

TRUST BOARD
28th September 2017

AGENDA ITEM NUMBER	6.7	
TITLE OF PAPER	NHSI Use of Resources Assessment Framework	
Confidential		
Suitable for public access	√	
PLEASE DETAIL BELOW THE OTHER SUB-COMMITTEE(S), MEETINGS THIS PAPER HAS BEEN VIEWED		
This was reviewed at the Financial Management Committee meeting held on 21 st September 2017.		
STRATEGIC OBJECTIVE(S):		
Best outcomes	√	
Excellent experience	√	
Skilled & motivated teams	√	
Top productivity	√	
EXECUTIVE SUMMARY	<p><u>Use of Resources: Assessment Framework</u></p> <p>NHS Improvement (NHSI) and the Care Quality Commission (CQC) have now published their final Use of Resources (UoR) Framework following feedback from its consultation; it has also been informed by work with pilots, which included ASPH, the output of which has helped to refine the Framework.</p> <p>NHSI will introduce the Use of Resource assessment alongside CQC's new inspection approach from autumn 2017, initially in the acute non-specialist sector. The next step will see the CQC and NHSI consulting on how the Use of Resources ratings can be combined with other ratings to yield an overall Trust-level rating and it anticipates this will be introduced from 2018.</p> <p>The aim of NHSI's Use of Resources assessments is to help patients, providers and regulators understand how effectively trusts are using their resources to provide high quality, efficient and sustainable care. They will do this by assessing:</p> <ul style="list-style-type: none"> ➤ how financially sustainable Trusts are, ➤ how well they are meeting financial controls; and ➤ how efficiently they use their finances, workforce, estates and facilities, data and procurement to deliver high quality care. <p>The framework mirrors the structure of the joint Well-Led framework and CQC's inspection approach, where key lines of enquiry (KLOEs), prompts and metrics are used for a balanced assessment of a Trust. The five use of resource areas are:</p> <ul style="list-style-type: none"> ➤ Clinical services ➤ People 	

	<ul style="list-style-type: none"> ➤ Clinical support services ➤ Corporate services, procurement, estates and facilities ➤ Finance <p>All relevant evidence will be collated into a brief report and used to reach a proposed Use of Resources rating of either:</p> <ul style="list-style-type: none"> ➤ Outstanding; ➤ Good; ➤ Requires Improvement; or ➤ Inadequate. <p>The CQC will consider NHSI's report and recommendations in determining the Trust's final Use of Resource rating and will publish the final report and rating alongside the Trust-level inspection report and the current Quality rating.</p> <p>The full Use of Resources: Assessment Framework is attached for information.</p> <p>The Trust's Regulation Team are reviewing how preparations for such an assessment can be integrated into current monitoring systems.</p> <p><u>Linkage to the Single Oversight Framework</u></p> <p>The Single Oversight Framework has a Finance and Use of Resources Rating that we report in the Finance Report and Trust Balanced Scorecard. That metric covers:</p> <ul style="list-style-type: none"> ➤ Capital service cover rating; ➤ Liquidity rating; ➤ I&E margin rating; ➤ I&E margin: distance from financial plan; and ➤ Agency rating <p>Under current consultation proposals this would now be renamed the Finance Score so as not to cause confusion.</p> <p>The five metrics in the Finance Score above will form part of the initial evidence used by assessors when reviewing the finance resource area in the Use of Resources Assessment.</p>
RECOMMENDATION	Note
SPECIFIC ISSUES CHECKLIST:	
Quality and safety	
Patient impact	
Employee	
Other stakeholder	
Equality & diversity	
Finance	

Legal	
Link to relevant Board Assurance Framework Principle Risk	
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DATE	22 September 2017
COMMITTEE ACTION	Receive

Use of Resources: assessment framework

August 2017

Delivering better healthcare by inspiring and supporting everyone we work with, and challenging ourselves and others to help improve outcomes for all.

