The Ipswich Hospital NHS Trust

Use of Resources assessment report

Address: Heath Road, Ipswich, IP4 5PD

Tel: 01473 712233
www.ipswichhospital.nhs.uk

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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.

How effectively is the trust using its resources?	**Requires improvement** ●

How we carried out this assessment

The aim of Use of Resources assessments is to understand how effectively providers are using their resources to provide high quality, efficient and sustainable care for patients. The assessment team has, according to the published framework, examined the trust's performance against a set of initial metrics alongside local intelligence from NHS Improvement's day-to-day interactions with the trust, and the trust's own commentary of its performance. The team conducted a dedicated site visit to engage with key staff using agreed key lines of enquiry (KLOEs) and prompts in the areas of clinical services; people; clinical support services; corporate services, procurement, estates and facilities; and finance. All KLOEs, initial metrics and prompts can be found in the Use of Resources assessment framework.

We visited the trust on 24 October 2017 and met the trust's executive team (including the chief executive), a non-executive director (in this case, the chair and deputy Chair) and relevant senior management responsible for the areas under this assessment's KLOEs.

Findings

Is the trust using its resources productively to maximise patient benefit?	Requires improvement

We rated use of resources as Requires Improvement because the trust is not consistently making best use of its resources to enable it to provide high quality, efficient and sustainable care for patients.

- For the year ended 31 March 2017, the trust reported a deficit of £17.6m, which was an improvement on the trust's plan and the target (referred to as the 'Control Total') set by NHS Improvement of £20.1m.
- After the first two quarters of the year the trust is off track to meet its £18.1m 2017/18 control total with a current Q2 deficit position of £14.1m excluding STF (£13.0m including STF) versus a Q2 plan of £12.3m and Forecast Outturn of £18.1m deficit. The current deficit position means the trust is reliant on DH revenue support loans in order to meet its obligations, and has one of the highest deficit / turnover ratios when compared to other trusts in the East of England (ranked 13 out of 17 at Q2 2017/18).
- The trust is forecasting income of £315m for 2017/18, income at M6 is £149.2m (2016/17 £323.4m).
- The scale of the deficit and corporate and financial productivity metrics benchmark poorly when compared to other trusts.
- Evidence regarding the return on investment and positive impact on financial performance was lacking.
- The trust spends more on non-pay per unit of activity than most other Trusts (£1,371 compared with the national average of £1,320). Cost per WAU metrics for clinical and general supplies, medicines and estates and facilities are all in the third most expensive quartile. This suggests that it may be able to reduce its spending on supplies and services.

However:

- The trust performed well, particularly in relation to clinical services, workforce and clinical support services productivity metrics, where the pay cost per WAU is £1,893, the 11th lowest in the country.
- The trust is currently meeting Referral To Treatment (RTT) and cancer core operational performance standards and has made significant progress in reducing delayed transfers of care. It is consistently in the top quartile for Accident & Emergency Care (A&E) performance nationally.
- The trust is particularly engaged in identifying efficiency opportunities around pharmacy, through reviewing the skill mix within its pharmacy team and putting pharmacists on wards in the afternoons and weekends to speed up discharge and there is an opportunity to extend this to other areas.
- The trust has made good progress towards a transaction with Colchester Hospital which alongsideclinical benefitsis expected to realise back office efficiencies including procurement, more efficient staffing to make best use of of scarce clinical resourceand use of collaborative banks.

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 is currently meeting the core operational performance standards of Referral to Treatment and Cancer waiting times. Although not consistently performing above the

national standard for A&E, it has averaged 6.9% above the average performance for the Midlands and East year-to-date (YTD) and is consistently in the top quartile for ED performance nationally.

- The trust has reduced Delayed Transfers of Care from 6.4% at April 2016 to 3.5% at October 2017 through joint working with social care. The trust has engaged well with the wider health economy to deliver an agreed stretch target of 20 Delayed Transfers of Care, which it is currently meeting, although at times of stress this is exceeded. The trust recognises that it has fewer weekend discharges than its peers and has clear plans in place to address including social care providing a Saturday and Bank Holiday service.
- The trust and clinical commissioning group (CCG) have jointly developed Clinical Transformation Groups (CTGs) which bring together system partners to enable efficient and effective holistic pathways. Musculoskeletal (MSK) services was the first CTG which has brought together a redesigned pathway, with greater use of community physiotherapy, who also undertake referral triage and has driven down Trauma & Orthopaedics (T&O) outpatient activity from 1,200 to 775 per month for First Outpatients Appointment and from 1,500 to 1,200 per month for Follow Up Appointments from April 2016 to October 2017. CTGs are now in place in: Paediatrics, Gastroenterology, Ophthalmology and Respiratory.
- Through admission avoidance schemes the trust has seen an overall reduction in the number of emergency admissions in excess of plan. Community services are now the responsibility of the trust, which has provided more opportunity to improve discharges and reduce admissions.
- Clear pre-operative assessments are in place for patients to ensure good use of resources with 'one stop' clinics and a surgical pathway pre-admission stay in place for MSK and Colorectal patients where treatment is required in advance of surgery.
- The trust has reduced demand for outpatient appointments by 16% and for follow up attendances by 7.5% between April and October 2017 through utilising electronic referrals, ensuring pre-referral guidance is followed by GPs and developing innovative solutions to support specialities with capacity issues, for example, implementing remote monitoring ('myCOPD') within respiratory.
- The trust has reviewed which of their services are financially sustainable but is mindful that clinical viability should take priority to ensure patient care is maintained.
- A conscious decision has been made to invest in upskilling the AHP workforce, particularly in therapies, to address increased demand arising from an ageing and growing population. This has led to a relatively low length of stay (LoS) in T&O.
- The Getting It Right First Time (GIRFT) programme is being well adopted across a number of specialities with examples of improvement shared from paediatric urology reviews. However, there is no GIRFT champion at executive level, and the lessons from the GIRFT reviews have not been shared widely across the trust or formally reported at Board level.

