University Hospital Southampton NHS Foundation Trust

| Report to the Trust Board of Directors | | | | |
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| **Title:** | **Finance Report 2022-23 Month 10** | | | |
| **Agenda item:** | **11.2** | | | |
| **Sponsor:** | **Ian Howard – Chief Financial Officer** | | | |
| **Author:** | **Philip Bunting – Director of Operational Finance**<br>**David O'Sullivan – Assistant Director of Finance – Financial Performance** | | | |
| **Date:** | **28 February 2023** | | | |
| **Purpose** | **Assurance or reassurance** | **Approval** | **Ratification** | **Information**<br>**X** |
| Issue to be addressed: | The finance report provides a monthly summary of the key financial information for the Trust. | | | |
| Response to the issue: | **M10 Financial Position**<br><br>UHS has received confirmation of an additional £3.8m of income in 22/23, including £2.3m from Specialised Commissioning and £1.5m of national discharge funding. A further £5.3m requested for ERF over-performance is unlikely to be received as the ICB has not over-performed overall and claw-back has not been applied.<br><br>As a result, a revised forecast position of **£16.4m (1.4%) deficit** has been agreed with HIOW ICB subject to any further income flowing into the system. This has now been formally signed off as part of the forecast protocol and shared with NHS England.<br><br>Due to the additional income being received in M10, UHS reported a surplus of £1.6m in January 2023, which is now a £16.3m deficit YTD. A 'flight path' was developed as part of the financial recovery process and the in-month position was reported as expected following receipt of the additional income.<br><br>**Underlying Position**<br><br>The underlying position for January is £3.6m deficit which is a reduction to that of December £4.1m. This improvement is due to lower than anticipated energy cost pressures in month. The overall position remains increased in comparison to Q1 and Q2 due to significant operational pressures requiring further spend on unfunded capacity and an overall increase in energy costs vs prior periods.<br><br>**Key drivers**<br><br>The key drivers for the underlying position remain consistent with previous monthly reports and are listed in the table below. Most of these are classed as uncontrollable with UHS having limited ability to directly influence the level of cost pressure being experienced in some areas. These have been partly offset by planned CIP and further to that additional CIP or additional income being achieved. This has helped UHS report a lower deficit number than the underlying position of £35.4m deficit YTD. | | | |

| Cost Driver | Rationale | Controllable / Uncontrollable | Underlying Variance to Breakeven (YTD £m) |
|---|---|---|---|
| Covid Costs | Covid volumes in excess of 'low covid environment' assumed within plan | Uncontrollable | 5.1 |
| Pay Inflation | Pay award funding does not cover costs in full | Uncontrollable | 1.9 |
| Non Pay Inflation | Rates of inflation are in excess of planned expectations | Uncontrollable | 9.9 |
| Energy Costs | Energy costs have increased beyond that expected. | Uncontrollable | 9.5 |
| Criteria to Reside | Medically optimised patients still residing leading to flex bed costs. | Uncontrollable | 2.6 |
| Additional Bank Holiday | One off costs were incurred relating to bank holiday enhancements | Uncontrollable | 0.2 |
| Drugs and devices expenditure in excess of block funding | Drugs and devices costs have been in excess of the block funded level due to additional NICE approvals and new treatments approved. | Uncontrollable | 9.7 |
| Emergency Department | ED costs are in excess of planned levels due to activity and workforce pressures. | Controllable | 4.4 |
| CIP | Planned CIP Offset | Controllable | (7.9) |
| **Underlying Deficit YTD** | | | **35.4** |
| Additional CIP Achievement / Additional Income / Other One Offs | | | (19.1) |
| **Reported Deficit YTD** | | | **16.3** |

## ERF Position

UHS achieved 100% in January which is a reduction from December and below the national target. January was a month of significant operational pressure and included two days of industrial action. It is estimated that without the industrial action activity would have been 104% of 19/20 levels.

UHS is reporting achievement of 105% YTD ahead of the national 104% target and consistent with that planned. Indicatively UHS has achieved £5.0m of income relating to ERF. This is part of the fixed settlement with Specialised Commissioning for their element of income.

ERF funding for overperformance in ICB contracts is unlikely to be funded. This creates a funding pressure for UHS but given the lack of clawback in other organisations nationally creates a distorting impact when comparing like for like bottom-line financial performance. UHS maintains a higher cost-base from maintaining the higher levels of activity.

## CIP

The Trust has achieved delivery of £33.3 YTD, £1.2m below the target of £34.5m. Identification of CIP schemes remains at £42.7m of the £45.4m target (94%) and equates to an overall achievement of 3.5% of income. We are looking to commit to achievement of the full target and close the remaining gap within the Financial Recovery Plan.

This achievement level is beyond what has previously been achieved by the Trust, particularly given the operational challenges faced and the financial framework meaning inability to achieve CIP through additional activity. In month the finance team have managed to embed the recurrent learning from previous VAT advisor's annual reviews and are now recognising increased VAT recovery of c£0.1m per month.

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| | **Financial Recovery**<br><br>Financial recovery remains a significant priority for the trust. Progress continues to be made via the Trust Savings Group and Transformation Oversight Group following on from the finance summit held in December. Actions completed since the December F&IC:<br><br>• Outsourcing spend has reduced in January after enacting stricter controls on its usage<br>• Revised financial governance and controls have been discussed and agreed at the Trust Executive Committee in January<br>• A review of the trusts balance sheet has taken place with HIOW ICS and NHSE Regional colleagues<br>• Tightened agency spend controls continue to report reduced spend on high-cost agency<br>• The Transformation Oversight Group (TOG) is in the process of setting priorities for 23/24<br><br>**Capital**<br><br>The Trust has reported capital expenditure of £12.7m in month and has spent £54.7m YTD. Within the remaining two months of 2022/23 the trust has £35.3m still to spend in order to deliver internal CDEL spend in full and externally funded commitments in full.<br><br>Due to the risk of slippage, we have identified a number of schemes to bring forward expenditure from 2023/24, including increasing in year spend on the wards development. This is mitigating the risk of underspend at the end of the year. The amount left to spend has been circulated to responsible owners in month to ensure clarity, with progress and risks reported regularly at the Trust Investment Group.<br><br>Although this represents a significant step change feedback from project managers is that there is confidence in delivery. Due to the level of risk however further mitigations are being explored as slippage into 2023/24 will cause a problem as future projects may need deferring in order to contain costs within CDEL allocations.<br><br>**Cash**<br><br>The cash position has deteriorated £7.0m from the previous month reducing to £92.9m. This was predominantly due to capital expenditure increases in month. The underlying trend remains consistent with the previous forecast. Cash is therefore anticipated to reduce further in the remainder of 2022/23 as capital expenditure increases and with it an underlying deficit prevails. There is also a significant amount of cash drawdown for external CDEL schemes anticipated in Q4. We are therefore anticipating short-term volatility in the cash position.<br><br>We are continuing to have a current-account deficit, which is being funded by our capital investment savings account. Should the current run-rate continue, UHS will approach the set Minimum Cash Holding position in mid-2023/24. This continues to be monitored closely. A revised cash forecast is being prepared as part of the planning process.<br><br>**HIOW ICB Position**<br><br>A revised forecast position for the HIOW ICS is still under review. A verbal update on the latest position will be provided. |
| Implications: | • Financial implications of availability of funding to cover growth, cost pressures and new activity.<br>• Organisational implications of remaining within statutory duties. |

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| Risks: (Top 3) of carrying out the change / or not: | • Financial risk relating to the underlying run rate and projected potential deficit if the run rate continues.<br>• Investment risk related to the above<br>• Cash risk linked to volatility above<br>• Inability to maximise CDEL (which cannot be carried forward) and the risk of a reducing internal CDEL allocation for 2023/24 due to the forecast deficit for 2022/23. |
| Summary: Conclusion and/or recommendation | Members of Trust Board are asked to:<br>• Note the update to the financial position. |

**Finance Report Month 10**

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|---|---|
| **Report to:** | **Board of Directors and Finance & Investment Committee**<br><br>**January 2022** |
| **Title:** | **Finance Report for Period ending 31/01/2023** |
| **Author:** | **Philip Bunting, Director of Operational Finance** |
| **Sponsoring Director:** | **Ian Howard, Chief Financial Officer** |
| **Purpose:** | **Standing Item** |
| | **The Board is asked to note the report** |

**Executive Summary:**

**In Month and Year to date Highlights:**

1. In Month 10, UHS reported a surplus position of £1.6m which was £0.2m favourable to the planned £1.4m surplus. The YTD position is £16.3m deficit which is £13.3m adverse to the planned deficit target of £3.0m.

2. The underlying position is however £35m deficit YTD with one off benefits helping improve the in year reported position. Estimates of the forecast indicate an intermediate projection of £16.4m after accounting for non recurrent costs and benefits. This is heavily influenced by largely uncontrollable costs relating to covid, inflation, MOFD numbers and energy expenditure.

3. CIP YTD delivery is £33.3m, an increase from the £29.5m achieved at M9. This is below the planned YTD delivery of £34.5m by £1.1m. Of the £33.3m delivered YTD £15.4m has been transacted by Divisions and Directorates and £17.9m has been transacted through Central Schemes.

4. The main income and activity themes seen in M10 were:
    1. UHS has delivered 100% of Elective Recovery activity in M10.
    2. Indicative ERF income totals £5.0m year to date.
    3. At M10 the unfunded pressure for ICB block funded drugs and devices is £9.7m of which £7.2m is from drugs.

5. The underlying deficit of £3.6m in month is driven by:
    1. Drugs & Devices (£0.8m per month) – partly offset with CIP
    2. Energy costs – (£0.8m per month) – Inflationary pressure increasing – partly offset by CIP
    3. Covid related staff costs – (£0.6m per month) – continued sickness absence costs and covid spend which has not reduced as per planning assumptions
    4. Inflationary and pay award pressures (£1.2m per month) – costs are unfunded
    5. Activity and MOFD related pressures (£0.5m per month) – ED costs above plan as a result of significant operational pressure.

## Finance: I&E Summary

A surplus position of £1.6m was reported in January favourable to the planned position of £1.4m surplus. The YTD position of £16.3m deficit is £13.3m adverse to the planned £3.0m deficit target.

In month there was particular pressure on bank spend due to sickness absence and continued operational pressures requiring flex bed capacity to be utilised. Overspends are being experienced across the majority of expenditure categories which are being partially offset by overachievement of income such as pay award funding and pass through income.
Other income is significantly over plan YTD (£40.9m) relating to two significant covid R&D studies. These do however have offsetting costs within Other non pay.

The Trust has formally revised its reported outturn forecast for 2022/23 to £16.4m.

| | | Current Month | | | Cumulative | | | Full Year | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Plan £m | Actual £m | Variance £m | Plan £m | Actual £m | Variance £m | Plan £m | Forecast £m | Variance £m |
| NHS Income: | Clinical | 69.7 | 69.6 | 0.2 | 697.6 | 708.9 | (11.4) | 837.0 | 850.7 | (13.7) |
| | Pass-through Drugs & Devices | 11.2 | 15.7 | (4.5) | 112.2 | 130.5 | (18.3) | 134.6 | 156.6 | (22.0) |
| Other income | Other Income excl. PSF | 10.5 | 31.5 | (20.9) | 105.5 | 146.4 | (40.9) | 126.6 | 155.7 | (29.1) |
| | Top Up Income | 0.6 | 0.5 | 0.0 | 7.2 | 6.7 | 0.5 | 8.3 | 8.0 | 0.3 |
| **Total income** | | **92.1** | **117.3** | **(25.2)** | **922.4** | **992.5** | **(70.1)** | **1,106.6** | **1,171.0** | **(64.4)** |
| Costs | Pay-Substantive | 49.7 | 51.7 | 2.0 | 491.2 | 505.9 | 14.7 | 591.6 | 607.1 | 15.5 |
| | Pay-Bank | 2.4 | 4.3 | 1.9 | 29.0 | 39.2 | 10.1 | 33.2 | 42.0 | 8.9 |
| | Pay-Agency | 0.9 | 1.0 | 0.2 | 10.6 | 12.1 | 1.5 | 12.0 | 12.5 | 0.5 |
| | Drugs | 4.7 | 3.7 | (1.0) | 50.2 | 50.8 | 0.5 | 59.7 | 63.4 | 3.7 |
| | Pass-through Drugs & Devices | 11.2 | 15.7 | 4.5 | 112.2 | 130.5 | 18.3 | 134.6 | 156.6 | 22.0 |
| | Clinical supplies | 5.2 | 4.9 | (0.3) | 64.3 | 67.0 | 2.7 | 74.6 | 77.9 | 3.3 |
| | Other non pay | 15.7 | 34.1 | 18.4 | 158.4 | 195.2 | 36.7 | 189.6 | 216.4 | 26.8 |
| **Total expenditure** | | **89.8** | **115.5** | 25.8 | **916.0** | **1,000.6** | **84.6** | **1,095.3** | **1,175.99** | **80.7** |
| **EBITDA** | | **2.3** | **1.8** | **0.6** | **6.4** | **(8.1)** | **14.5** | **11.2** | **(5.0)** | **16.2** |
| **EBITDA %** | | 2.6% | 1.5% | 1.0% | 0.7% | -0.8% | 1.5% | 1.0% | -0.4% | 1.4% |
| | Non operating expenditure/income | (0.9) | (0.2) | 0.7 | (9.3) | (8.1) | 1.2 | (11.1) | (11.1) | 0.0 |
| **Surplus / (Deficit)** | | **1.4** | **1.6** | **(0.2)** | **(2.9)** | **(16.2)** | **13.3** | **0.1** | **(16.1)** | **16.2** |
| Less | Donated income | (0.1) | (0.2) | 0.0 | (1.2) | (1.4) | 0.2 | (1.4) | (1.4) | 0.0 |
| | Gain/ Loss on absorption | | | 0.0 | | (0.4) | 0.4 | | (0.9) | 0.9 |
| Add Back | Donated depreciation | 0.1 | 0.2 | 0.1 | 1.1 | 1.7 | 0.6 | 1.3 | 2.0 | 0.7 |
| **Net Surplus / (Deficit)** | | **1.4** | **1.6** | **(0.2)** | **(3.0)** | **(16.3)** | **13.3** | **0.0** | **(16.4)** | **16.4** |

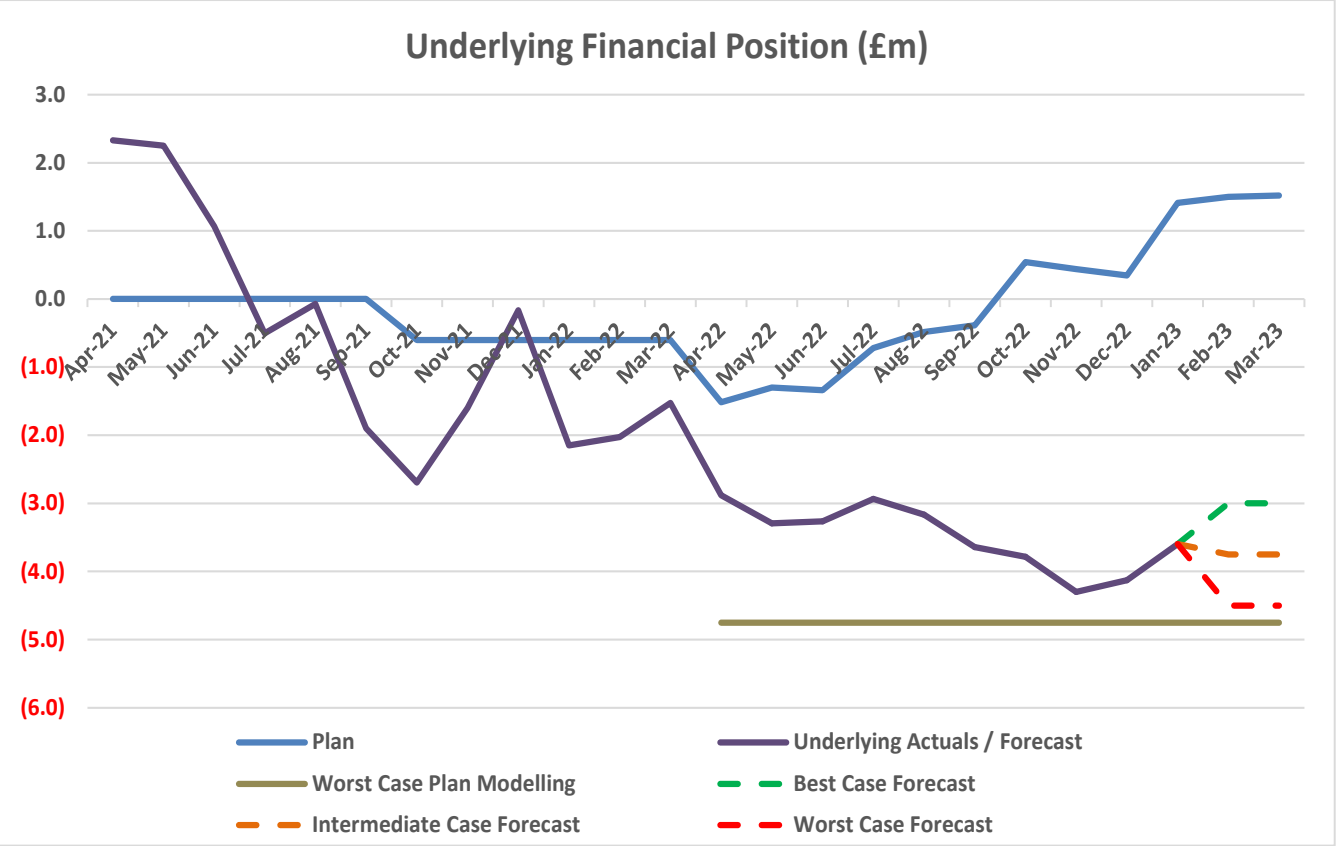
**Finance Report Month 10**

## Monthly Underlying Position

The graph shows the underlying position for the Trust from April 2021 to present.