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Introduction

1. As public-sector organisations, NHS trusts and NHS foundation trusts (here together referred to as trusts) are expected to demonstrate to their patients, communities and taxpayers that they are delivering value for money, evidencing both efficiency and effectiveness. This is even more important in times of fiscal constraint. NHS Improvement and the Care Quality Commission (CQC) believe there is significant potential for more productive use of resources across the NHS, which would improve quality of care for patients.
2. NHS Improvement's Use of Resources assessments aim to help patients, providers and regulators understand how effectively trusts are using their resources to provide high quality, efficient and sustainable care in line with the recommendations of Lord Carter's review of *Operational productivity and performance in English NHS acute hospitals*. They will do this by assessing how financially sustainable trusts are, how well they are meeting financial controls, and how efficiently they use their finances, workforce, estates and facilities, data and procurement to deliver high quality care for patients. Initially, our approach will focus on acute non-specialist services, due to the availability and quality of data in this area. As we develop metrics for specialist acute, ambulance, mental health and community services, we will include them in this framework before introducing Use of Resources assessments to providers of these services.
3. The principles that underpin the Use of Resources assessment are that it should:
 - lead to a focus on better quality, sustainable care and outcomes for patients
 - be proportionate, minimising regulatory burden, and draw on existing data collections where possible
 - be clear to trusts what information we will look for and what 'good' looks like – all data will be made available to all trusts through the Model Hospital¹
 - promote good practice to aid continuous innovation and improvement

¹ <https://model.nhs.uk/>

- help us to identify trusts' support needs through the [Single Oversight Framework](#), as well as being a useful improvement tool for organisations.
4. The framework mirrors the structure of the joint Well-Led framework and CQC's inspection approach, where key lines of enquiry (KLOEs), prompts and metrics are used for a balanced assessment of a trust.
 5. NHS Improvement will introduce Use of Resources assessments alongside CQC's new inspection approach from autumn 2017. In autumn 2017 CQC and NHS Improvement will also consult on how Use of Resources ratings should best be combined with other ratings to yield an overall trust-level rating, to be introduced from 2018.

Use of Resources: the assessment

6. Use of Resources assessments are based on a number of KLOEs, which are the lens through which trust performance should be seen (see Figure 1). The KLOEs correspond to the main areas of productivity – clinical services; people (including doctors, nurses and allied health professionals – AHPs); clinical support services (including pharmacy and pathology services); corporate services, procurement, estates and facilities; and finance. Data relating to all these areas can be found on the Model Hospital.

Figure 1: Overview of key lines of enquiry

Use of resources area	Key lines of enquiry (KLOEs)
Clinical services	How well is the trust using its resources to provide clinical services that operate as productively as possible and thereby maximise patient benefit?
People	How effectively is the trust using its workforce to maximise patient benefit and provide high quality care?
Clinical support services	How effectively is the trust using its clinical support services to deliver high quality, sustainable services for patients?
Corporate services, procurement, estates and facilities	How effectively is the trust managing its corporate services, procurement, estates and facilities to maximise productivity to the benefit of patients?
Finance	How effectively is the trust managing its financial resources to deliver high quality, sustainable services for patients?

7. The starting point for Use of Resources assessments will be an analysis of trust performance against a small number of initial metrics, local intelligence gathered during NHS Improvement's day-to-day interactions with the trust, as well as any other relevant evidence, such as specific data and analysis drawn from the work of the Operational Productivity directorate within NHS Improvement and made available to trusts through the Model Hospital.
8. This analysis will be followed by a qualitative assessment carried out during a one-day site visit to the trust and using the KLOEs and prompts to help probe trust performance in a consistent and comparable manner. NHS Improvement's assessment team, made up of approximately five senior staff, will obtain input from the leadership team with responsibility in the areas of clinical and operational services, workforce and finances. We are likely to meet the trust's chair, chief executive officer, medical director, nursing director, finance director, human resources director, chief operating officer, head of procurement, head of estates and chief pharmacist.
9. All relevant evidence will be collated into a brief report and used to reach a proposed rating of outstanding, good, requires improvement or inadequate in accordance with CQC practice. NHS Improvement will use the Use of Resources draft report and proposed rating to identify potential support needs at trusts.
10. NHS Improvement will also submit the draft Use of Resources assessment report and proposed rating to CQC, which will consider it as part of the process of preparing and finalising its trust-level inspection reports. CQC will consider NHS Improvement's report and recommendations in determining the trust's final Use of Resource rating and will publish the final report and rating alongside the trust-level inspection report and the current Quality rating.

