is given as an absolute figure so there will be a tendency for larger organisations to show larger variances. The figure given is total forecast operating income for the year minus the total forecast net expenditure for the year.

	the introduction of Choice and Payment by Results develop. • Submit to the board full reports including details of all provisions, efficiency and recovery plans. • Integrate patient-related activity trends into the financial position. They should be directly linked through specialty level and case mix (HRG) weighted. This will show where activity trends and variances are arising. • Give equal measure to the accuracy of the data that deals with intra-NHS accounting. Historically this area has been neglected and has caused a number of "unexpected" problems late into financial years.	
1.2 Monitoring Cashflow	• Prepare an annual cash flow plan that demonstrates clearly the sources and timing of material in and out flows of cash. This should, as a minimum, show weekly and preferably daily positions. It should be capable of being reconciled to the income and expenditure budgets to demonstrate that any service developments are accommodated in the cash plan. • Include a summary and commentary from the finance director in regular board reporting. The cash plan should be updated for all material changes: not just investment decisions but also changes in demand patterns, new service configuration, indeed any material change with financial input. • Support the plan with details of any movements in both creditors and debtors, and outstanding long term problems that could turn into bad debts or non payment of income assumed to be due. This applies equally to NHS and non-NHS sources.	This indicator shows the percentage variance between actual cash drawings from, or cash repayments made to, the Department of Health, compared to those in the plan, shown as a percentage variance from plan. This is calculated using year to date figures as follows. Cash drawings are calculated as Temporary PDC Received minus Temporary PDC Repaid, plus Permanent PDC Received minus Permanent PDC Repaid, plus Loans received from DH minus Loans Repaid to DH. From this is subtracted the planned cash drawings, and the remaining variance is divided by the planned figures for each of the above and expressed as a percentage. Since trusts can be net drawers, or net repayers, or cash, there are footnotes applicable to some trusts. The data is for the quarter shown at the top of the page.
1.3 Monitoring Monthly Run	• Prepare a month by month expenditure budget for all categories of spend, including pay (including temporary	**Monthly run rate** This indicator shows the extent of the variance in income

Rate	staff) and non-pay. This should be consistent with an annual budget adopted by the trust prior to the start of the financial year. • Prepare a month-by-month income budget, consistent with the NHS tariff and based on a phasing of annual income budgets that matches the trust's activity plan. This requires a methodical approach to planning, monitoring and reporting clinical activity through the financial year. • Ensure that monthly accruals accounting for expenditure are realistic and open to scrutiny. Pay particular attention to the treatment of reserves and to any "accruing to budget" by management accountants, especially where the sums in question are material. • Ensure that monthly accruals for income are directly linked to clinical activity for all income derived from the payment by results tariff, rather than payments received from commissioners. The concept of accounting prudence should be paramount. Although in some instances it may be necessary to apportion income to clinical directorates, especially for diagnostics and some trust-wide support functions, this limits the power of the run rate indicator to motivate clinicians, unless the apportionment of overheads occurs on the same basis as clinical income.	and expenditure in the last month of the quarter. The variance is expressed as a percentage of total operating income. This is calculated by taking the total actual operating income for the month and subtracting first the total actual net expenditure for the month and then any planned surplus or deficit. This is divided by the total actual operating income for the month to give the indicator. A negative figure shows that the organisation has failed to achieve its financial plan for the month. The calculation excludes any non-recurrent impact of RAB carry forward and the reversal of previous years' financial support, in order to establish the true underlying recurrent position.
2.Clinical Productivity		
2.1 Reducing Length of Stay	• Benchmark length of stay performance in as much detail as possible down to HRG, operation and even consultant or ward level to identify opportunities for improvement. • Map processes in order to identify potential delays to patients' discharge. This analysis should focus on identifying bottlenecks, any disruption to the information flow during the patient journey and on patterns of	**Potential Bed days saved** This is calculated by working out the number of bed days that would have been saved if there had been a 25% reduction in the amount of time spent by patients in excess of the median length of stay for patients with the same age, sex, diagnosis, method of admission and social deprivation. This is expressed as a percentage of all bed days in the trust. The 25% figure has been chosen as representing an