This differs from the reported financial position as it has been adjusted for non recurrent items (one offs) and also had any necessary costs or income rephased by month to get a true picture of the run rate. The underlying position is £3.6m deficit in M10 down from £4.1m in M9.

The run rate from month 1 to month 10 is on average £3.5m deficit per month due mainly to energy cost pressures (seasonality impact also), continuing covid pressures, inflationary pressures and the unfunded pay award pressures. This is in addition to activity related operational pressures especially within ED and related to delayed discharges. A range of deficit scenarios have been modelled which are shown on the graph and are shown within the table overleaf.



## Financial Risks

The table illustrates the key variables driving the underlying deficit position.

This illustrated an underlying forecast between £40.5m deficit and £44.5m deficit with an intermediate forecast assessment of £42.5m deficit before non recurrent CIP is added and any additional income or stretch applied. This remains consistent with the previous month.

| | | | Forecast Assessment | | |
|---|---|---|---|---|---|
| **Risk Variable** | **Controllable / Uncontrollable** | **Original Worst Case Assessment (£m)** | **Best Case (£m)** | **Intermediate Case (£m)** | **Worst Case (£m)** |
| Cost Improvement Plans not fully delivered | Controllable | (28.9) | 0.0 | 0.0 | 0.0 |
| Covid 19 remains at above 'background' levels meaning costs don't reduce | Uncontrollable | (17.0) | (4.9) | (5.1) | (5.3) |
| Inflationary pressures impacting the price of goods and services (including stockouts) | Uncontrollable | (11.3) | (11.7) | (11.9) | (12.1) |
| Energy Cost prices continue to rise | Uncontrollable | | (10.7) | (11.0) | (11.3) |
| Block drugs and devices costs continue to overspend | Uncontrollable | 0.0 | (11.0) | (11.5) | (12.0) |
| Medically optimised for discharge numbers do not reduce and flex beds remain open | Controllable | 0.0 | (2.9) | (3.1) | (3.3) |
| Emergency Department | Controllable | 0.0 | (5.2) | (5.3) | (5.4) |
| Pay Award Funding Gap | Uncontrollable | 0.0 | (2.3) | (2.3) | (2.3) |
| Additional Bank Holiday Costs | Uncontrollable | 0.0 | (2.9) | (2.9) | (2.9) |
| Cost Improvement Plans Offsetting (Within Plan) | Controllable | 0.0 | 10.6 | 10.6 | 10.6 |
| **Underlying Deficit Subtotal** | | **(57.2)** | **(41.0)** | **(42.5)** | **(44.0)** |
| Non Recurrent CIP (Within Plan) | | | 5.0 | 5.0 | 5.0 |
| Additional Income / Stretch Achievement | | | 21.1 | 21.1 | 21.1 |
| **Reported Deficit Total** | | **(57.2)** | **(14.9)** | **(16.4)** | **(17.9)** |

University Hospital Southampton NHS
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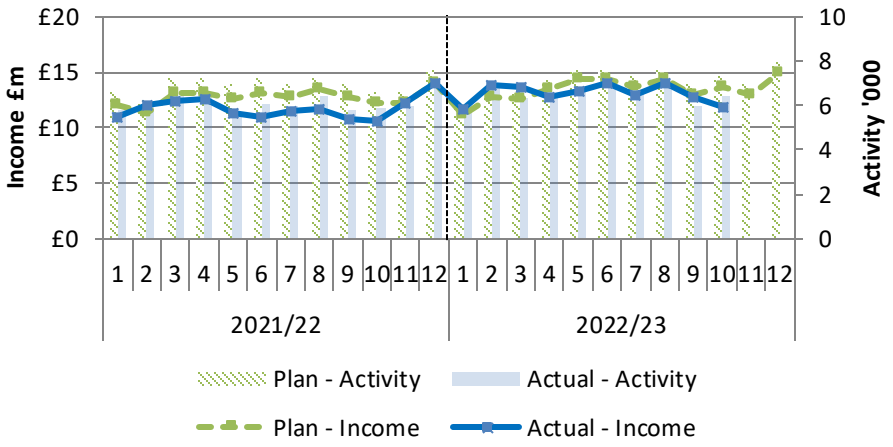
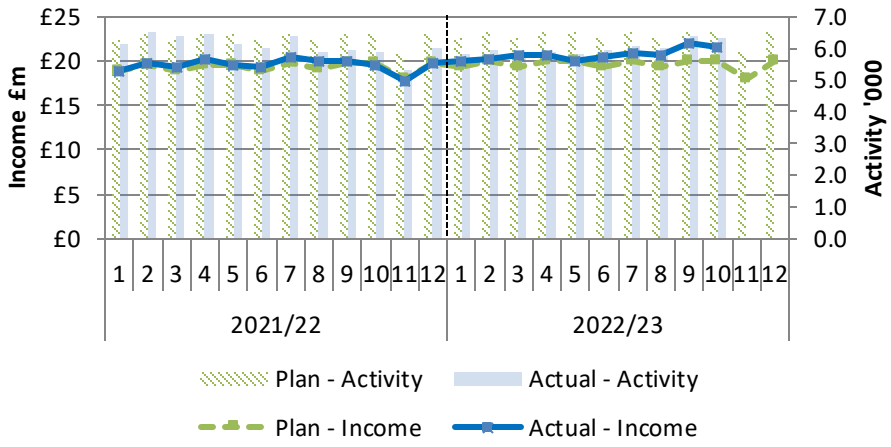
Clinical Income

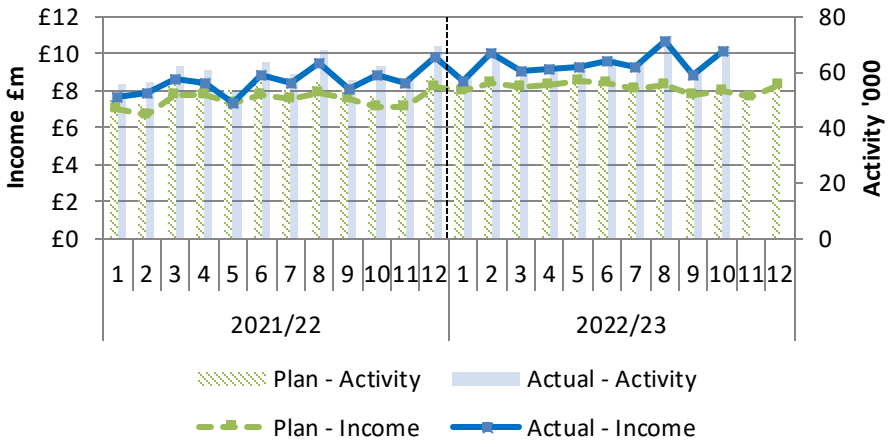
## Elective spells



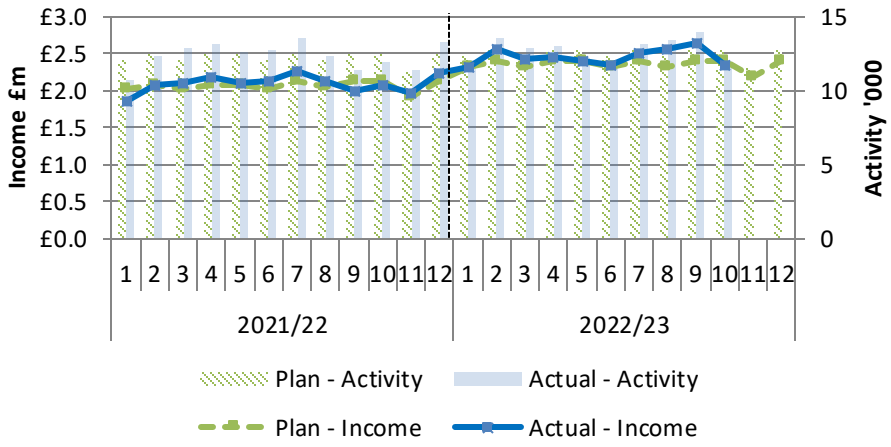

## Non elective spells




## Outpatients Total




## A&E



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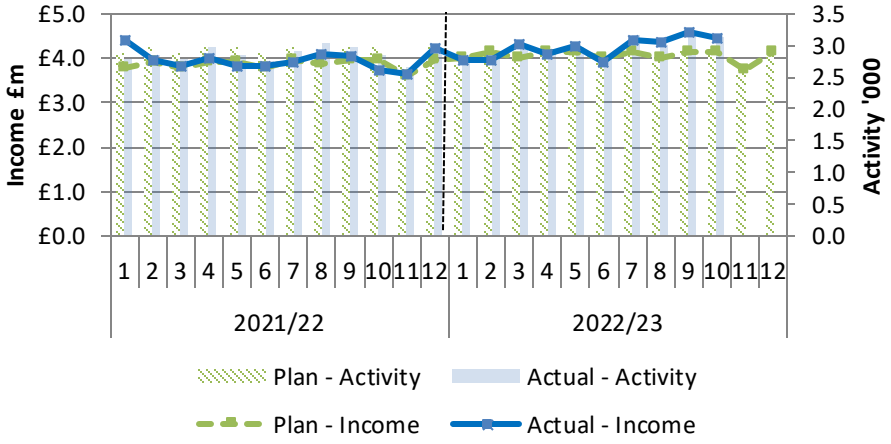
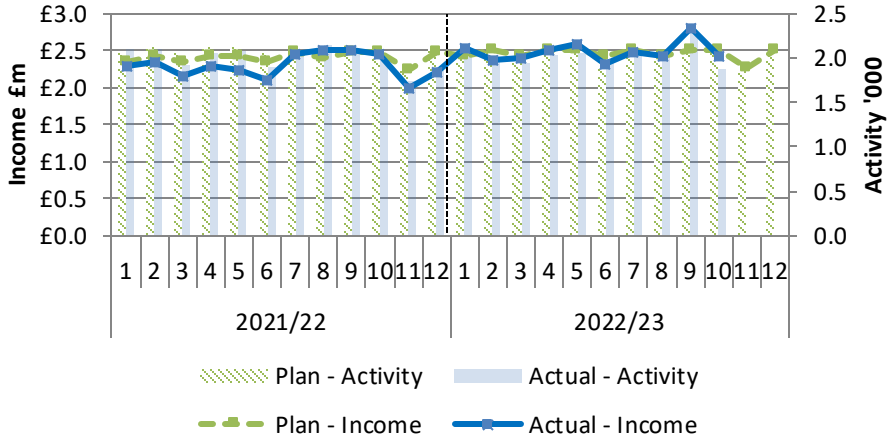
NHS Foundation Trust