Use of Resources: the evidence

11. The Use of Resources assessment centres on delivery and performance at trust level currently and looking back over the previous 12 months. We recognise that trusts do not work in isolation and are working with, and affected by, their local health and care economies. CQC will assess the way trusts are working in their local systems through the updated [Well-Led framework](#).² The Use of Resources assessment focuses on how effectively trusts are using their resources in the context of the funds available to them.
12. NHS Improvement will draw on a wide range of evidence that will include a basket of initial metrics, additional data or information collected by us and shared by the trust, local intelligence from our day-to-day interactions with the trust, and evidence gathered during a qualitative assessment (see Figure 2).

Figure 2: Evidence for Use of Resources assessments

Initial metrics	<ul style="list-style-type: none"> • How is the trust performing on each initial metric? • Is the trust an outlier on any of the initial metrics?
Additional evidence	<ul style="list-style-type: none"> • Is the trust an outlier on any of the wider set of metrics (eg Model Hospital, Getting It Right First Time (GIRFT), data supplied by the trust)? • Is there any data or information, shared with us by the trust, which is used internally to assess productivity?
Local intelligence	<ul style="list-style-type: none"> • Are there any areas of finance and productivity not covered by the metrics where the trust's performance is notable? Are there any areas of unrealised efficiencies? • What do we know about the trust's performance more generally, eg cost improvement programmes, private finance initiatives, local health and care economy context?
Qualitative assessment	<ul style="list-style-type: none"> • Please see key lines of enquiry and prompts

² <https://improvement.nhs.uk/resources/well-led-framework/>

Initial metrics

13. The initial metrics are the starting point for the Use of Resources assessment (see Figure 3). They include productivity metrics drawn from the work of the Operational Productivity directorate in NHS Improvement and cover clinical services; people (workforce); clinical support services; and corporate services, procurement, estates and facilities. All such metrics are available to trusts through the Model Hospital. The initial metrics under the finance KLOE contain the Finance and Use of Resources theme metrics currently in NHS Improvement's [Single Oversight Framework](#).
14. For all metrics we consider in assessing trusts' use of resources, we will ask the following general questions:
 - How does performance compare with the national average and the trust's peer group?
 - Has the measure improved or deteriorated in the last 12 months?
 - Is there a reason or relevant context for the trust's performance?
 - Has the trust implemented any activities or interventions to improve performance as appropriate in the given area? Have these been effective?
15. The metrics will be used as the basis for engagement with trusts to understand the drivers for performance in these areas, and no single metric (and indeed no single piece of evidence throughout the assessment) will determine a trust's Use of Resources rating. (See Appendix A for further details about the rationale for inclusion of the initial metrics.)
16. All the initial metrics will be made available through the Model Hospital. However, it is important to note that not all of the metrics available on the Model Hospital are included in the initial metrics for this assessment. Other metrics on the Model Hospital are intended to give a broader, more granular view of productivity to support trusts to drive their own improvement, alongside the assessment process. Where new robust, high quality metrics become available, we will consider whether they provide broader insight into the productivity of trusts and should become part of the initial metrics.
17. A number of metrics, including 'cost per test', have only been recently developed and are currently being refined. This will be taken into

consideration when performing the assessments. We are also working to develop productivity metrics for specialist, mental health, community and ambulance trusts. The Use of Resources assessment will be adapted and introduced for non-acute trusts as and when these metrics are available.