	discharge by day, hour and specialty. • Give patients a planned date for discharge on, or prior to, their admission. This date should be based on protocols for common conditions. The patient, their family or carer, and where necessary social services, should then be involved in individual discharge planning. • Discharge patients daily. A regular decision-making ward round should take place at least once per day, including weekends. Staff rotas may need to be adjusted to facilitate this. • Discharge patients throughout the day. Criteria-led discharge by nurses and other healthcare professionals facilitates discharge at other times of the day, other than the daily ward round. • Prevent hospital procedures from holding up discharge. Lead-in times for processes required for discharge, including tests and results availability, medicines, transport and social services, should be determined so that measures can be taken to ensure that they do not hold up patient discharge. • Ensure that the admissions and discharge processes work seamlessly together. Patient discharges peak late in the afternoon, while the peak for admissions is usually earlier. Trusts working with the NHS Modernisation Agency have shown that matching the hour of discharge to the times that beds are required for transfer from A&E can have a significant impact on reducing A&E waiting times. • Target initiatives for bringing forward discharge times for both long-stay and short-stay patients. Hospitals have traditionally concentrated efforts on patients in hospital for more than 28 days. However, this represents less than 25% of patients. One trust saw a 505 decrease in	achievable reduction in above average bed days. In general, the lower the percentage, the better the performance in terms of avoiding above average hospital stays. The data is for the quarter shown at the top of the page. **Productivity opportunity** The savings are calculated by multiplying potential bed days saved by the excess bed day tariff for the relevant HRG. The savings figure excludes potential savings from reduction in length of stay for non-tariff activity. Savings are expressed as annualised figures by multiplying by four the savings of the quarter measured.

	cancelled operations and 10% increase in elective admissions after it widened its efforts to tackle length of stay. A one-day reduction in length of stay for patients staying 10 days or less would result in an approximate 10% reduction in total bed days used.	
2.2 Increasing Day Case Surgery Rates	• Think of day care as the norm for elective surgery and redesign systems accordingly. Rather than asking 'Is the patient suitable for day surgery?', the question should be 'What is the justification for admitting the patient?' • Prioritise use of day surgery units for day surgery requiring full operating theatres, rather than using them for minor surgery and endoscopies that could be moved to other setting. • Set an appropriate level of day cases for each of the 25 basket procedures and then monitor the actual rates at procedure and speciality level. Improvements should then be focused on poorly performing specialties rather than on individual procedures. Actions should take the form of implementing procedures and processes that make day cases the norm and inpatient care the exception. • Theatre use should also be optimised. Setting aside dedicated theatres for day cases can help reduce cancellations and increase productivity. • Maximise time for which theatres are used. The Healthcare Commissions found that on average trusts plan to use their theatres for 29.8 hours per week, but actually use them for only 16 hours. Cancelled or short-running operating lists and gaps between patients can account for 45 per cent of planned operating hours. One in four-day surgery units cancels 9 per cent of operations. • Reserve day surgery recovery facilities for day surgery patients. The rate of day surgery is limited and some	**Day case rates** The day case rate is the percentage of all operations from the Audit Commission basket of 25 procedures performed as a day case. Note that the indicator is expressed as a percentage of all activity so trusts that perform well on the indicator may still have scope for significant potential improvement. In general, the higher the day case rate, the better. **Productivity opportunity** This is an estimate of the potential cost savings that could be achieved if all trusts achieved a rate of day-case surgery inline with the top quartile. Overall top quartile trust achieved a day case rate of 76.5% across all 25 procedures. The figures are based on trusts achieving top quartile performance for each operation so a trust which performs in line with top quartile overall but below top quartile in one procedure may still show a productivity opportunity. Savings are expressed as annualised figures by multiplying by four the savings of the quarter measured.

	cancellations are caused when aftercare facilities are used to accommodate elective or emergency inpatients when beds cannot be found for these patients in the main hospital. This leads to cancelled day case procedures and expensive operating theatres standing idle. The Healthcare Commission found that inpatients account for more than 20 per cent of weighted throughput at 5per cent of day surgery units. • Practise pre-assessment of day surgery patients to reduce last minute cancellations and encourage pooling of referrals for basket procedures rather than to a named surgeon. • Ensure that the staffing level of day surgery units is appropriate. On average one member of staff is needed for 13 true day case patients treated each month. However, one in ten have one staff member for more than 24 patients and one in ten one staff member for less than five patients. Some unites make extensive use of bank staff which adds to the cost base significantly.	
2.3 Reducing Pre-Operative Bed Days	• Analyse rates of patient admission on day prior to their procedure and rates of discharge before a procedure to ensure that they are not out of line with expected levels. • Revise protocols to ensure that patients are not admitted on day prior to surgery unless clinically necessary. • Use outpatient pre-operative assessment to ensure that patients admitted on day prior to surgery unless clinically necessary. • Use outpatient pre-operative assessment to ensure that patients admitted are fit for surgery. This assessment can be carried out in the hospital where the procedure is to be carried out on an outpatient basis or at a local diagnosis and treatment centre in the community.	**Pre-operative bed days** The pre-operative bed days indicator is the percentage of all bed days for patients undergoing a procedure in hospital between date of admission and date of operating where valid data were available. Note that trusts that perform well on this indicator may have scope for larger improvement than trusts that perform less well if they have significantly more activity. In general, the lower the percentage of pre-operative bed days, the better. **Productivity opportunity** This is an estimate of the cost savings that could be achieved by reducing the number of pre-operative bed days to the level of the top quartile. Top quartile trusts use 22% of their