Clinical Income

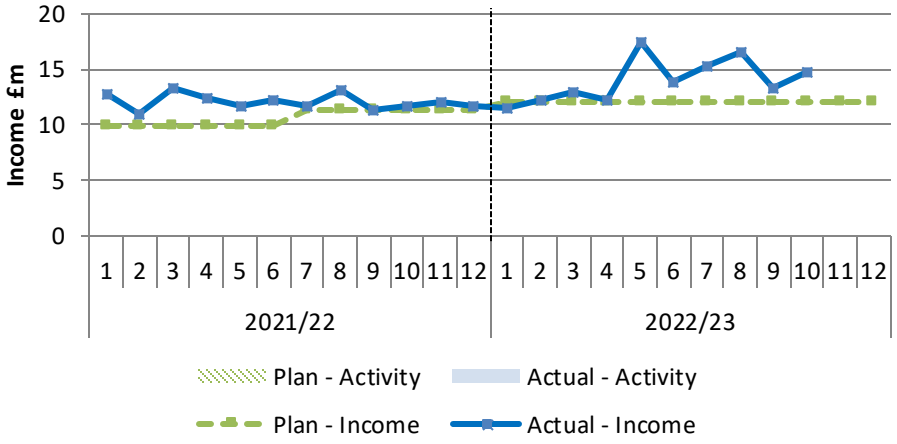
## Adult critical care



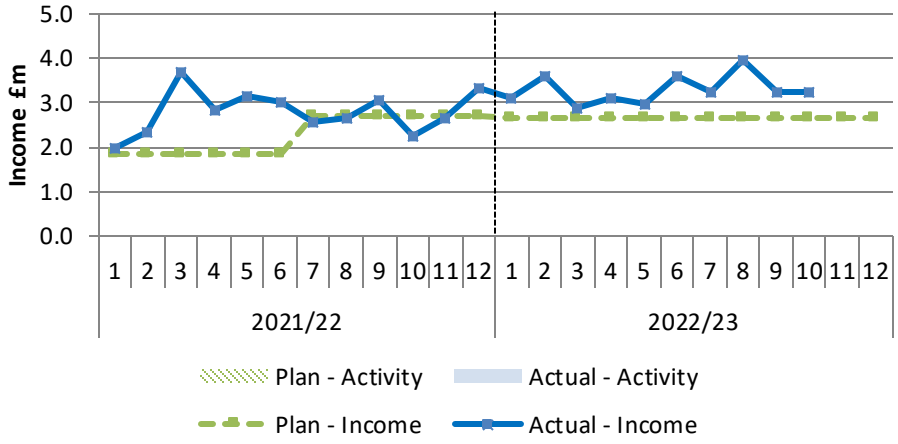

## Neonatal & paediatric critical care




## Tariff excluded drugs




## Tariff excluded devices



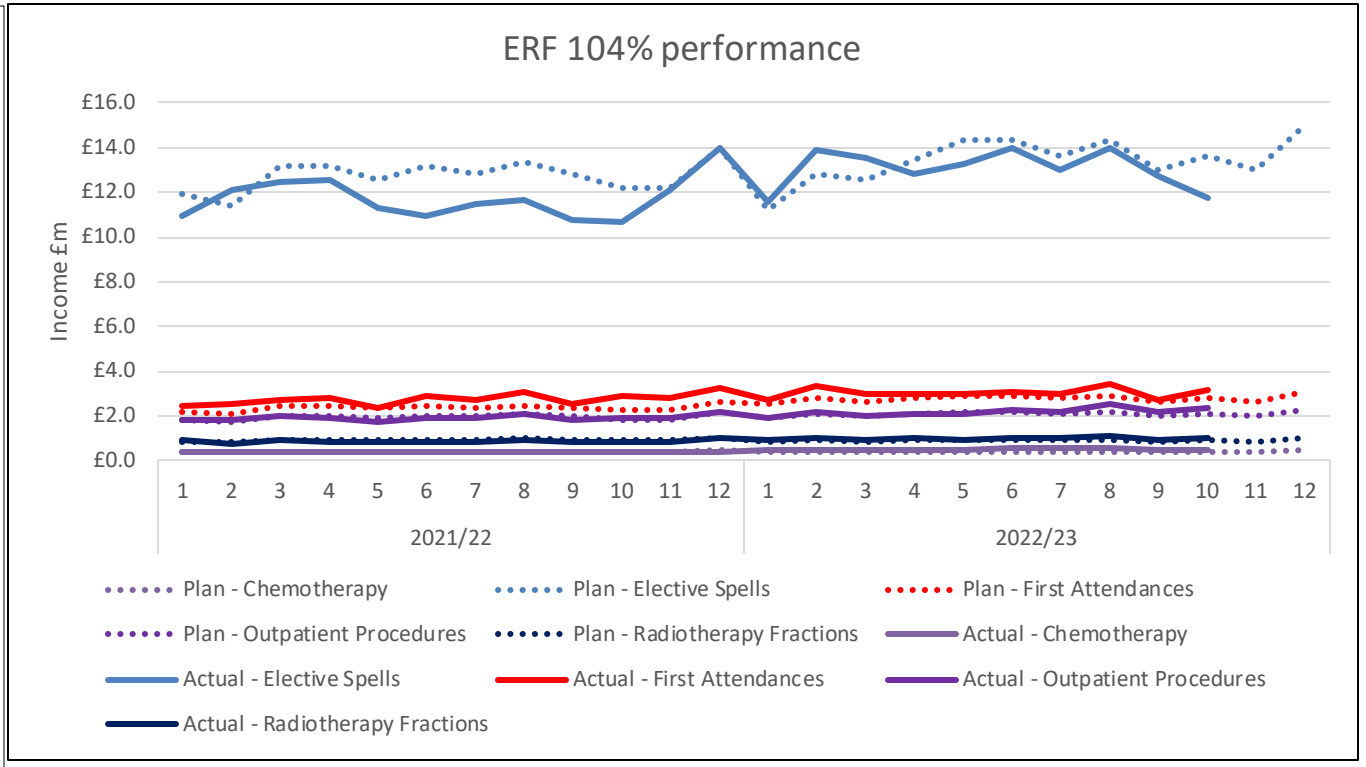
## Elective Recovery Fund 22/23

The graph shows the ERF performance for 22/23 as well as a trend against plan for 21/22.

In 22/23 the Trust has a plan to achieve 106% of 19/20 activity for elective inpatients, outpatient first attendances and outpatient procedures, above the 104% national target. This stretch was applied as part of the plan resubmission.

The table highlights overall performance against the 19/20 pre-Covid baseline, highlighting M10 performance of 100% and 105% YTD. Indicatively this has generated £4.9m in ERF income YTD. M10 was impacted by two days of industrial action losing c£0.5m of notional income as a result.

Although a fixed agreement has been made with specialised commissioning, Income will continue to be monitored in shadow form for the remainder of 22/23.




| Elective Recovery Framework Performance | M1 | M2 | M3 | M4 | M5 | M6 | M7 | M8 | M9 | M10 | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Elective performance | 99% | 107% | 110% | 99% | 98% | 103% | 101% | 104% | 104% | 91% | 102% |
| Outpatient first and procedures performance | 109% | 117% | 112% | 108% | 104% | 109% | 111% | 120% | 108% | 118% | 112% |
| Chemotherapy performance | 146% | 127% | 142% | 127% | 128% | 133% | 142% | 140% | 139% | 136% | 136% |
| Radiotherapy performance | 119% | 112% | 114% | 116% | 104% | 113% | 112% | 117% | 114% | 113% | 113% |
| **Overall ERF performance** | **104%** | **111%** | **112%** | **103%** | **101%** | **106%** | **104%** | **109%** | **106%** | **100%** | **105%** |
| Anticipated ERF payment (incl. A&G) | **£826** | **£1,673** | **£1,502** | **£125** | **-£409** | **£337** | **£172** | **£876** | **£424** | **-£578** | **£4,948** |
| Outpatient follow up performance | 130% | 137% | 130% | 125% | 120% | 125% | 126% | 139% | 127% | 127% | 130% |

**Finance Report Month 10**

## Cost Pressures 2022/23

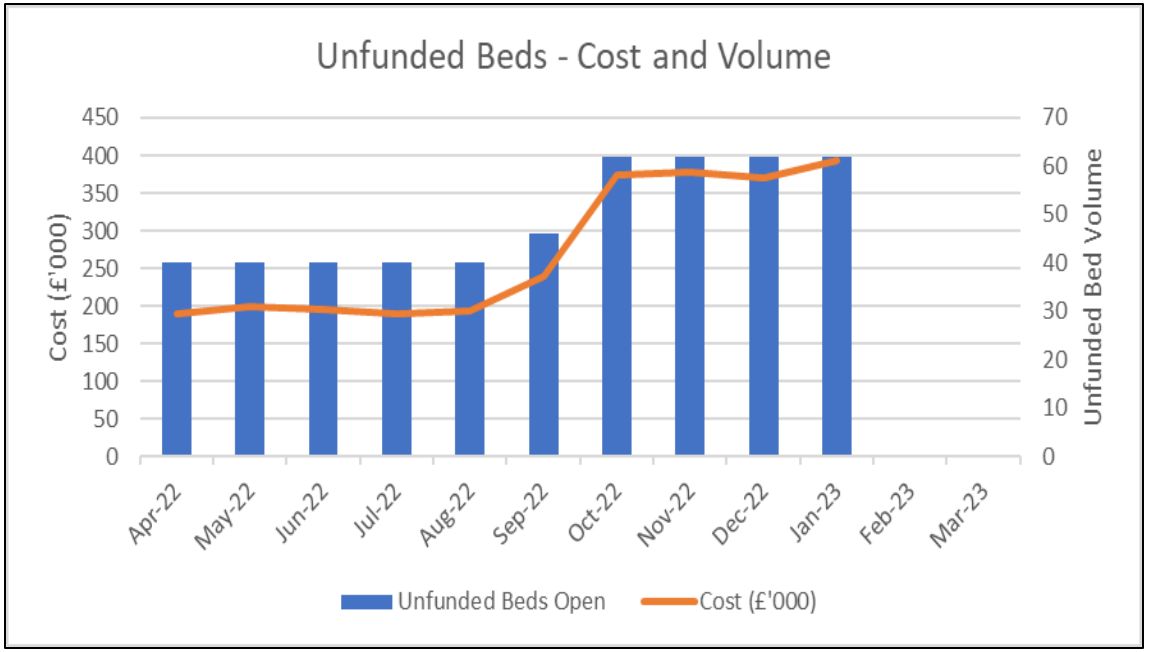
The top tables show the performance for block funded and pass-through drugs in 22/23. The majority of NHS England Specialised Commissioned drugs and devices are being funded on a cost and volume (C&V) basis but all those which are ICB commissioned are subject to a fixed block payment.

At M10 the unfunded pressure for these block funded drugs and devices is £9.7m of which £7.2m is from drugs. Long term conditions form one of the key areas of cost growth particularly within gastroenterology, rheumatology and ophthalmology. These services are seeing disproportionate growth in patient numbers and significant impact from NICE technical appraisals particularly around biologics.

The graph shows the costs of 'unfunded beds' open within UHS. These are required due to increasing numbers of patients (c200) not meeting the criteria to reside. Flex bed pressures have increased over recent months with costs increasing to £394k in month (£2.7m YTD).

| Block | YTD Plan | YTD Actual | Unfunded performance |
|---|---|---|---|
| Drugs | £30,671,893 | £37,842,253 | £7,170,359 |
| Devices | £4,892,086 | £7,420,145 | £2,528,058 |
| **Total** | **£35,563,980** | **£45,262,397** | **£9,698,417** |

| C&V | YTD Plan | YTD Actual | Funded performance |
|---|---|---|---|
| Drugs | £90,509,442 | £102,128,514 | £11,619,071 |
| Devices | £21,677,977 | £25,511,946 | £3,833,969 |
| **Total** | **£112,187,419** | **£127,640,460** | **£15,453,040** |



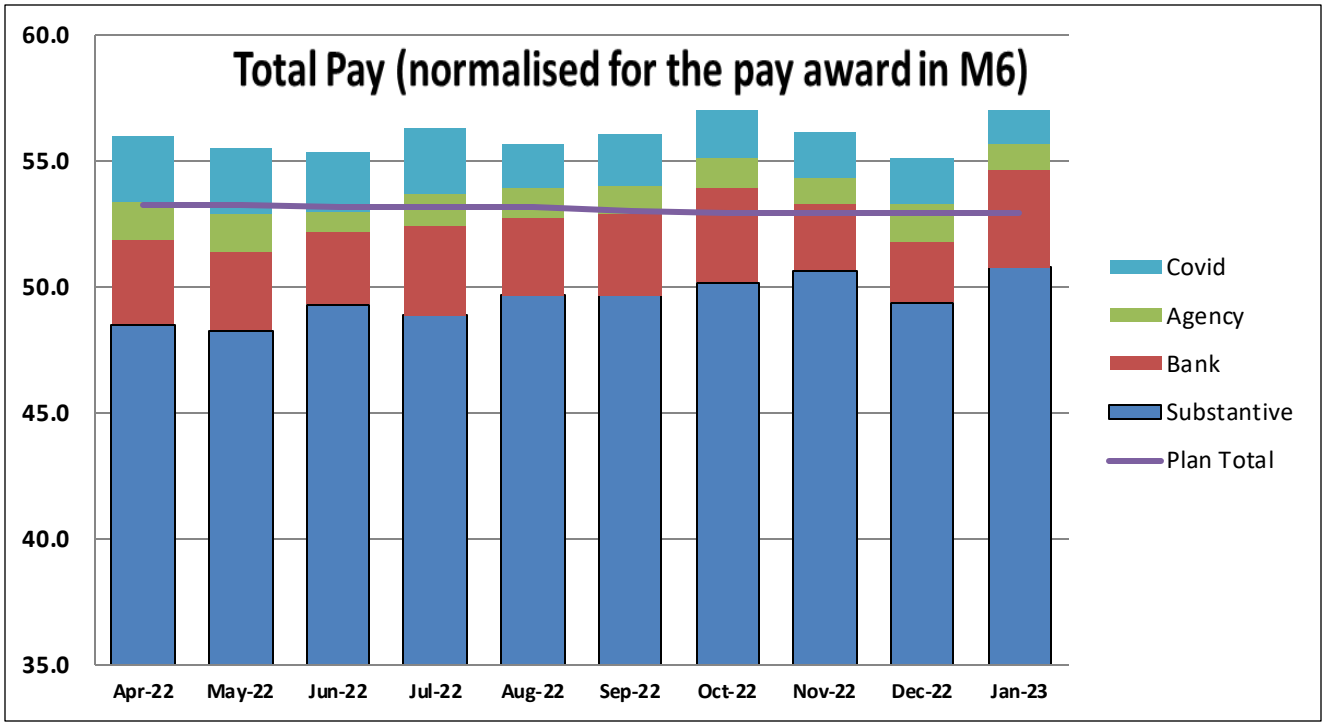
**Finance Report Month 10**

## Substantive Pay Costs

Total pay expenditure in January was £57.0m, up from December's £55.1m. This related to £0.5m enhancements relating to December (paid in Jan) and a return to run rate following a £0.5m one off benefit in December. Normalising for these pay was up £0.9m which was predominantly within bank costs.

This was due to an increased volume of working days in January, and additional operational activity pressure. Industrial action has also impacted staff availability in January with increased bank (reduced substantive costs will come through in February).

Staff costs are over plan £26m YTD for which £16m relates to pay award costs not within plan and largely funded. The residual £10m is due mainly to operational and covid related pressures meaning temporary staffing costs have remained even though substantive costs have increased over the year.

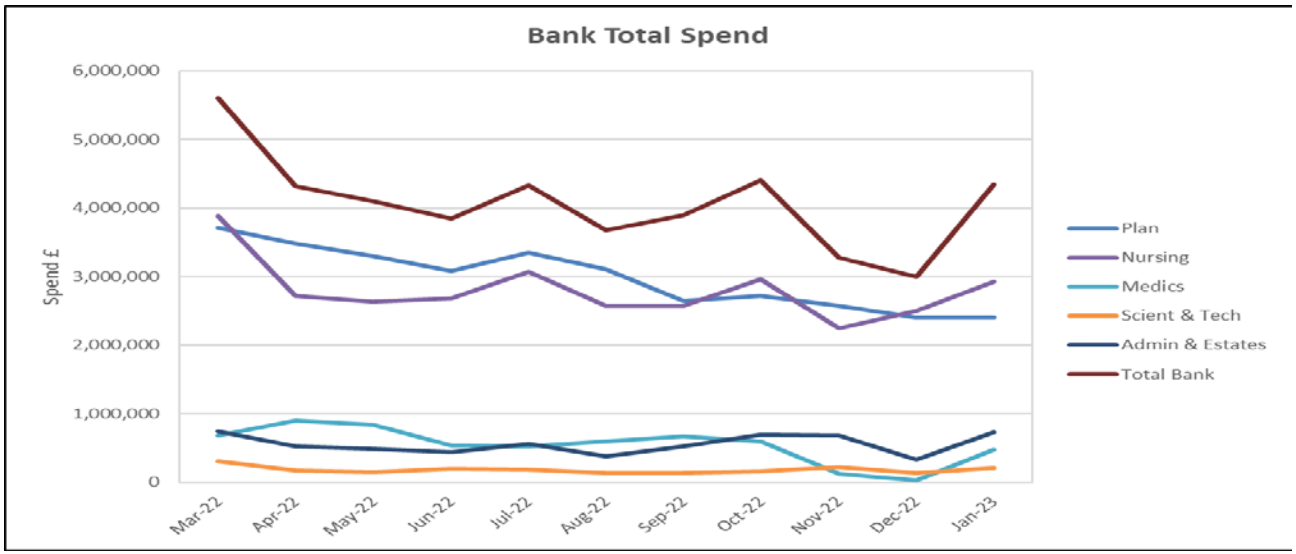


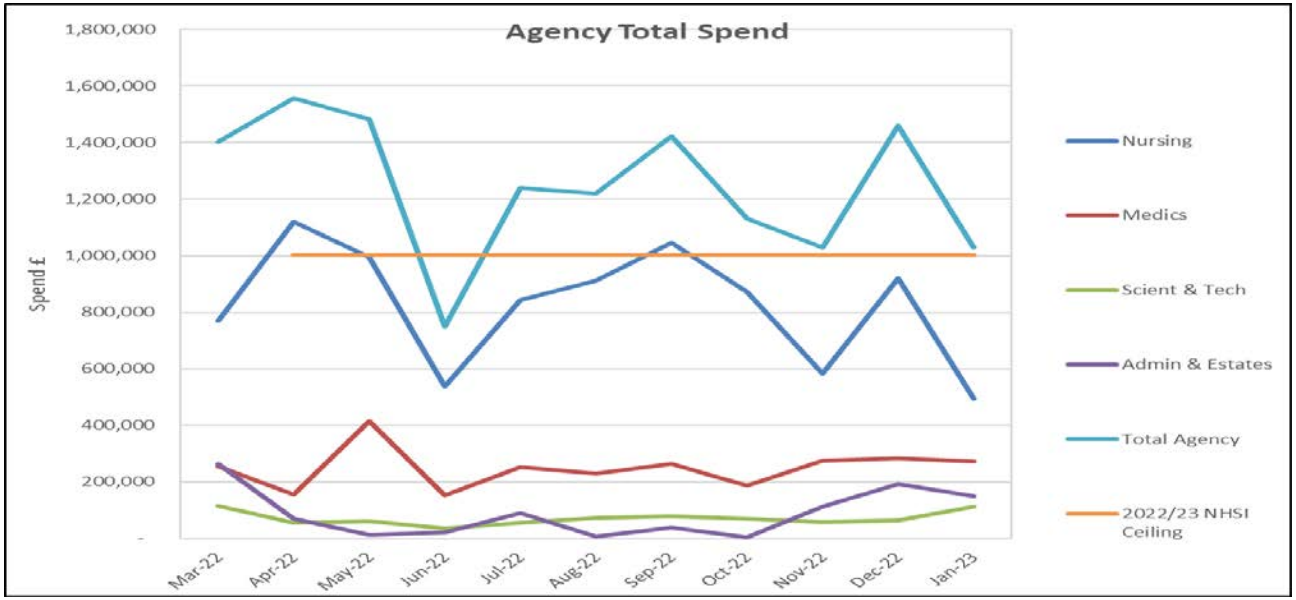
**Finance Report Month 10**

## Temporary Staff Costs

Expenditure on Bank staff increased by £1.4m from December to £4.4m in month. The increase was driven by increases across nursing £0.4m, medical £0.4m and administrative and estates £0.4m staffing in month. December was artificially low however as there was a correction for previously overstated costs in year of £0.5m.