Figure 3: KLOE themes and initial metrics

Use of resources area	Initial metrics
Clinical services	Pre-procedure non-elective bed days Pre-procedure elective bed days Emergency readmissions (30 days) Did not attend (DNA) rate
People	Staff retention rate Sickness absence rate Pay cost per weighted activity unit (WAU) Doctors cost per WAU Nurses cost per WAU Allied health professionals cost per WAU (community adjusted)
Clinical support services	Top 10 medicines – percentage delivery of savings target Overall cost per test
Corporate services, procurement, estates and facilities	Non-pay cost per WAU Finance cost per £100 million turnover Human resources cost per £100 million turnover Procurement Process Efficiency and Price Performance Score Estates cost per square metre
Finance	Capital service capacity Liquidity (days) Income and expenditure margin Distance from financial plan Agency spend

Additional evidence and local intelligence

18. Additional evidence and local intelligence gathered during day-to-day interactions with trusts will give NHS Improvement a broader and more rounded view of trust performance, helping us understand the context in which the trust operates. This may include any other relevant and useful data, such

as information from the Getting It Right First Time (GIRFT) specialty programmes or other data contained on the Model Hospital, such as proportion of consultants with an active job plan, pharmacy staff cost per WAU, medicines cost per WAU, percentage of transactions on e-catalogue, and estates and facilities cost per WAU. It will help identify areas of good performance, unrealised efficiencies and areas for improvement that may have been missed by examining the initial metrics alone.

19. In a similar way to CQC's inspection process and as part of CQC's provider information return, trusts will be asked to provide brief, high-level commentary against each KLOE ahead of each assessment. Trusts will also be asked to review NHS Improvement's analysis of the initial metrics and share more recent data that they think might be helpful to inform the assessment. NHS Improvement will review all submissions to inform our understanding of the trust's performance and identify areas that would benefit from particular focus at the on-site assessment. Some additional evidence may occasionally be requested after the on-site assessment to support qualitative evidence collected on the day.

Qualitative assessment

20. The aim of the prompts (see Figure 4) is to get a better understanding of trust performance, contextual information and improvement action undertaken by the trust. NHS Improvement will rely on these during the site visit, but will not be bound by them. Assessment teams are likely to ask additional questions and will not necessarily use all the prompts during the assessment.

Figure 4: Prompts for key lines of enquiry

KLOE	Prompts
<p>Clinical services: How well is the trust using its resources to provide clinical services that operate as productively as possible and thereby maximise patient benefit?</p>	<ul style="list-style-type: none"> • How far are delayed transfers of care that are within the trust’s control leading to a lack of bed capacity and/or cancellations of elective operations? • Is the trust improving clinical productivity (elective and non-elective) by doing what could reasonably be expected of it in co-ordinating services across the local health and care economy? • What percentage of elective and non-elective cases are admitted on the day of surgery for each specialty? • Has the trust engaged with the GIRFT programme? What improvements have been made as a result?
<p>People: How effectively is the trust using its workforce to maximise patient benefit and provide high quality care?</p>	<ul style="list-style-type: none"> • How is the trust tackling excessive pay bill growth, where relevant? • Is the trust operating within the agency ceiling? • How well is the trust reducing its reliance on temporary staff, in particular agency nurses and medical locums? • Are there significant gaps in current staff rotas? What has the trust been doing to address these? • Is the trust making effective use of e-rostering or similar job management software systems for doctors, nurses, midwives, AHPs, healthcare assistants and other clinicians? How many weeks in advance are the trust’s rosters signed off? • Is there an appropriate skill mix for the work being carried out (clinical and otherwise)? • Are new and innovative workforce models and/or new roles being investigated? Is the trust making effective use of AHPs to improve flow? • Is the trust an outlier in terms of sickness absence and/or staff turnover? • What proportion of consultants has a current job plan? How is job plan data captured?