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

- Staff rostering work was an area of strength for the trust with rosters for clinical staff published 12 weeks in advance and reviewed weekly. Vacancy shifts are put out to bank before being issued to agencies.
- There is a nursing tool in place which focuses on effective rostering. This looks ahead three shifts to ensure the next 24 hours are adequately staffed. Acuity and dependency are reviewed and each ward is RAG rated to ensure gaps are identified and escalated appropriately.
- For long term locum doctors and nursing agency staff, teams have clear plans in place to either look at alternative solutions or for those staff to join the trust's bank. However, there

are a number of areas that are very dependent on locum doctors, such as the Emergency Department, radiology and surgery, due to difficulties with substantive recruitment.
- The trust's current run rate indicates that it will probably exceed its agency ceiling of £8m in 2017/18.
- Staff retention is good at 91.7% in 2016/17, although this has declined slightly to the current level of 90.6%. In response to the 2016 staff survey results the trust launched a 16 week staff engagement rapid action plan 'ENGAGE:IMPROVE:SUCCEED' - a structured programme of work which focusses on driving improvements in areas where staff reported low satisfaction. Both turnover and sickness have clear Board oversight with HR support to monitor and reduce both short and long term sickness and review recruitment processes. There is a POD (people, organisation and development) strategy in place. There was recognition that additional work was required to review employees who left the trust within 12 months of employment to understand their reasons for leaving.
- The trust is in the lower quartile for staff sickness at 4% for 2016/17 and short term sickness absence remains a challenge. The trust gives help to staff to manage their conditions at work and has three full time staff who work on employee relations.
- There is executive sign off of price cap overrides when hiring agency staff, however the team may need to consider tighter controls to ensure this is consistently applied.
- The trust has started to consider team job planning, however Medical job planning requires more focus. The trust told us at the site visit that 60-90% of job plans are in place which is lower than peers. (The expectation is that 90% of consultants have a job plan in place.) The trust has an existing Job Planning user group so there is an opportunity to use this to drive improvement. Job planning for pharmacists is not in place.
- Medical pay was both significantly above and significantly below the average depending on speciality.

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

- The pharmacy and medicine cost per WAU is in the third most expensive quartile. As at the end of August 2017, the Trust had delivered 93% of its top 10 medicine target for the year to date.
- Biosimilar uptakes are particularly good for Infliximab and Etanercept at 99.2% and 87.3% respectively, but much lower for other biosimilars. There is some mitigation in respect of the low progress for two of the biosimilars (Imatinib and Rituximab) for some cohorts of the trust's patients, but there are more biosimilar switching opportunities that the trust could pursue.
- The trust has reviewed the skill mix within its pharmacy team, has put pharmacists on wards in the afternoons and weekends to speed up discharge, and invested time to support frailty assessments.
- The trust is working as part of a joint pathology service with West Suffolk and Colchester, which it has had to re-build following an unsuccessful joint venture with six other trusts further west. The pathology cost per test is above average, and is driven up by high agency costs. The trust recognises that there are opportunities to reduce its pathology costs.
- The trust has taken positive steps to make better use of technology to improve productivity. For example the work done at the outpatients check in kiosk to check patients mobile and email details are up to date helps the trust contact patients in different ways, and contributes to the trust's very low Did Not Attend (DNA) rate of 5.38% for 2017/18 to date compared with the national average of 7.54%.
- The trust has an agreement with the Eastern Health Scientific Network (EASHSN) to develop and test apps to enable remote monitoring of some patient conditions. For example a "My COPD" app is currently being piloted with a group of patients.

- New technology is also being used to track equipment locations and servicing dates, to publish and book staff bank shifts on-line and to speed up digital identity checks.