Agency spend decreased by £0.5m. The majority of the reduction related to decreases in nursing agency spend of £0.4m in month.
Spend is above the 22/23 agency ceiling, however remains comparably lower than other similar sized trusts. Reducing agency spend remains a focus area for the Trust Savings Group (TSG). Thornbury spend increased slightly to £75k in month however remained below the average of previous months spend to date (£105k per month).



University Hospital Southampton NHS
NHS Foundation Trust

## Covid Costs 22/23

The table illustrates Covid costs incurred YTD versus 22/23 plan.

YTD costs are £22.4m which is £5.1m ahead of plan. This is due to Critical Care and ED additional capacity and costs which are reporting £7.0m of costs in excess of plan.

All areas of spend are under continuous review especially those associated with national guidance changes.
Alternatively for some areas where an ongoing need has been identified discussions with commissioners have taken place to explore recurrent funding sources. Critical care is the main example of this with NHSE supporting £1.5m in recurrent funding increase from 22/23.

ED remains a particular concern as demand remains much higher than pre-Covid levels.

| Description | 2022/23 Annual Plan (£'000) | 2022/23 YTD Plan (£'000) | 2022/23 YTD Actual (£'000) | 2022/23 YTD Variance (£'000) |
|---|---|---|---|---|
| Covid Related Staff Sickness / Absence | 9,123 | 7,603 | 6,718 | 885 |
| Critical Care Additional Capacity | 4,914 | 4,095 | 7,511 | (3,416) |
| Emergency Department Additional Costs | 1,800 | 1,500 | 5,071 | (3,571) |
| Car Parking Income - Patients / Visitors | 1,320 | 1,100 | 1,100 | 0 |
| Additional Cleaning / Decontamination | 812 | 677 | 718 | (41) |
| C5 uplift to L2 facility for 12 beds for Covid | 480 | 400 | 400 | 0 |
| Staff / High Risk Patient Covid Testing | 500 | 417 | 210 | 207 |
| PPE / Perso Hoods and Consumables | 320 | 267 | 12 | 255 |
| Staff Psychology Support | 200 | 167 | 40 | 127 |
| Car Parking Income - Staff | 183 | 153 | 153 | 0 |
| Clinical Engineering | 138 | 115 | 0 | 115 |
| Covid Medical Model (Div B) | 115 | 95 | 95 | 0 |
| PAH Theatres social distancing | 108 | 90 | 0 | 90 |
| Infection Control Team | 107 | 89 | 18 | 71 |
| Other (sub £100k plans) | 694 | 578 | 358 | 220 |
| **TOTAL** | **20,813** | **17,344** | **22,404** | **(5,059)** |

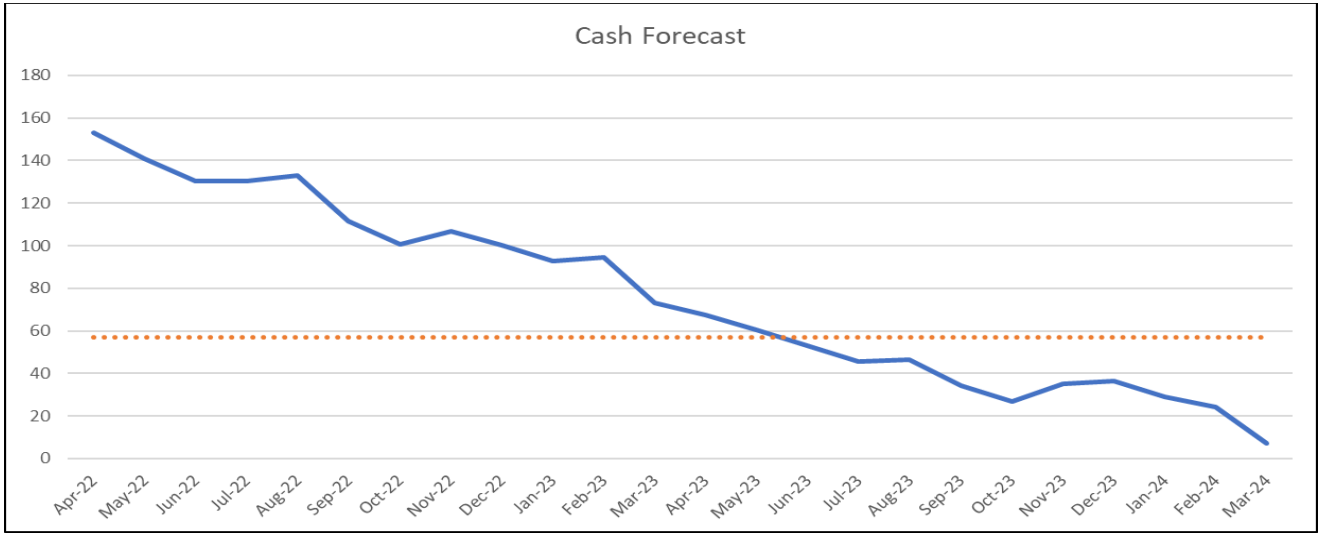
**Finance Report Month 10**

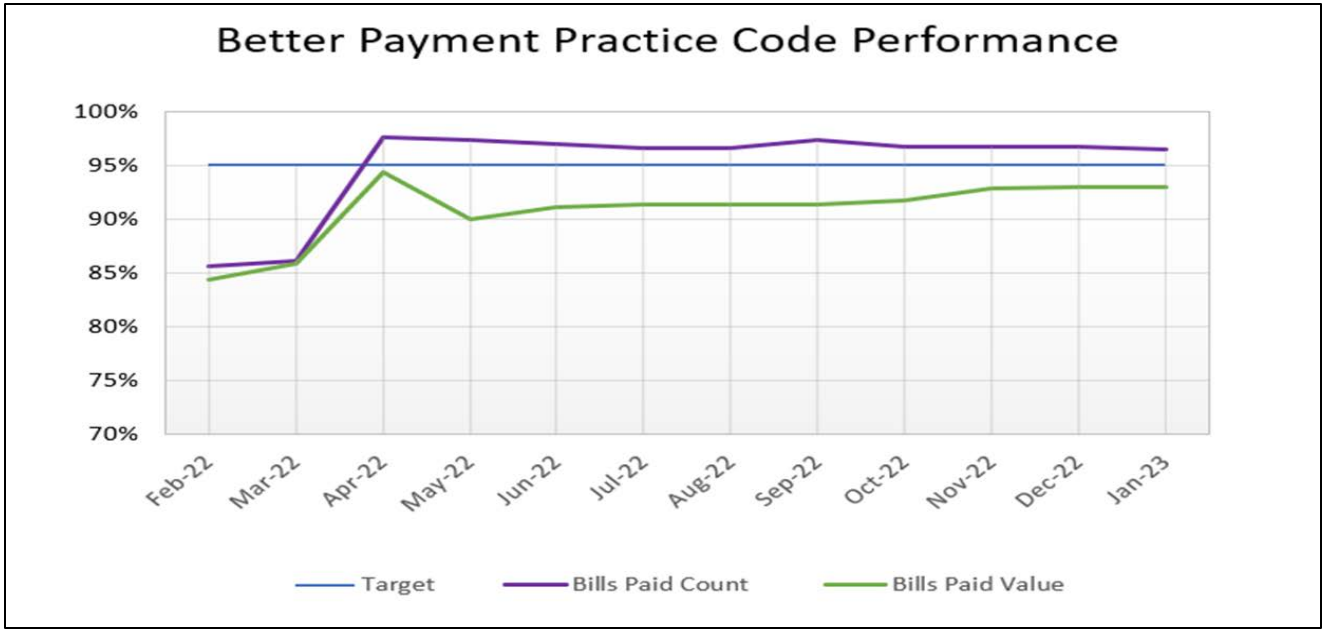
## Cash

The cash balance decreased by £7.0m in January to £92.9m and is analysed in the movements on the Statement of Financial Position.

A cash forecast has been completed for the next 18 months projecting a material decline in cash driven by an underlying deficit and sizeable internally funded capital programme of £49m per annum. It is however difficult to predict beyond 22/23 as the financial regime has yet to be confirmed for future years.

BPPC in month for January is just over the 95% target at 95.09%, (December 95.75%) for count of invoices and now below target for value at 93.62% (December 93.34%). With a small increase in January our YTD position still shows a similar stable position with improvement needed to reach the 95% target for value.



## Capital Expenditure

(Fav Variance) / Adv Variance

Expenditure on capital schemes was £54.7m for the year to Month 10. The total expenditure in month was £12.7m; a significant increase on average for months 1 to 9 (£4.7m). The high level of expenditure was driven by the wards above oncology scheme, where £5.9m was spent in month and the C-Level MRI scheme where £3.2m was spent via the Siemens managed service contract. There was also significant expenditure on refurbishment of theatres 10 & 11 (£1.6m) and an increased rate of spend on the strategic maintenance and IT programmes.

The trust is forecasting to spend £90m by the end of the year. To achieve this, the trusts needs to spend £35.3m in February and March. This should be achieved through high expenditure on wards above oncology (£4.2m), IT (£6.7m), Strategic Maintenance (£3.7m) and imaging equipment though the Siemens managed service contract (£12.9m).

| | Month | | | Year to Date | | | Full Year Forecast | | |
|---|---|---|---|---|---|---|---|---|---|
| | Plan | Actual | Var | Plan | Actual | Var | Plan | Actual | Var |
| **Scheme** | £000's | £000's | £000's | £000's | £000's | £000's | £000's | £000's | £000's |
| **Internally Funded Schemes** | | | | | | | | | |
| **Estates** | | | | | | | | | |
| Strategic Maintenance | 897 | 774 | 123 | 5,625 | 3,232 | 2,393 | 7,185 | 6,915 | 270 |
| Refurbish of neuro theatres 2 & 3 | 0 | 0 | (0) | 730 | 3,332 | (2,602) | 1,800 | 3,409 | (1,609) |
| Decorative Improvments/Small Projects/Fire/DDA | 135 | 1 | 134 | 589 | 109 | 480 | 950 | 285 | 665 |
| General Refurbishment Fund | 304 | 0 | 304 | 453 | 160 | 293 | 1,097 | 1,374 | (277) |
| NICU Pendants | 0 | (51) | 51 | 528 | 739 | (211) | 528 | 739 | (211) |
| Theatres 10 & 11/F level Fit Out | 965 | 1,552 | (587) | 3,070 | 2,896 | 174 | 5,000 | 5,000 | 0 |
| Oncology Centre Ward Expansion Levels D&E | 2,479 | 5,829 | (3,350) | 4,804 | 5,845 | (1,041) | 8,000 | 10,092 | (2,092) |
| Fit out of C Level VE (MRI) Capacity | 0 | 3,265 | (3,265) | 6,592 | 3,655 | 2,937 | 6,592 | 4,625 | 1,967 |
| PICU Side Rooms | 0 | 0 | 0 | 1,203 | 1,234 | (31) | 1,203 | 1,381 | (178) |
| Donated Estates Schemes | 161 | 42 | 119 | 3,696 | 1,007 | 2,689 | 5,327 | 6,495 | (1,168) |
| **Information Technology** | | | | | | | | | |
| Information Technology Programme | 350 | 608 | (258) | 3,950 | 3,680 | 270 | 5,000 | 5,998 | (998) |
| Pathology Digitisation | 42 | 114 | (72) | 351 | 390 | (39) | 448 | 448 | 0 |
| **Equipment** | | | | | | | | | |
| IMRI | 0 | 0 | 0 | 1,300 | 323 | 977 | 1,300 | 358 | 942 |
| Medical Equipment panel (MEP) | 375 | 58 | 317 | 1,500 | 1,842 | (342) | 2,500 | 3,260 | (760) |
| Purchased Equipment / Lease Buyouts | 47 | 211 | (164) | 393 | 381 | 12 | 500 | 960 | (460) |
| Divisonal Equipment | 46 | 0 | 46 | 392 | 218 | 174 | 500 | 500 | 0 |
| Donated Equipment | 53 | 0 | 53 | 212 | 0 | 212 | 350 | 50 | 300 |
| Subsidiaries Equipment | 17 | 11 | 6 | 170 | 11 | 159 | 200 | 461 | (261) |
| Surgical Robot | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 590 | (590) |
| **Other** | | | | | | | | | |
| Other | 0 | 185 | (185) | 691 | 1,545 | (854) | 691 | 2,088 | (1,397) |
| Slippage | (780) | 0 | (780) | (3,780) | 0 | (3,780) | (4,681) | 0 | (4,681) |
| Donated Income | (256) | (156) | (100) | (4,859) | (1,397) | (3,462) | (6,760) | (7,109) | 349 |
| **Total Trust Funded Capital excl Finance Leases** | **4,835** | **12,444** | **(7,609)** | **27,610** | **29,202** | **(1,592)** | **37,730** | **47,919** | **(10,189)** |
| **Leases** | | | | | | | | | |
| Medical Equipment Panel (MEP) - Leases | 46 | 0 | 46 | 392 | 309 | 83 | 700 | 390 | 310 |
| Equipment leases | 105 | 0 | 105 | 420 | 187 | 233 | 500 | 400 | 100 |
| IISS | 500 | 167 | 333 | 785 | 167 | 618 | 3,115 | 1,941 | 1,174 |
| Fit out of C Level VE (MRI) Capacity | 0 | 0 | 0 | 0 | 0 | 0 | 5,619 | 2,969 | 2,650 |
| **Total Trust Funded Capital Expenditure** | **5,486** | **12,611** | **(7,125)** | **29,207** | **29,865** | **(658)** | **47,664** | **53,619** | **(5,955)** |
| Disposals | 0 | (217) | 217 | 0 | (217) | 217 | 0 | (217) | 217 |
| Capital to Revenue Adjustment | 0 | 0 | 0 | 0 | 0 | 0 | 0 | (2,899) | 2,899 |
| Top Up to external Schemes | 0 | 0 | 0 | 0 | 0 | 0 | 0 | (2,839) | 2,839 |
| **Total Including Technical Adjustments** | **5,486** | **12,394** | **(6,908)** | **29,207** | **29,648** | **(441)** | **47,664** | **47,664** | **0** |

## Capital Expenditure

(Fav Variance) / Adv Variance

Additional external funding for frontline digitisation (£3.9m) and Imaging equipment (£3.6m) has now been confirmed. Applications to draw down a total of £24.3m of additional cash funding have now been submitted and will be all paid to us by the end of February.

| | Month | | | Year to Date | | | Full Year Forecast | | |
|---|---|---|---|---|---|---|---|---|---|
| | Plan | Actual | Var | Plan | Actual | Var | Plan | Actual | Var |
| Scheme | £000's | £000's | £000's | £000's | £000's | £000's | £000's | £000's | £000's |
| **Externally Funded Schemes** | | | | | | | | | |
| Maternity Care System (Wave 3 STP) | 0 | 0 | 0 | 89 | 89 | 0 | 89 | 89 | 0 |
| Digital Outpatients (Wave 3 STP) | 50 | 21 | 29 | 492 | 180 | 312 | 592 | 472 | 120 |
| Oncology Centre Ward Expansion Levels D&E | 0 | 88 | (88) | 0 | 10,000 | (10,000) | 0 | 10,000 | (10,000) |
| Neonatal Expansion | 0 | 112 | (112) | 0 | 168 | (168) | 0 | 200 | (200) |
| Targeted Lung Health Checks CT Scanner | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1,364 | (1,364) |
| Pathology Digitisation / LIMS | 0 | 38 | (38) | 0 | 191 | (191) | 0 | 250 | (250) |
| Community Diagnostic Centre Phase 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3,200 | (3,200) |
| Asceptic Pharmacy Building | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 761 | (761) |
| Frontline Digitisation | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3,945 | (3,945) |
| Cyber Security | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 118 | (118) |
| MRI Scanner | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2,000 | (2,000) |
| Nasendoscopy system for Cancer ENT/Head & Neck | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 88 | (88) |
| Endoscopy IT - New Scheduling / Referral system | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 700 | (700) |
| CT Scanner | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1,560 | (1,560) |
| Breast Screening Equipment | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 36 | (36) |
| Transfer from schemes within CDEL | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2,839 | (2,839) |
| **Total Externally Funded Capital Expenditure** | **50** | **259** | **(209)** | **581** | **10,629** | **(10,048)** | **681** | **27,622** | **(26,941)** |
| **Total CDEL Expenditure** | **5,536** | **12,654** | **(7,118)** | **29,788** | **40,277** | **(10,489)** | **48,345** | **75,286** | **(26,941)** |
| **Outside CDEL Limit** | | | | | | | | | |
| Adanac Park Car Park | 0 | 0 | 0 | 0 | 14,400 | (14,400) | 0 | 14,400 | (14,400) |
| Surgical Robot Lease Element | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 265 | (265) |
| **Total Capital Expenditure** | **5,536** | **12,654** | **(7,118)** | **29,788** | **54,677** | **(24,889)** | **48,345** | **89,951** | **(41,341)** |

## Statement of Financial Position

(Fav Variance) / Adv Variance

The January statement of financial position illustrates net assets of £528.5m, an increase of £8.6m.