<p>Clinical support services: How effectively is the trust using its clinical support services to deliver high quality, sustainable services for patients?</p>	<ul style="list-style-type: none"> • Is the trust collaborating with other service providers to deliver non-urgent pathology and imaging services? • Is the trust an outlier in terms of medicines spend? • Is the trust using technology in innovative ways to improve operational productivity? For example, patients receive telephone or virtual follow-up appointments after elective treatment.
<p>Corporate services, procurement, estates and facilities: How effectively is the trust managing its corporate services, procurement, estates and facilities to maximise productivity to the benefit of patients?</p>	<ul style="list-style-type: none"> • What is the trust doing to consolidate its corporate service functions? Which functions are being consolidated and how? • Is the trust an outlier in terms of procurement costs? • Is the trust looking for and implementing appropriate efficiencies in its procurement processes? • What is the value of the trust's backlog maintenance (as cost per square metre) and how effectively is it managed? • How efficiently is the trust using its estate and is it maximising the opportunity to release value from NHS estate that is no longer required to deliver health and care services?
<p>Finance: How effectively is the trust managing its financial resources to deliver high quality, sustainable services for patients?</p>	<ul style="list-style-type: none"> • Did the trust deliver, and is it on target to deliver, its control total and annual financial plan for the previous and current financial years respectively? • What is the trust's underlying financial position? • How far does the trust rely on non-recurrent cost improvement programmes (CIPs) to achieve financial targets? • What is the trust's track record of delivering CIP schemes? • Is the trust able to adequately service its debt obligations? • Is the trust maintaining positive cash reserves? • Is the trust taking all appropriate opportunities to maximise its income? • How does the trust use costing data across its service lines? • To what extent does the trust rely on management consultants or other external support services?

Ratings characteristics

21. The ratings characteristics (see below) describe what outstanding, good, requires improvement and inadequate use of resources look like. This framework, when applied using judgement and taking into account good practice and recognised guidelines, will guide NHS Improvement and CQC when assessing trusts' use of resources and determining ratings.
22. The characteristics set out the kinds of factors that will be taken into account in making the overall assessment. Ratings will reflect all the available evidence and the specific circumstances of the trust. A trust will not have to demonstrate all the attributes in a ratings characteristic to have it applied to them nor will a characteristic be applied purely because the majority of the attributes are considered to be present. Where a trust is in special measures for financial reasons, the trust rating will be no better than 'requires improvement'.

Outstanding

The trust is achieving excellent use of resources, enabling it to provide high quality, efficient and sustainable care for patients.

The trust takes a proactive, and often innovative, approach to managing its financial and non-financial resources, which supports the delivery of high quality, sustainable care and achieves excellent use of its resources.

There is a holistic approach to planning patient discharge, transfer or transition to other services that are more appropriate for the delivery of care or rehabilitation, for example a discharge to assess model, ensuring sufficient bed capacity and low numbers of delayed transfers of care.

Clinical productivity improvements are achieved by, for instance, appropriately co-ordinating services across the local health and care economy and in line with good practice identified through the GIRFT programme.

The organisation actively involves patients in scheduling elective care, leading to low DNA rates. Effective capacity and demand planning, and patient-centred care pathways support low levels of emergency readmissions and pre-procedure non-

elective and elective bed days.

There is effective control over staff costs with expenditure on staffing not exceeding initial staffing budget, low pay bill growth and low pay cost per weighted activity unit (WAU). The trust is operating below or at its agency cap and has low staff turnover and sickness levels. Innovative and efficient staffing models and roles are used to deliver high quality and sustainable care, including by ensuring there is an appropriate skill mix for the work being undertaken.

The organisation makes extensive use of job planning to effectively organise and deploy its entire workforce, including consultants, nurses and AHPs, to maximise productivity.

The trust can demonstrate the use of technology in innovative ways to improve productivity, for example through telephone and virtual follow-up appointments, real-time monitoring and reporting of operational data, medical staff job planning through e-rostering and electronic shift booking systems, e-prescribing, electronic catalogues for procurement and electronic payments.

The trust has implemented efficiencies across the majority of its procurement and back office functions, pharmacy, and pathology services through collaborative arrangements, including consolidation wherever possible, and leads transformation initiatives in these areas.

The trust's estates management, human resources and finance functions are cost effective, which is reflected in, for example, low estates and facilities running costs and a well-managed property maintenance backlog.

Financial resources are used as efficiently and effectively as possible to provide the best possible value (that is, quality and cost) to patients and taxpayers, as demonstrated by the trust's income and expenditure position.