	• Avoid admitting patients for diagnostic procedures. This can be achieved by improving access to diagnostics on an outpatient basis, again at the hospital or through increased availability of diagnostics in the community. Community services can take the form of diagnostic and treatment centres or GP supersurgery (surgeries offering a wide rate of testing facilities as well as primary care services).	elective surgical bed days for pre-operative patients. The productivity opportunity is calculated by applying the excess bed day tariff of the HRG of each patient to the number of days that would have been spent pre-operatively if performance had been in line with the top quartile. This is calculated separately for each HRG so trusts that perform in line with or better than top quartile overall may still show a productivity opportunity if they are below top quartile in one HRG. Savings are expressed as annualised figures by multiplying by four the savings of the quarter measured.
3. Workforce		
3.1 Reducing Staff Turnover	• Monitor turnover within 12 months of appointment. This is not yet routinely measured in the NHS. • Conduct exit interviews routinely when staff leave in order to identify potential issues. • Introduce more flexibility in working patterns, including hours and career breaks. • Invest in career development for all staff. • Improve the recruitment and selection process, matching skills appropriately to the post people are appointed to. • Take diversity and equality seriously as an organisation, in order that all staff feel fully supported. • Improve line management capacity and capabilities, including proper induction arrangements, objective setting, regular appraisal and training and development plans. • Monitor and act on feedback from the national staff survey, including how satisfied staff are with the working environment and the quality of management and leadership in the organisation. • Monitor staff perceptions of access to opportunities to learn and develop, to progress their careers and to be involved as part of a team, align with the management	**Staff turnover** This indicator shows the number of full-time equivalent leavers from an individual organisation over one quarter, multiplied by four to give an annualised figure. The turnover rate is expressed as a percentage of the average number of staff in post.

	view of these areas.	
3.2 Reducing Sickness Absence Rates	• Measure sickness absence and report rates to the Board regularly, including trends and benchmarking against similar organisations. • Review the national staff survey, including the implementation of Improving Working Lives. The Improving Working Lives Standard sets a model of good HR practice against which NHS Employers and their staff can measure an organisation's HR management. • Introduce line management training to improve management support. If staff are dissatisfied at work they may suffer from burn-out reduced self-esteem and depression and anxiety. • Manage long term sickness more effectively-including putting occupational health support in place at an early stage; encouraging the long term sick to return to work, such as offering alternative jobs; and introducing return to work interviews. • Introduce return to work interviews and alternative jobs where long term sick absence is used as an alternative to managing poor performance. • Improve the work life balance for staff – such as introducing flexible working. When staff do not have sufficient flexibility in their working hours or are put on a shift rota which is difficult to manage, it may lead to poor morale and increased short term sick leave. • Promote staff health and well being – for example, initiatives to encourage staff to lead more healthy lifestyles. • Introduce financial incentives to encourage attendance and reduce sick pay.	Sickness Absence This indicator shows the number of full-time equivalent staff days lost to sickness absence. It is expressed as a percentage of staff in post for the time period. Low values in general indicate good performance. The data is for the quarter shown at the top of the page.
3.3 Reducing	• Monitor and plan for the use of temporary staff, including	Agency Costs -

Agency Costs	understanding and controlling the demand of agency staff. • Draw on the staff bank run by NHS Professionals or on local staff banks based on flexible working pools. NHS Professionals has a bank of 60,000 nurses across the NHS work on a temporary basis, according to strict pay standards and rigorous quality procedures. • Create an in-house 'bank' of staff. • Join with other trusts to manage the spend on agency staff, for nurses in particular. • Seek support from the Purchasing and Supply Agency where use of agency staff is unavoidable or appropriate. The agency has developed best practice contract frameworks to help trusts in this process. The frameworks specify qualify and costs criteria for the NHS and provide details of approved suppliers.	This indicator shows the amount spent on agency staff, expressed as a percentage of paybill plus agency spend. A low value in general indicates good performance. The data is for the quarter shown at the top of the page.