The underlying cause of the increase is in fixed assets of £10.5m, which is the main driver of the reduction in cash of £7.0m. This is in line with the capital program activity for the organisation, as investment is made in the Trust infrastructure.

There are movements with receivables and payables, with a net increase of £4.8m which is due to the timing of invoice receipts and payments.

| Statement of Financial Position | 2021/22 YE Actuals £m | 2022/23 M9 Act £m | 2022/23 M10 Act £m | 2022/23 MoM Movement £m |
|---|---|---|---|---|
| Fixed Assets | 471.9 | 542.6 | 553.1 | 10.5 |
| Inventories | 17.0 | 17.0 | 17.1 | 0.2 |
| Receivables | 53.1 | 61.8 | 73.5 | 11.7 |
| Cash | 148.1 | 99.9 | 92.9 | (7.0) |
| Payables | (204.2) | (189.2) | (196.1) | (6.9) |
| Current Loan | (1.7) | (1.7) | (1.7) | 0.0 |
| Current PFI and Leases | (9.1) | (10.5) | (10.3) | 0.2 |
| **Net Assets** | **475.0** | **519.9** | **528.5** | **8.6** |
| Non Current Liabilities | (23.0) | (20.6) | (20.5) | 0.1 |
| Non Current Loan | (6.8) | (5.6) | (5.6) | 0.0 |
| Non Current PFI and Leases | (33.6) | (96.3) | (96.0) | 0.3 |
| **Total Assets Employed** | **411.6** | **397.4** | **406.4** | **9.0** |
| Public Dividend Capital | 261.9 | 265.6 | 273.0 | 7.4 |
| Retained Earnings | 115.6 | 97.7 | 99.3 | 1.6 |
| Revaluation Reserve | 34.1 | 34.1 | 34.1 | 0.0 |
| Other Reserves | | | | |
| **Total Taxpayers' Equity** | **411.6** | **397.4** | **406.4** | **9.0** |

# Efficiency and Cost Improvement Programme 22/23 – M10

University Hospital Southampton NHS
NHS Foundation Trust

**UHS Total** - £42.7m identified, 93% of the total 22/23 requirement which = £45.4m

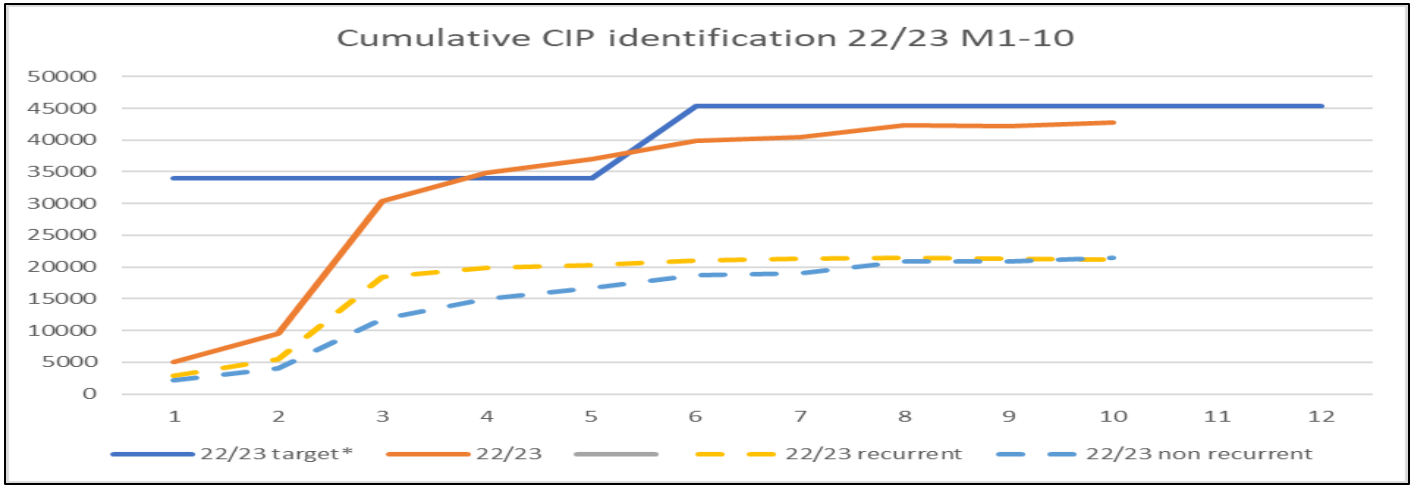
**Divisions and Directorates** - £18.7m of CIP schemes identified. This represents 94% of it's 22/23 target which = £20m

**Central Schemes** - £24m of CIP schemes identified. This represents 94% of the 22/23 target which = £25.4m

Of the identified UHS total, £9.0m is Pay, £26.0m is Non-Pay, and £7.7m is Income

Divisional identification varies from 82% to 99%, a detailed breakdown by Care Group can also be found in Appendix 1

| Month 10 CIP Identification | Non Recurrent ('000s) | Recurrent ('000s) | Total ('000s) | Target ('000s) | % Identified |
|---|---|---|---|---|---|
| Division A | £2,771 | £1,465 | £4,236 | £4,260 | 99% |
| Division B | £2,364 | £2,159 | £4,524 | £5,535 | 82% |
| Division C | £2,973 | £658 | £3,631 | £3,938 | 92% |
| Division D | £1,131 | £2,120 | £3,251 | £3,573 | 91% |
| THQ | £849 | £1,692 | £2,541 | £2,695 | 94% |
| Unallocated Procurement Schemes | £0 | £574 | £574 | | |
| Central Schemes | £11,422 | £12,542 | £23,964 | £25,400 | 94% |
| **Grand Total** | **£21,510** | **£21,211** | **£42,721** | **£45,400** | **94%** |




**based on 75% identification by the end of Q1 and 100% identification by the end of Q2*

## Efficiency and Cost Improvement Programme 22/23 – M10

University Hospital Southampton NHS
NHS Foundation Trust

M10 Trust YTD delivery is £33.3m, an increase from the £29.5m achieved at M9.

Our £33.3m delivery YTD is below our planned YTD activity of £34.5m.

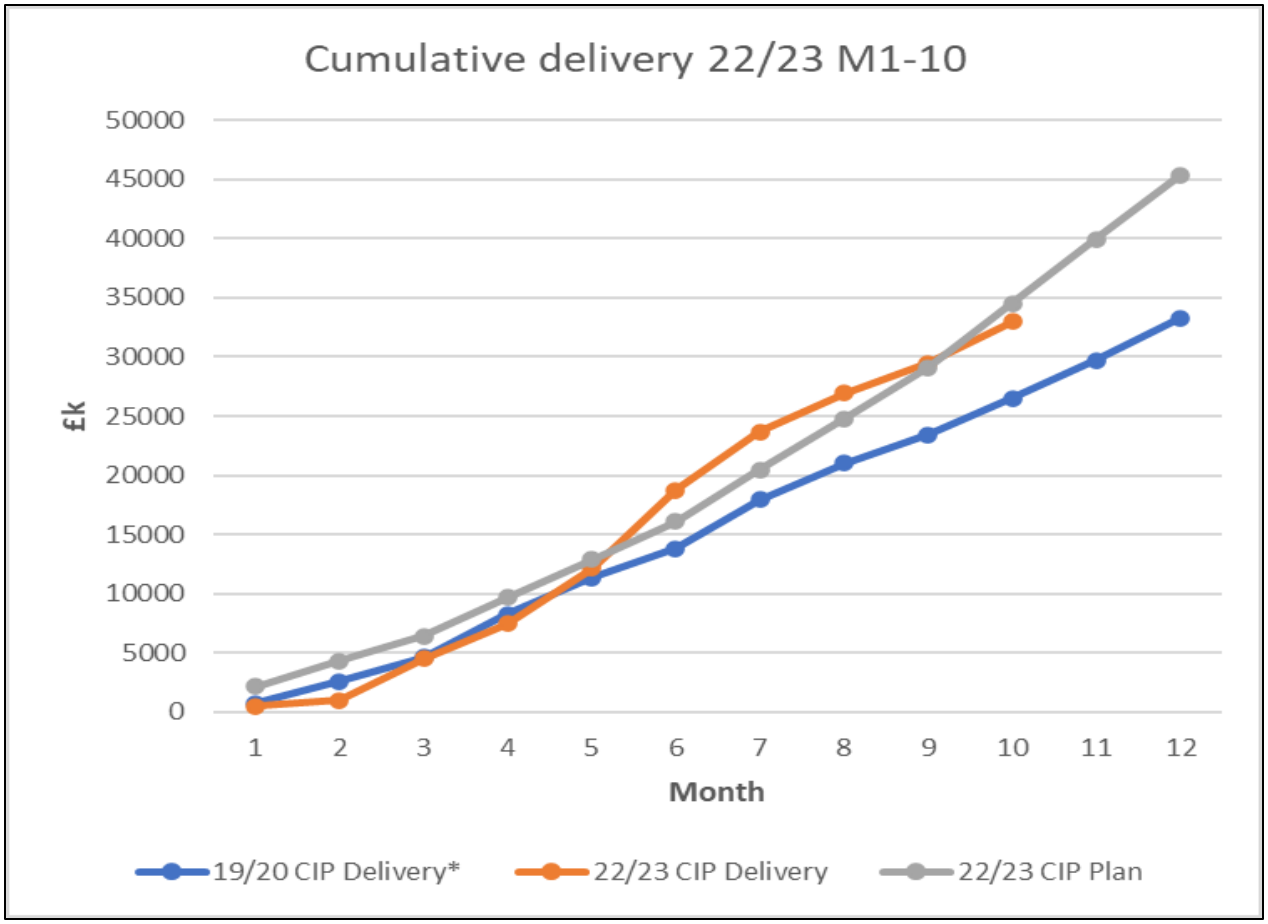
Of the £33.3m delivered YTD:

- £15.4m has been transacted by Divisions and Directorates

- £17.9m has been transacted through Central Schemes.

Of the trust YTD achievement, £18.4m is non-recurrent.

This includes £9.8m of non-recurrent Central Schemes.




**19/20 CIP Delivery included profit generated on NHS commissioner income, and LOS scheme 'buy-out'*

University Hospital Southampton
NHS Foundation Trust

| Report to the Trust Board of Directors | | | | |
|---|---|---|---|---|
| **Title:** | **Integrated Performance Report 2022/23 Month 10** | | | |
| **Agenda item:** | **11.1** | | | |
| **Sponsor:** | **David French, Chief Executive Officer** | | | |
| **Author** | **Jason Teoh, Director of Data and Analytics** | | | |
| **Date:** | **28 February 2023** | | | |
| **Purpose** | **Assurance or reassurance Y** | **Approval** | **Ratification** | **Information** |
| Issue to be addressed: | The report aims to provide assurance:<br>• Regarding the successful implementation of our strategy<br>• That the care we provide is safe, caring, effective, responsive, and well led | | | |
| Response to the issue: | The Integrated Performance Report reflects the current operating environment and is aligned with our strategy. | | | |
| Implications: (Clinical, Organisational, Governance, Legal?) | This report covers a broad range of trust services and activities. It is intended to assist the Board in assuring that the Trust meets regulatory requirements and corporate objectives. | | | |
| Risks: (Top 3) of carrying out the change / or not: | This report is provided for the purpose of assurance. | | | |
| Summary: Conclusion and/or recommendation | This report is provided for the purpose of assurance. | | | |

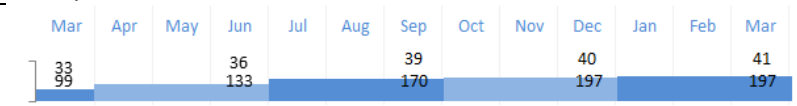
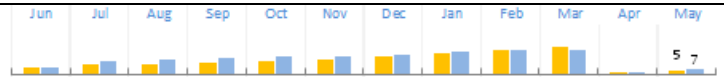
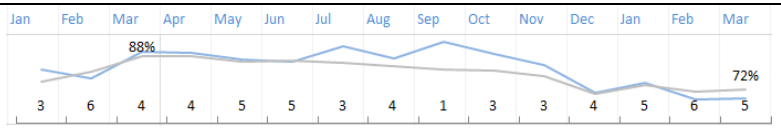
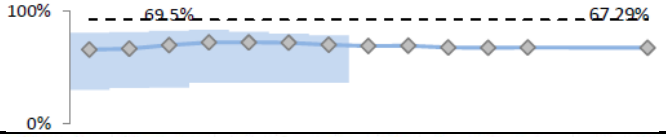
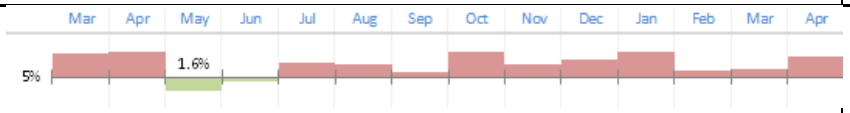
University Hospital Southampton NHS
NHS Foundation Trust

# Integrated KPI Board Report

## Covering up to
## January 2023

Sponsor – David French, Chief Executive Officer
Author – Jason Teoh, Director of Data and Analytics

# Report guide

| Chart type | Example | Explanation |
|---|---|---|
| Cumulative Column |  | A cumulative column chart is used to represent a total count of the variable and shows how the total count increases over time. This example shows quarterly updates. |
| Cumulative Column Year on Year |  | A cumulative year on year column chart is used to represent a total count of the variable throughout the year. The variable value is reset to zero at the start of the year because the target for the metric is yearly. |
| Line Benchmarked |  | The line benchmarked chart shows our performance compared to the average performance of a peer group. The number at the bottom of the chart shows where we are ranked in the group (1 would mean ranked 1st that month). |
| Line & bar Benchmarked |  | The line shows our performance, and the bar underneath represents the range of performance of benchmarked trusts (bottom = lowest performance, top = highest performance) |
| Control Chart |  | A control chart shows movement of a variable in relation to its control limits (the 3 lines = Upper control limit, Mean and Lower control limit). When the value shows special variation (not expected) then it is highlighted green (leading to a good outcome) or red (leading to a bad outcome). Values are considered to show special variation if they -Go outside control limits -Have 6 points in a row above or below the mean, -Trend for 6 points, -Have 2 out of 3 points past 2/3 of the control limit, -Show a significant movement (greater than the average moving range). |
| Variance from Target |  | Variance from target charts are used to show how far away a variable is from its target each month. Green bars represent the value the metric is achieving better than target and the red bars represent the distance a metric is away from achieving its target. |

# Introduction

The Integrated Performance Report is presented to the Trust Board each month.