The trust is in surplus and has an excellent track record of managing spending within available resources and in line with plans. It delivered its financial plan in the previous financial year and is on track to deliver its financial plan and meet its control total in the current financial year.

The trust has an ambitious cost improvement programme (CIP), which is currently delivering against plan, and delivered its planned savings in the previous financial year. CIPs have been driven by recurrent efficiency schemes, including those of a transformational nature.

The trust is able to meet its financial obligations and pay its staff and suppliers in the immediate term, as demonstrated by its capital service and liquidity metrics. The trust is maintaining positive cash balances without the need for interim support³ in the last 12 months.

Good

The trust is achieving good use of resources, enabling it to provide high quality and sustainable care for patients.

The trust is actively managing resources to meet its financial obligations on a sustainable basis to deliver high quality care and good use of resources. There is evidence of a systematic approach to identifying and realising efficiency opportunities.

There is a holistic approach to planning patient discharge, transfer or transition to other services that are more appropriate for the delivery of their care or rehabilitation, ensuring sufficient bed capacity and low numbers of delayed transfers of care.

Some clinical productivity improvements have been achieved by, for instance, engaging with good practice identified by the GIRFT programme.

There is some evidence of effective communication with patients in respect of scheduling care, which is manifested in the trust's DNA rates. There is evidence of pathway development and/or capacity planning at service-line level leading to reduced emergency readmission rates and pre-procedure non-elective and elective bed days.

Staff costs are generally well controlled, demonstrated by expenditure on staffing not exceeding initial staffing budget and by the trust's pay bill growth, pay cost per WAU and staff turnover and sickness levels. The trust is operating at or around its agency cap. There are some examples of staffing innovation replacing traditional models of care delivery (for example, use of nursing associates).

The organisation makes good use of job planning to organise and deploy much of

³ As defined in Secretary of State's Guidance under section 42A of the National Health Service Act 2006.

its workforce effectively, in particular doctors and nurses.

The trust uses technology in some areas to improve productivity and effectiveness, for example by good utilisation of digital systems, medical staff job planning and e-rostering systems.

The trust continues to look for and has implemented some efficiencies across its procurement and back office functions, pharmacy and pathology services, including consolidation or other collaborative arrangements.

The trust's estates management, human resources and finance functions are fairly cost effective, which is reflected in, for example, its estates and facilities running costs and an effectively managed property maintenance backlog.

The trust is in surplus and broadly on track to deliver its planned financial position in the current year. Or the trust is in deficit, but the planned position shows a marked improvement on the previous year and the trust is meeting its control total.

The trust is able to demonstrate delivery against a CIP which is forecast to deliver the planned level of improvement at the end of the year and has delivered planned savings in the previous financial year.

The trust is able to meet its financial obligations and pay its staff and suppliers in the immediate term, as reflected in its capital service and liquidity metrics. The trust is maintaining positive cash balances without the need for interim support.

Requires improvement

The trust is not consistently making best use of its resources to enable it to provide high quality, efficient and sustainable care for patients.

The trust does not consistently manage its resources to allow it to meet its financial obligations on a sustainable basis and to deliver high quality care. The approach to identifying and realising efficiency opportunities is not embedded across the organisation.

A material number of patients are not receiving care in the best clinical setting and the trust is not doing enough to address delayed transfers of care for patients out of acute hospital settings. Suboptimal discharge planning and a lack of collaborative

working are resulting in relatively high rates of emergency readmissions.

Some clinical improvements have been made; however, these have been inconsistently implemented and have not sufficiently taken into account the sustainability of the trust's service lines.

Staff costs are not effectively controlled within budget, as evidenced by the trust's pay bill growth, pay cost per WAU, distance from the trust's agency cap, and staff turnover and sickness levels. The trust consistently struggles to fill gaps in rotas, and has not maximised the benefits of innovative workforce models and new roles (for example, use of nursing associates).

The trust's use of technology to improve productivity is elementary, for example failing to maximise the benefits of job planning, e-rostering systems or basic electronic catalogues for procurement.