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

- The trust's non pay cost is above average. This suggests that the trust may be able to reduce its spending on supplies and services.
- The NHS Improvement Procurement Process and Price Performance score for this trust is in the lowest quartile. This is because the trust has not made use of NHS Improvement's Purchase Price Index and Benchmark (PPIB) tool and is paying on average 12.8% above the median prices in the PPIB database. This equates to a potential productivity opportunity of £1.2m in the trust's procurement operations. The trust has not identified a specific saving against this in its cost improvement plans (CIPs). The trust has outsourced its procurement operations, but has not used the procurement intelligence available to manage the contract in a way that realises these potential savings and reduces its expenditure on supplies and services.
- Overall 2015/16 estates and facilities costs per m^2 are above average. Metrics covering cleaning and portering are better than average. The catering cost per meal is £4.49 which is high and patient satisfaction, as measured by the patient PLACE survey is very low. The Laundry cost per item is high and the number of items per weighted activity unit of treatment is also in the highest quartile, suggesting there are productivity opportunities here. The trust has started a tendering process to re-let its current hotel services contract.
- The main hospital buildings are predominately single storey with over 30% of under-utilised space. There is a maintenance backlog of £17m and the critical infrastructure risk is £7.3m. The trust has acquired a piece of land to the south of the current hospital site. This will enable the trust to reconfigure the hospital site to make it more productive through better clinical adjacency. Although the trust has identified that some land could be disposed of as a result of the re-configuration, it does not have the estimated £170m that would be required for the scheme.
- In respect of corporate services, relative to the trust's turnover, HR costs are average, but finance costs are in the highest quartile. The trust suspect that the high finance costs were due to a small number of expensive temporary staff who were recruited for specific projects and are no longer with the trust. The trust has not done any up to date benchmarking to confirm this. Payroll costs are in the lowest (best) quartile.

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

- The initial metrics for this domain are based on reported financial performance.
- In 2016/17 the trust reported a deficit of £17.6m. This was an improvement on plan and the designated Control Total, but placed the trust in the lowest (worst) category of the other core NHS Improvement Single Oversight Framework metrics of Liquidity, Capital Servicing, and Income and Expenditure Margin. This remains unchanged at Q2 2017/18.
- In 2016/17 the trust received non recurrent income of £9.5m (standard Sustainability and Transformation Funding (STF) of £7m and bonus STF of £2.5m). This left an underlying deficit of £27.1m which was supported by non-recurrent CIP of £3.8m. Therefore the underlying position going into 2017/18 was a £30.8m deficit.
- The reported position shows the trust has one of the highest (worst) deficit / turnover ratios when compared to other trusts in the East of England (ranked 15 out of 20 for 2016/17 and 13 out of 17 at M6 2017/18) and in order to meet its financial obligations, the trust is reliant on access to external financial support from Department of Health.
- The trust reported 2016/17 savings of £11.6m (4.1% of expenditure), of which £8.2m (2.8% of expenditure) were reported as recurrent. This level of delivered savings compares well

with peers, although the level of recurrent savings does not. However, this has not resulted in a significant improvement to the trust's underlying deficit. At M6 2017/18, excluding STF the trust has a deficit of £14.1m against a planned deficit of £12.3m.

- The divisional CIP target for 2017/18 is £15.75m or 5% of expenditure (including a £2m 'stretch target') of which £13.3m is identified (£12.7m recurrently).
- The trust is in the process of completing a financial recovery plan for 2017/18 and is working with divisions to improve their CIP delivery with targeted support to struggling divisions and stretch targets in place. As discussed at the site visit, a range of actions were identified for Board approval in an October Board paper and the Quality Impact Assessment was being completed at the time of the visit.
- The trust has been on a guaranteed income contract for the last two financial years. It has a good relationship with commissioners and discussions around additional financial support during 2017/18 are ongoing.
- The trust has not made much progress in freeing up capacity to enable it to carry out additional activity from local areas, including independent sector repatriation. We noted that the trust should consider whether there is any additional retail or commercial income opportunity. The trust regularly reviews its forecasting accuracy and working capital management. It has good costing tools in place which it plans to roll out further as part of the partnership working with Colchester Hospital University NHS Foundation Trust.
- The trust is in the process of implementing work around unwarranted variations in clinical costs and this appeared to have good clinical buy-in, but was at an early stage of implementation.

Outstanding practice

The trust and CCG have jointly developed Clinical Transformation Groups (CTGs) which bring together system partners to enable efficient and effective holistic pathways, driving down system costs. MSK services was the first CTG which has brought together a redesigned pathway, with greater use of community physiotherapy who also undertake referral triage. CTGs are now in place in: Paediatrics, Gastroenterology, Ophthalmology and Respiratory.

Areas for improvement

- The trust demonstrated a number of examples of innovative practice, but evidence regarding the return on investment and positive impact on financial performance was lacking.
- The trust has made no use of NHS Improvement's PPIB tool and is paying on average 12.8% above the median prices in our PPIB database. The Trust has not identified a specific saving against this in its cost improvement plans (CIPs).
- The trust has outsourced its procurement operations, but has not used the procurement intelligence available to manage the contract in a way that realises these potential savings and reduces its expenditure on supplies and services. Specific opportunities were identified by the Use of Resources assessment team in catering and laundry. Medical job planning requires more focus as only 60-90% of job plans are in place, which is lower than peers.

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)	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.

cost per £100 million turnover	
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	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.