The report aims to provide assurance:

- regarding the successful implementation of our strategy; and
- that the care we provide is safe, caring, effective, responsive, and well led.

The content of the report includes the following:

- The 'Spotlight' section, to enable more detailed consideration of any topics that are of particular interest or concern. The selection of topics is informed by a rolling schedule, performance concerns, and requests from the Board;
- An 'NHS Constitution Standards' section, summarising the standards and performance in relation to service waiting times; and
- An 'Appendix', with indicators presented monthly, aligned with the five themes within our strategy.

This month the following changes have been made to the report.

- Data update UT11 – Medication errors (severe / moderate): The historic data and YTD figure have been updated and have reduced following downgrades which were agreed after the incidents were reviewed at a recent Medicines Safety Group meeting.

## Summary

This month the 'Spotlight' section contains an update on the UHS Referral to Treatment (RTT) waiting list specifically focussing on longer waiters, and Emergency Department performance.

The RTT spotlight highlights that:

- The continued growth in the Referral To Treatment waiting list, despite an increase in Trust activity compared to pre-pandemic baselines. Although there was a small decrease in the waiting list in December 2022, this was linked to Christmas / New Year seasonality, and the January 2023 waiting list is again at record levels.
- We have made good progress on our longest waiters with no two year waiters, and the cohort of patients at risk of hitting 78 week waits by March 2023 seeing consistent reductions. However, recent operational pressures (Strep A cases, critical incident, strikes cancelling non-clinically urgent elective surgery) mean that we currently forecast having approximately 70-100 patients breaching 78 weeks at the end of March 2023.
- Looking further forward, the NHS England target for the upcoming financial year is to have no patients waiting more than 65 weeks by the end of March 2024. This looks like an equally challenging target, and we do not yet have a clear line of sight to how we will fully achieve this target.

The ED spotlight highlights that:

- That ED four hour performance continues to be extremely challenged and is not at the level we aspire to. We continue to benchmark well to teaching hospital comparators, as well as across the South East – even though we do not have a Type 3 Urgent Treatment Centre at UHS.
- Alongside increased attendance, our performance is being impacted by other factors such as patients no longer meeting the Criteria to Reside (CtR) at UHS leading to a lack of availability of beds, rising acuity (more people requiring treatment in majors), and an increase in mental health cases which are being treated at UHS.
- We are maintaining a conscious decision to ensure that patients do not queue in ambulances, although this is at the expense of patients being queued within ED Majors. This is reflected within our statistics which shows very low rates of 30 and 60 minute handovers at UHS.

Areas of note in the appendix of performance metrics include:

1. Cancer performance in December 2022 (the latest available month) is not at the level that we would expect both at an absolute level or relative to our peers. Regular meetings with the key, underperforming, tumour sites are in place.
    a. Two week wait (2WW) performance improved six percentage points to 79.5%, despite the Breast tumour site (performance at 20%) still being a significant drag on performance due to staffing challenges. This has moved UHS to second quartile relative to other teaching

hospitals. Improvements in the high volume Skin (performance improved to 96%) and Head and Neck (performance improved to 88.7%) tumour sites have helped improve overall performance. However, the main driver of improved performance is likely linked to the lower volume of referrals received in December 2022 (1,625, 23% lower than November 2022) – which was the lowest since February 2021.

   b. 31 day performance had a small improvement to 89.5% although a smaller number of patients were treated in December due to the Christmas period. The most challenged pathway continues to be Skin, mainly due to the higher volume of patients, with performance in the Skin tumour site just short of 50%. The Care Group have worked with the Wessex Cancer Alliance to review the pathway, and the Alliance has also provided additional funding for new insourcing capacity.
   c. 62 day performance remains broadly flat at 55.6%, and we have dropped to third quartile compared to other teaching hospitals, with performance impacted by our 2WW and 31 day performance. There is considerable improvement effort across our cancer sites including dedicated improvement resource to review current pathways, additional funding for targeted improvements from the Wessex Cancer Alliance, and implementation of new pathways to improve higher volume tumour sites.

2. Emergency Department (ED) four hour performance improved to 61.5% in January 2023. There were comparatively fewer ED attendances in January 2023 compared to December 2022 – which was impacted by the critical incident (10,617 vs 12,761 – 17% fewer in January). However, it should be noted that this remains below the NHS England revised target of 76% by March 2024.
3. Good improvement in infection prevention, with reductions in COVID-19 infection rates and Clostridium difficile cases. Although Clostridium difficile cases remain above the year to date target (a national trend), January 2023 saw only two reported cases in month, the lowest this financial year and the first time since August 2022 that we have been better than our monthly target. We continue to work with our teams to remind and reinforce on best case infection prevention.
4. The number of patients waiting diagnostic tests reduced to just over 10,500 patients as diagnostic activity returned to normal levels after the Christmas period. There has also been a small decrease in the proportion of diagnostic breaches to 28.7% of patients waiting more than six weeks, and we are working with Care Groups to further improve their diagnostic performance.
5. The number of My Medical Record logins in January 2023 exceed 30,000 logins for the first time, with the total number of cumulative accounts now at over 144k patients as we continue to push digitalisation with our patients.

**Ambulance response time performance**

NHS England published ambulance handover data has been removed, and so we have reverted to the unvalidated weekly data which is provided by the South Coast Ambulance Service (SCAS). UHS does not significantly contribute to ambulance handover delays. In the week commencing 6 February 2023, our average handover time was approximately 17 minutes across 748 emergency handovers, and 17 minutes and 16 seconds across 51 urgent handovers. There were 46 handovers over 30 minutes, and no handovers taking over 60 minutes within the unvalidated data. This is in line with historic performance.

# Spotlight: Referral to Treatment Waiting List

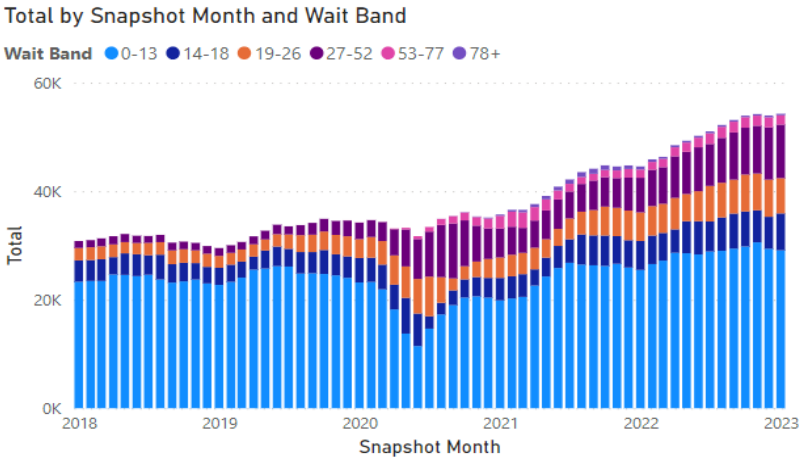
The following information is based on the validated January 2023 submission, with additional operational text based on more recent weeks provided for the long waiter elements.

As in previous months, we have continued to see a growth in the waiting list, and in January 2023 it stands at 54,254 patients, an increase of 313 patients compared to the previous month (Graph 1), and 9,703 patients (17.9% increase) more than the previous year.

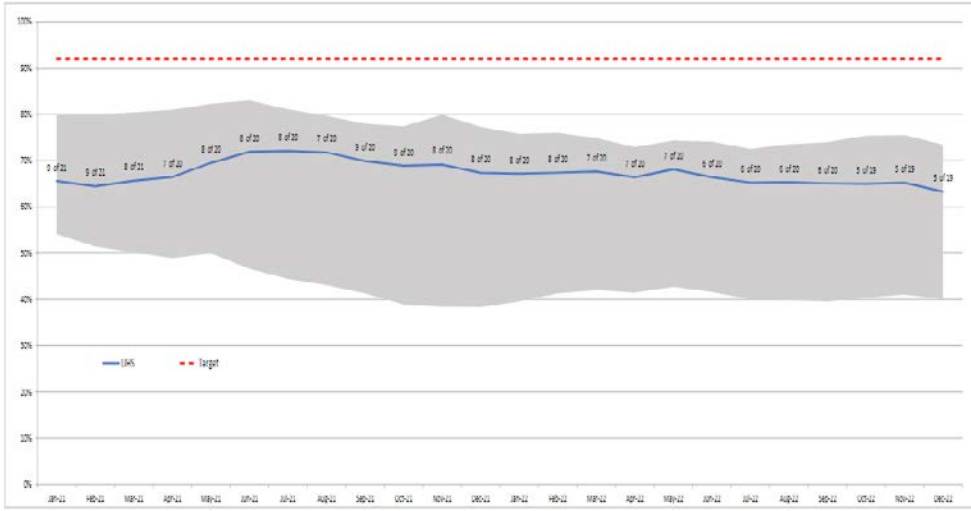
Despite UHS's continued over performance on elective recovery, the waiting list continues to grow. The volume of referrals into UHS services over recent months has exceeded capacity by between 3-3.5% and we need to look at alternative ways of addressing patient demand that go beyond additional capacity delivered by UHS. It has been indicated (although not formally confirmed) within the 2023/24 planning process that referral demand may further increase by 2%, and therefore it is likely that the waiting list will further grow in the short to medium term.

As such, the 18 week wait constitutional standard remains unmet, and presently only 67% of patients are currently waiting 18 weeks or less. While this is below the national target of 92%, we remain in the top tercile of other comparator teaching hospitals (5 of 19 benchmark hospitals in graph 2), reflecting that this continues to be a national challenge throughout the NHS.

**Graph 1: PTL by wait band**



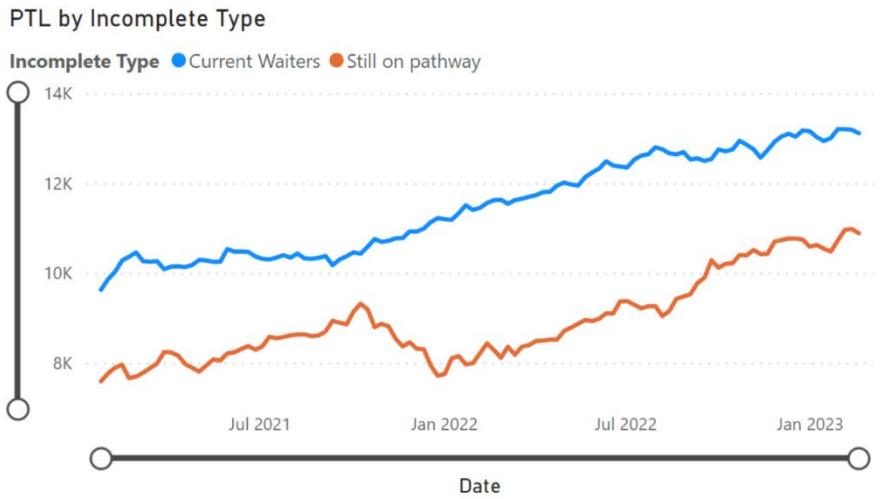

**Graph 2: RTT 18 week performance comparison for Teaching Hospitals**



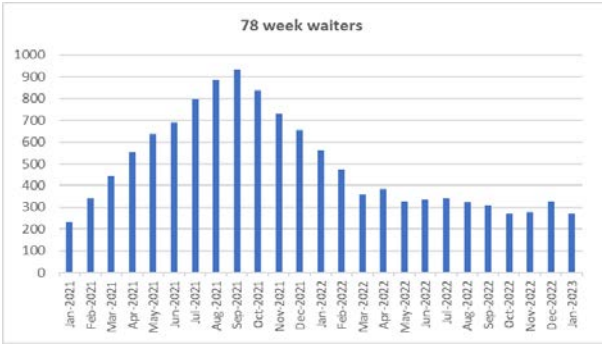
Looking specifically at the patients waiting for admission ("current waiters") in graph 3, this stands at 12.2k patients (22.4% of the waiting list). This remains proportionally similar to pre-pandemic levels (where it was between 20-22%) although the absolute number of patients waiting is higher. We continue to review how we can further optimise our operating services to generate additional capacity from the existing estate, in addition to the new ward capacity coming online in 2023/24.

However, we have had challenges in maintaining operating capacity due to issues such as poor patient flow within the hospital meaning beds are unavailable for planned operations, anaesthetic and theatre staff availability, and more recently strikes which have led to the cancellation of non-urgent surgical procedures. We have also reduced outsourced activity where we can do so without impacting the longest waiting patients to support our financial position.

**Graph 3: Waiting list for Current Waiters and Still on Pathway**




**Graph 4: 78+ week waits**




A key focus this year has been on our longest waiters. We have had no reported two year waits since November 2022, and since June 2022 any two year breaches were due to patient choice (where they specifically wished to delay their treatment). This represented a significant improvement from the peak of 171 patients reported back in December 2021.

In this financial year, the national NHS England target was to ensure that there are no patients waiting more than 78 weeks for treatment by the end of March 2023. At the end of January 2023, there were 271 patients who had waited more than 78 weeks (graph 4).

We have made good progress in reducing the number of 78 week breaches and are individually tracking all of the patients who may breach 78 weeks by the end of March 2023. This can be seen in Graph 5 which is our glide tracking our weekly performance. We have had some significant headwinds in recent months which has affected our ability to address the longest waiters and slowed our progress. In particular, the number of COVID-19 patients in hospital over November and December 2022 significantly reduced available beds, the Trust was in critical incident just before the Christmas period, and more recently the nursing strikes have also impacted elective activity.

Therefore, we do not believe that we will deliver zero 78+ week breaches by March 2023. Our current externally reported position to NHS England is that we expect in the region of 70-100 breaches (compared to a peak of over 900 patients in September 2021), although we are continuing to review options to further improve this position. The NHSE position remains an expectation of zero breaches. We have placed patients who are willing to travel on the NHS Digital Mutual Aid System (DMAS) which is intended to utilise spare capacity within other providers. This will also be supplemented with use of the Independent Sector where it is financially prudent to do so. We are also ensuring that we have robust application of the Trust's Access Policy where patients are not ready to be treated in a timely manner.

As a tertiary and specialist hospital, UHS is always likely to have more complex cases within its waiting list. These most complex cases are often more challenging to schedule leading to these patients being long waiters – although not necessarily the most clinically urgent. When combined with the volume of emergency and cancer work requiring surgical intervention that UHS receives, this also creates challenges in prioritising these patients for surgery as a more clinically urgent patient may end up being scheduled or prioritised ahead of longer waiters. This is demonstrated within the waiting list – when we review the specialties with the highest volumes of long waiters (Table 6), these are ones with high cancer referral demand (e.g. Gynaecology, Urology, ENT, Colorectal).

**Graph 5: Forecast clearance for 78+ week waits**

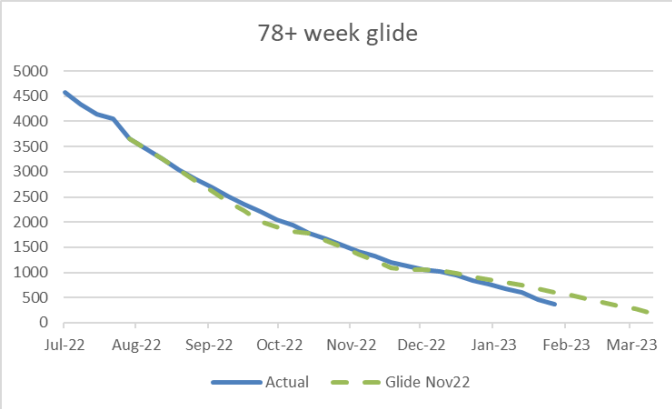



**Table 6: Breakdown of cohort by specialty remaining to be treated by March 2023**

| Specialty | Patients at risk of breaching by March 2023 |
|---|---|
| 502 - GYNAECOLOGY | **72** |
| 101 - UROLOGY | **45** |
| 100 - GENERAL SURGERY | **39** |
| 120 - EAR NOSE & THROAT | **38** |
| 110 - TRAUMA AND ORTHOPAEDIC | **37** |
| 171 - PAEDIATRIC SURGERY | **35** |
| 140 - ORAL SURGERY | **30** |
| 214 - Paediatric Orthopaedics | **26** |
| 104 - COLORECTAL SURGERY | **22** |

We remain conscious of the risk of patients being on the waiting list for a significant period of time without contact from their clinician. To help maintain patient safety, we are continuing our patient texting process with all long waiters being contacted every three to six months (depending on their clinical priority), checking that their condition hasn't changed. If the patient reports a change in their condition, one of the Care Group team will contact them, and where necessary arrange a further appointment or consultation.