The trust is still at early stages of considering the implementation of efficiencies across its procurement and back office functions, pharmacy and pathology services, including through consolidation or other collaborative arrangements.

The trust's estates management, human resources and finance functions could be more cost effective, which is reflected, for example, in its estates and facilities running costs and inconsistent management of its property maintenance backlog.

The trust is in deficit and is delivering a financial plan that does not improve on the previous year's position or meet its control total.

The trust did not realise its cost improvement programme for the previous financial year. Its current cost improvement programme is behind plan, and there is significant risk it will not be achieved by the end of the year.

The trust is not able to consistently meet its financial obligations or pay its staff and suppliers in the immediate term, as demonstrated by its capital service and liquidity metrics. The trust is unable to maintain positive cash balances without the need for interim support or is expecting to require this support in its current plans.

Inadequate

The trust is not making adequate use of its resources, putting at risk its ability to provide high quality, efficient and sustainable care for patients.

The trust is not managing its resources in a way that supports the delivery of high quality care or demonstrates adequate use of resources is being achieved. There are significant and wide-ranging unmet efficiency opportunities.

The trust is unable to control its staff costs, including, for instance, unwarranted pay bill growth that is significantly higher than comparable peers, high pay cost per WAU, and agency costs that are more than 50% above the trust's agency cap. The trust's workforce is not being used effectively, demonstrated by substantial or frequent staff shortages, high turnover and staff sickness rates and ineffective job planning.

The trust's estates management, human resources and finance functions are inefficient, demonstrated by, for example, high estates and facilities running costs. There is no effective programme in place to repair and maintain the trust's estate.

The trust is not utilising its existing digital systems effectively and is doing little to use technology to improve efficiency; for example, there is no use of basic electronic catalogues for procurement and no payments are made electronically.

The trust has undertaken little or no work to implement efficiencies across its procurement and back office functions, pharmacy and pathology services, including through consolidation or other collaborative arrangements.

Plans for patient discharge or transfers are incomplete or significantly delayed, and as such patients are not moved into settings that are more appropriate for the delivery of their care or rehabilitation, or are not being cared for in the best clinical setting. Poor discharge planning and a lack of collaborative working are resulting in unacceptably high rates of emergency readmissions.

Few clinical improvements have been made, often implemented inconsistently and having little or no impact on the sustainability of the trust's service lines.

The trust is in deficit and its financial plan does not improve on the previous year's position or meet its control total. Or the trust is in deficit and off track to deliver its financial plan and is not expecting to recover within the financial year.

The trust's CIP is materially behind plan and it is not able to recover the position.

The trust is not able to meet its financial obligations or pay its staff and suppliers in the immediate term, as demonstrated by its capital service and liquidity metrics.

The trust is unable to maintain positive cash balances without the need for interim support.

Appendix A: Use of Resources metrics and rationale

Area	Initial metrics	Rationale
Clinical services	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.
	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.
	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. Better performers will have a lower rate of readmission.
	Did not attend (DNA) rate	A high level of DNAs indicates a system that might be making unnecessary 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.
People	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.
	Sickness absence	High levels of 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.

	Pay cost per weighted activity unit (WAU, a unit of clinical output)	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.
	Doctors cost per WAU	This is a doctor-specific version of the above 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.
	Nurses cost per WAU	This is a nurse-specific version of the above 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.
	AHP cost per WAU	This is an AHP-specific version of the above 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.
Clinical support services	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. A 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.
	Top 10 medicines	As part of the top 10 medicines project, trusts are set trust-specific monthly savings targets related to their choice of medicines. This includes the uptake of biosimilar medicines (complex medicines that are clinically comparable to the branded product), 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).
Corporate services, procurement, estates and facilities	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.

	HR cost per £100 million turnover	This metric shows the annual cost of the 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.
	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.
	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 for five 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.
	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	Capital service capacity	This metric assesses the degree to which the organisation's generated income covers its financing obligations.
	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.
	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.
	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.
	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.

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