Looking further forward, from April 2023 onwards the national NHS England target moves to be zero 65+ week waits by the end of March 2024. This target is likely to again prove to be challenging – firstly, because it is targeting a lower week wait (which increases the proportion of the waiting list which needs to be addressed), and secondly because of the size of the overall waiting list is greater than last year (which increases the number of patients which need to be treated). While it is likely that additional capacity next year will partially help to address these issues, and long range forecasting is challenging, at present we believe that we have a significant risk to the achievement of this standard by the end of March 2024. We will work to improve this position through the next financial year.

For awareness, the following tables provide breakdowns of the current waiting list, for the top ten specialties in descending size order, split between patients in outpatient care and those waiting for admission. There have been no significant changes to the top specialties over the last few months.

**All Waiters**

| Specialty | Current Waiters | Referrals & Still on pathway | Total |
|---|---|---|---|
| 130 - OPHTHALMOLOGY | 1074 | 4768 | **5842** |
| 502 - GYNAECOLOGY | 1162 | 3386 | **4548** |
| 400 - NEUROLOGY | 77 | 3807 | **3884** |
| 101 - UROLOGY | 1327 | 1853 | **3180** |
| 330 - DERMATOLOGY | 1088 | 1990 | **3078** |
| 320 - CARDIOLOGY | 786 | 2144 | **2930** |
| 110 - TRAUMA AND ORTHOPAEDIC | 1874 | 982 | **2856** |
| 104 - COLORECTAL SURGERY | 421 | 2155 | **2576** |
| 311 - CLINICAL GENETICS | | 2105 | **2105** |
| 140 - ORAL SURGERY | 600 | 1328 | **1928** |

**78+ week waiters**

| Specialty | Current Waiters | Referrals & Still on pathway | Total |
|---|---|---|---|
| 502 - GYNAECOLOGY | 39 | | **39** |
| 100 - GENERAL SURGERY | 21 | 8 | **29** |
| 101 - UROLOGY | 26 | 2 | **28** |
| 171 - PAEDIATRIC SURGERY | 24 | 1 | **25** |
| 120 - EAR NOSE & THROAT | 24 | | **24** |
| 140 - ORAL SURGERY | 20 | | **20** |
| 110 - TRAUMA AND ORTHOPAEDIC | 16 | | **16** |
| 214 - Paediatric Orthopaedics | 14 | 1 | **15** |
| 105 - HEPATOBILARY & PANCREATIC SUR | 12 | | **12** |
| 104 - COLORECTAL SURGERY | 9 | 1 | **10** |

# Spotlight: Emergency Department (ED) performance

**Four hour standard, from arrival to admission, transfer or discharge from the Emergency Department**

UHSFT is not currently meeting the national ED target, although our performance has continued to be strong compared with similar teaching hospitals and the South-East region as shown in the graphs below (although more recently it has dipped since post January 2023).

Type 1 attendances to ED continue to be high and have averaged over 375 per day from April 2022 to January 2023, compared to an average of 326 per day for the same time-period in 2019/20 (a 15% increase). In particular, December 2022 was challenging, with a daily attendance average of 412 largely due to the Group A Streptococcus outbreak impacting on paediatric attendances and the usual surge in respiratory conditions. Despite this our ambulance handover performance remained good relative to other trusts during December with the number of ambulances being held over 60 minutes lower than most.

Patient processing power is being focussed on at present within the ED and the Emergency Care Improvement Support Team (ECIST) for NHS England (NHSE) are visiting the department to discuss this alongside several other topics in quarter 4.

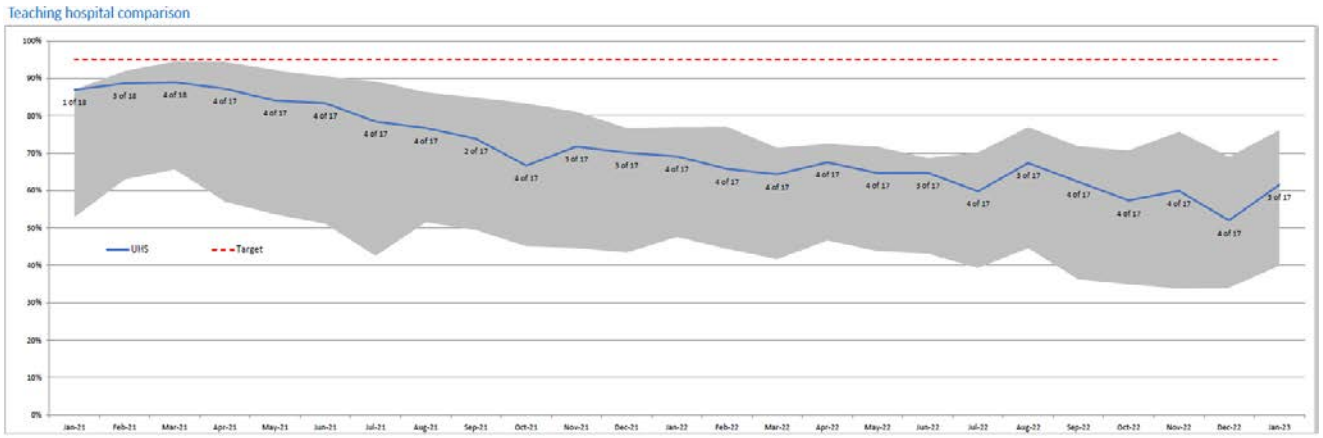
Alternative routes into UHS ED are being discussed with other UHS specialties to either avoid going to ED in the first place or to ensure a fast-track through the department once a patient has attended. The latter is proving difficult related to current capacity issues within the Trust but also due to challenges within most admitting specialties mainly impacting on patient flow out of hours. The establishment of an Emergency and Urgent Care Board with Executive presence is currently being discussed by the Chief Operating Officer with Divisional Management Teams.

A new initiative is being trialled in quarter 4 related to GPs in the ED to support turning patients back out into an appropriate community setting or via a second GP triaging patients at the UHS front door. This trial will be focussed on adults only and for all patients who walk into the department.

The ED, Emergency Medicine Care Group and Division B Management Team are currently reviewing actions plans alongside the newly published Urgent and Emergency Care (UEC) Strategy produced by NHSE to strengthen our focus and resources to deliver the improvements required to support managing our UEC demand.

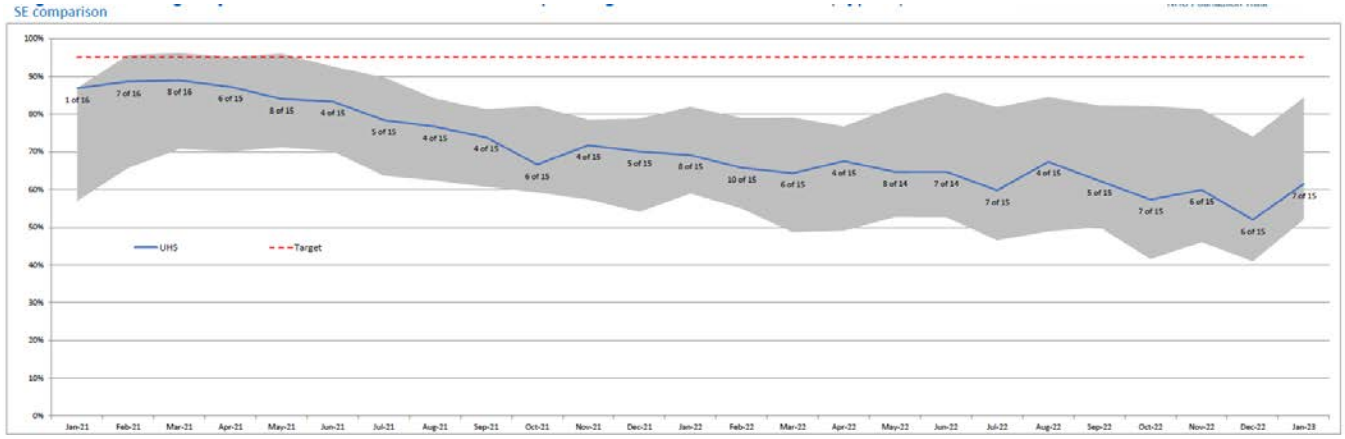
**Teaching Hospital Performance Comparison**

The graph below highlights our Type 1 performance compared to 17 similar Teaching Hospitals, where UHS ED has consistently ranked in the upper quartile.




**South-East Region Performance Comparison**

The following graph highlights our Type 1 performance compared to all 17 hospitals reporting results in the South-East region, where in January 2023 UHS ED ranked seventh best. This is a deterioration from December 2021 where the Trust were fifth best and also from December 2020 where we were top in the region with an average performance of over 90%.



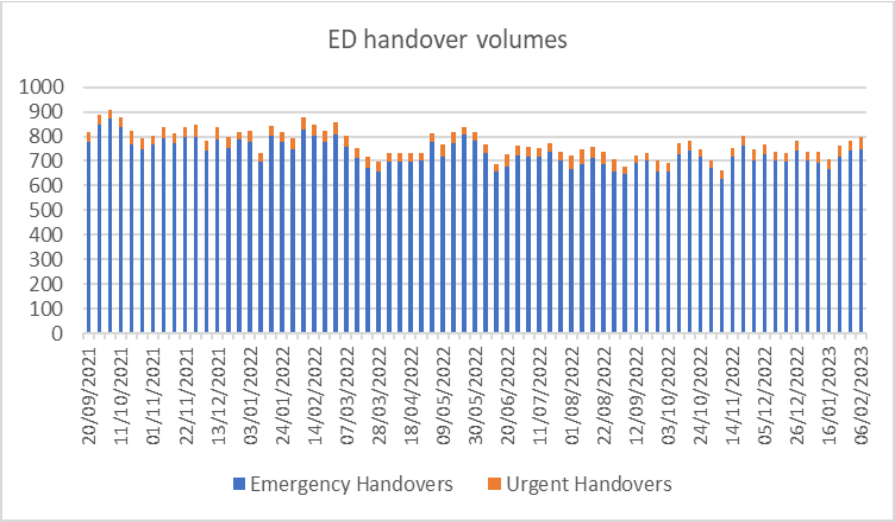

**Ambulance Handover Performance Target "All handovers must take place within 15 minutes with none waiting more than 30 minutes"**

Ambulance Handovers are a current focus area for NHS England and is also one of the key priority areas within the national priorities for 2023/24. UHS performs very well in relation to measures of timely ambulance handover, and recent trends demonstrate further local improvement. As a Trust we made, and are maintaining, a conscious decision to ensure that patients do not queue in ambulances, although this is at the expense of patients being queued

within ED Majors. However, every effort is made to manage the queue safely. Releasing ambulances in as timely a manner as possible and therefore queuing patients whilst waiting to be seen will potentially impact negatively on UHS four hour performance but is done consciously with a view to keeping ambulances on the road and available for those in need.

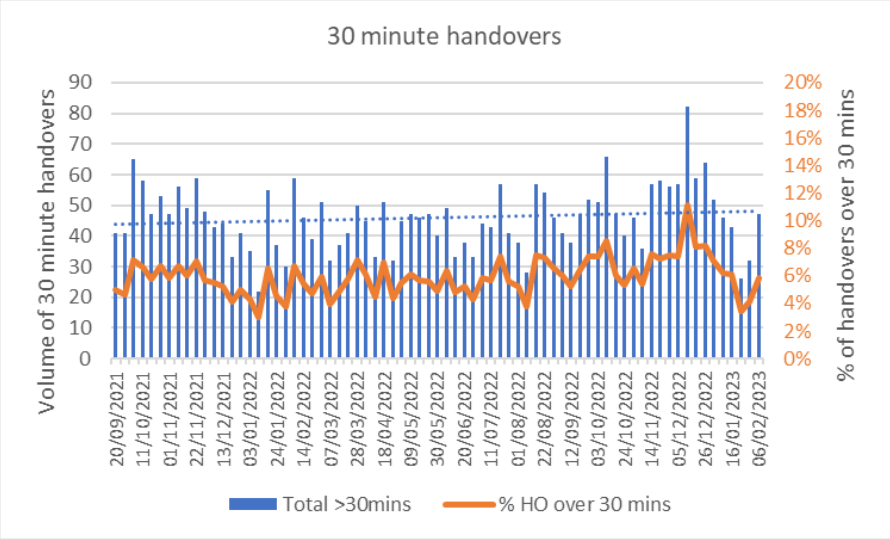
Since April 2022, we have seen, on average, up to 800 ambulance handovers each week at UHS. Although there are occasional challenges (linked to the overall challenges we experienced in ED and across the Trust), over this financial year we have sustained the good performance on the number of 30 minute handovers, and rarely see any 60 minute handover delays.

**UHS Performance (unvalidated):**




**Total ambulance handover volumes into the Emergency Department per week from September 2021 to beginning of February 2023.**

- Overall volumes have been relatively static and are reducing from the high seen in 2021 although February 23 shows an increase since December 22.
- Current ambulances handing over to the ED per day are still on average 120.
- 70% of our daily attendances are from patients who walk-in to the ED.
- One of our key areas of work is to tackle the high level of attendances walking into the ED as discussions with the regional Clinical Director has shown UHS ED are an outlier looking at current national trends. This is potentially linked to access to primary care within Southampton City. Discussions planned with ECIST.

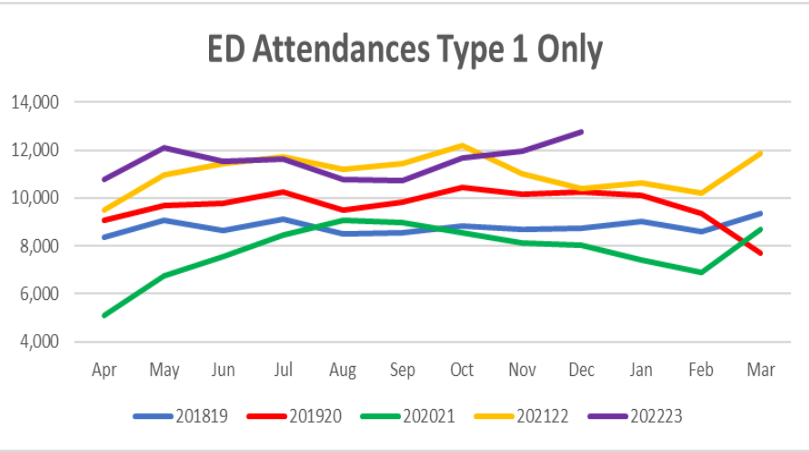


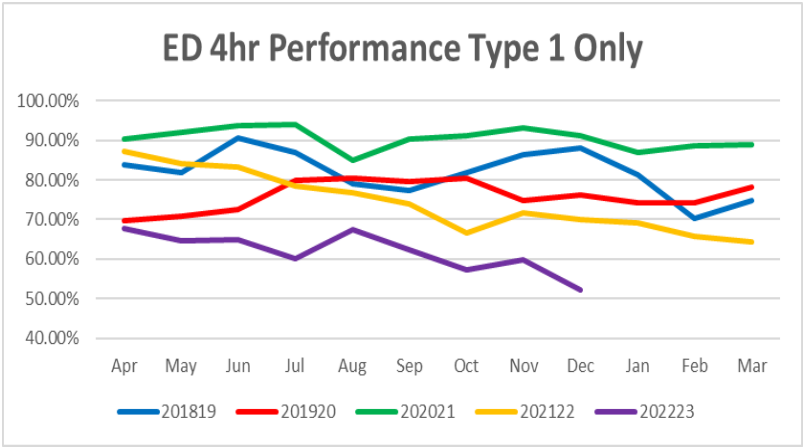

**Ambulance handovers into the Emergency Department taking longer than 30 minutes as a volume and percentage, per week, from September 2021 to beginning of February 2023.**

- UHS ED 30 minute handover performance remains strong, and our average handover time is less than 17 minutes.
- Equally our performances versus 60 minute handover delays continue to hold-up compared to other trusts in the SE & SW regions.
- Ongoing discussions take place regarding risk held within the Trust and as such we have agreed we queue in the ED and not outside in ambulances. Resource requirements to manage this from a nursing perspective is part of 2023/24 planning and budget setting.

**Trended ED attendance and performance information**

The graphs below highlight the number of main (Type 1) UHS ED attendances, and associated four hour performance, over the last four years, to December 2022.



Excluding the Covid impacted financial year of 2020/21, ED attendance growth has been rising year on year with an overall increase of 26% from 2018/19 to 2021/22.

The performance graphs demonstrate the link between a rise in attendances and our ability to manage patients within four hours. Other factors linked to performance challenges, but not exhaustive, include:

- Rising acuity – measured by resus being "double-bayed" more frequently, alongside the number of times majors is over capacity.
- Hospital wide bed flow – partly driven by rise in the number of Medically Optimised for Discharge (MOFD) patients which is now consistently at 220 per day.
- ED is seen as the place of safety for both the community, and our own hospital services, when these teams' own services are at capacity.
- Workforce – some rotas in ED are running at 50% vacancy levels increasing the difficulty to keep on top of timely decision-making although fewer patients are being admitted currently than historically.
- Continuing delays in getting patients back home due to transport and/or refusal from Care/Nursing Homes due to a combination of infection control challenges and numbers or time cut-offs placed by the individual organisations.
- Increase in complex patients alongside a rise in acuity. This is leading to an increase in the number of incidents of violence and aggression directed at staff in the Emergency Department, further impacting on the team's ability to manage demand in a timely fashion.

## Service Improvement Plans

The following are main areas of focus within the ED, Emergency Medicine Care Group, UHS, and wider external stakeholders.

| Scheme | How? |
|---|---|
| Focus on specialty pull out of ED | 1) Discussions ongoing post Chief Medical Officer & Chief Operating Officer comms requesting specialty teams to feedback on plan B pathway ideas to reduce the referral to ED for "known/expected" patients which occurs when specialty capacity is constrained<br>2) Weekly rapid change process to be established between site & ED (Emergency Department)<br>3) Ongoing review of performance against the 1 our standard linked to CRTP (Clinically Ready to Proceed) at Divisional Performance meetings<br>4) Medicine continuing with SDEC (Same Day Emergency Care) pilot downstream to support earlier discharge and improve flow at the front door<br>5) Constantly refining of the "Who goes where document" discussed at Divisional Clinical Directors and clinical leads to support e-referral discussions linked to output related to CRTP and to support enacting of direct admission from ED when appropriate |
| External Focus | 1) Review of Directory of Service (DoS) between ICB (Integrated Care Board), primary care and acute to ensure most appropriate place for treatment is clear for clinical teams<br>2) Establishing forums to discuss decompression of ED i.e. with Nursing /Care Homes to ensure patients can go home timely although this may have to be out of hours<br>3) Benchmarking work seeking an understanding of best practice/areas to improve at UHS via direct engagements with other local and regional departments. Data received from Oxford and visit planned with Royal Berkshire in Q4 22/23.<br>4) Ongoing comms in the community regarding messaging around alternative providers - 111, UTC (Urgent Treatment Centre), GP, pharmacy<br>5) Regular contact with clinicians who are part of SE region and NHS Emergency Care Improvement Support Team discussing hot topics such as demand & capacity modelling, workforce gaps |

| | |
|---|---|
| | 6) ICB discussions linked to utilisation of UTCs and increasing capacity at UHS times of surge. Discussions around better shared learning and working and understanding pressures<br>7) ECIST Visit in February to discuss demand and workforce capacity modelling plus in hospital interaction<br>8) GPs in ED pilot to start in February and end in April 2023<br>9) Review of National UEC Strategy and creation of UHS Plan focusing on metrics to support internal and external discussions around specialty pull / Length of Stay, use of Same Day Emergency Care (SDECs), virtual wards, Acute Respiratory Infection (ARI) Hubs for example |
| ED Escalation | 1) ED escalation policy/scoring reviewed and amended to include management of majors queue, awaiting Trust wide escalation framework review to then incorporate ED escalation framework into it. New document has been agreed and awaiting final sign-off before being used and reviewed alongside wider UHS escalation document<br>2) Trust wide review of boarding has been undertaken to support capacity at times of surge. Linked to use of discharge lounges. Discussion planned with Walsall around UEC Strategy and case study on what they have implemented around early flow<br>3) ED Huddle now also attended by AMU (Acute Medical Unit) and psychiatric liaison reps to support flow out of ED being escalated and management of complex MH patients<br>4) Creation of UHS Urgent Care Board to facilitate change and action internally led by COO |
| Mental Health focus | 1) Continuing to build up collaborative relationship with main mental health provider<br>2) Additional funding for CORE24 service resulting from work completed on the gap analysis with resources almost fully recruited to by SHFT |
| Workforce | 1) Ongoing quarterly meetings with senior ED team discussing all thing workforce linked to workforce strategy using output from workforce analysis looking at number of attendances, day of the week, time of day, senior decision makers and where they focus efforts. Discussions focus on new ideas to reduce gaps on the rota and resilience on bank and usage fill.<br>2) Outcome of UCV pilot focused on dedicated pitstop presence from ED senior. Business case in development, although recruitment to consultant where PAs have been reduced has been recently agreed |
| Estates | 1) Review of Ambulatory stream led by transformation team<br>2) Trust wide Point of Care business case discussed at Trust Investment Group to support central hub for all infection testing for admitting areas. New planning guidance received for 23/24 impacting on cost per test reimbursement is being reviewed alongside this case<br>3) Continued use of fallow pitstop as surge area Respiratory Assessment Unit or AMU 5<br>4) Use of existing space i.e. old Clinical Decisions Unit (CDU) and new CDU being discussed as could support specialty input of some kind |
| Culture & Staff Support | 1) Violence & Aggression discussions ongoing with Exec and multi-agency colleagues to respond the increase in volume of presentations and threat current posed to the ED team<br>2) Constant update to Exec and Trust Board via fortnightly meeting and regular updates to Trust Board |

# NHS Constitution - Standards for Access to services within waiting times

The NHS Constitution* and the Handbook to the NHS Constitution** together set out a range of rights to which people are entitled, and pledges that the NHS is committed to achieve, including:

The right to access certain services commissioned by NHS bodies within maximum waiting times, or for the NHS to take all reasonable steps to offer you a range of suitable alternative providers if this is not possible

- Start your consultant-led treatment within a maximum of 18 weeks from referral for non-urgent conditions
- Be seen by a cancer specialist within a maximum of 2 weeks from GP referral for urgent referrals where cancer is suspected

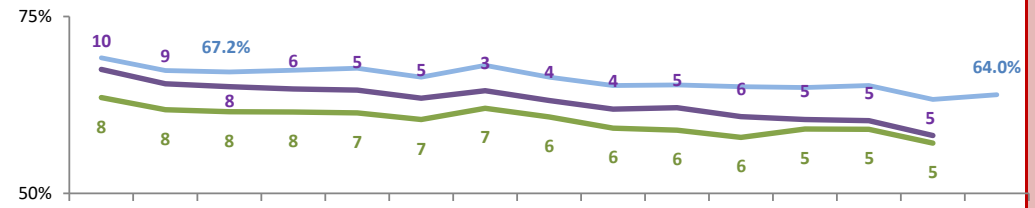
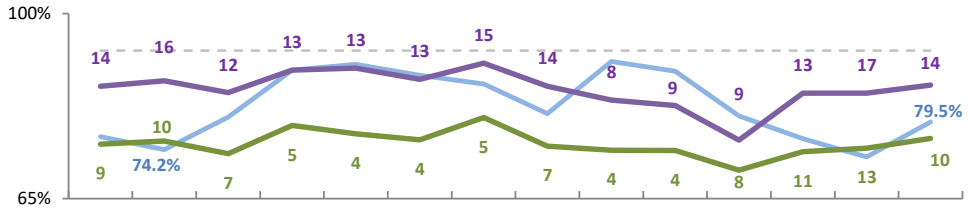
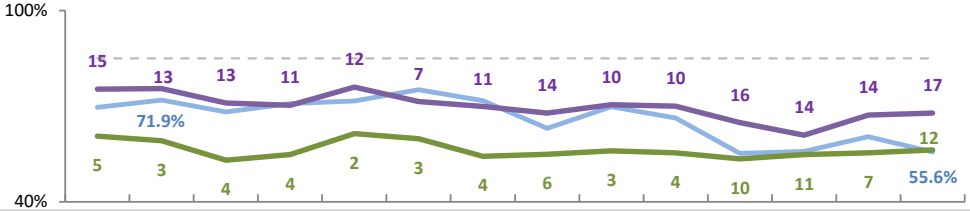
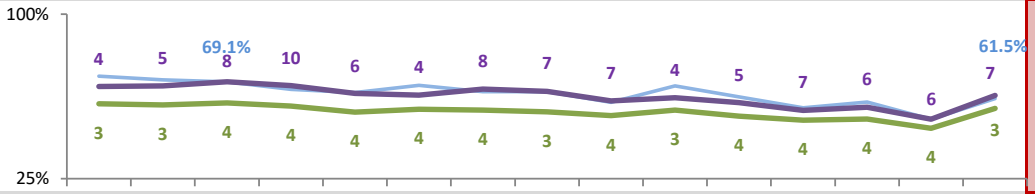
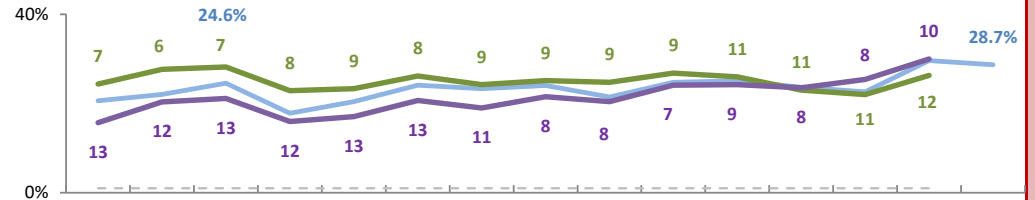
The NHS pledges to provide convenient, easy access to services within the waiting times set out in the Handbook to the NHS Constitution

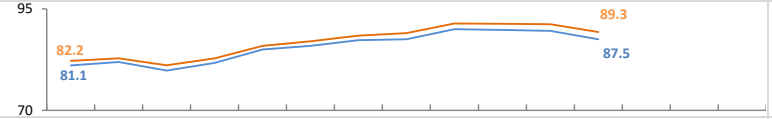
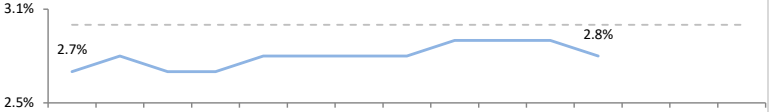
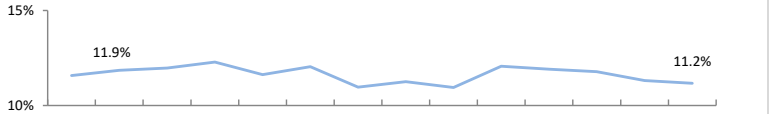
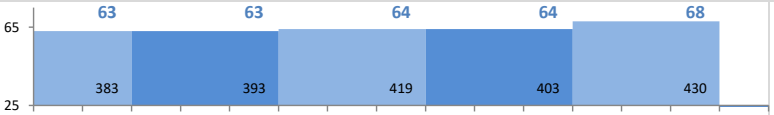
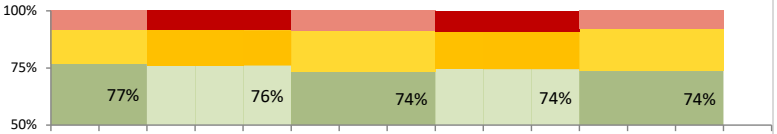
- All patients should receive high-quality care without any unnecessary delay
- Patients can expect to be treated at the right time and according to their clinical priority. Patients with urgent conditions, such as cancer, will be able to be seen and receive treatment more quickly

The handbook lists 11 of the government pledges on waiting times that are relevant to UHS services, such pledges are monitored within the organisation and by NHS commissioners and regulators.

Performance against the NHS rights, and a range of the pledges, is summarised below. Further information is available within the Appendix to this report.

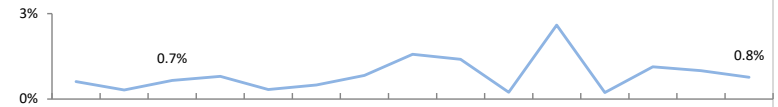
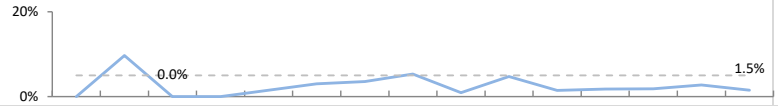
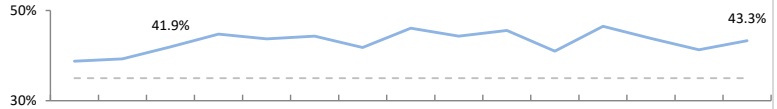
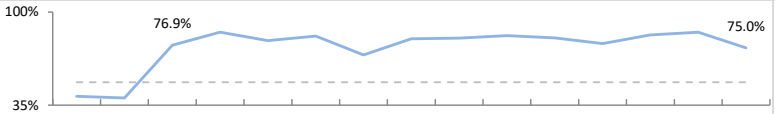
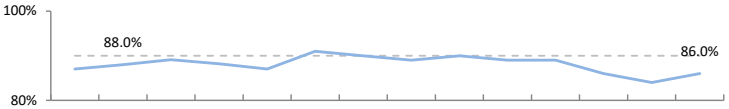
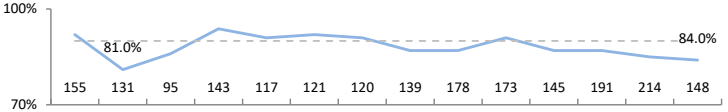
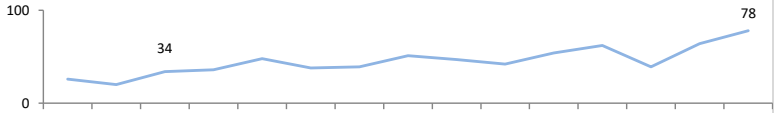
* https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england
** https://www.gov.uk/government/publications/supplements-to-the-nhs-constitution-for-england/the-handbook-to-the-nhs-constitution-for-england

| | | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Monthly target | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| UT28-N | % Patients on an open 18 week pathway (within 18 weeks )<br>UHSFT<br>Teaching hospital average (& rank of 20)<br>South East average (& rank of 17) |  | | | | | | | | | | | | | | | ≥92% | 65.4% |
| CN1-N | % Patients following a GP referral for suspected cancer seen by a specialist within 2 weeks (Most recently externally reported data, unless stated otherwise below)<br>UHSFT<br>Teaching hospital average (& rank of 20)<br>South East average (& rank of 17) |  | | | | | | | | | | | | | | | ≥93% | 82.9% |
| UT34-N | Cancer waiting times 62 day standard - Urgent referral to first definitive treatment (Most recently externally reported data, unless stated otherwise below)<br>UHSFT<br>Teaching hospital average (& rank of 19)<br>South East average (& rank of 17) |  | | | | | | | | | | | | | | | ≥85% | 64.0% |
| UT25-N | Patients spending less than 4hrs in ED - (Type 1)<br>UHSFT<br>Teaching hospital average (& rank of 16)<br>South East average (& rank of 16) |  | | | | | | | | | | | | | | | ≥95% | 61.5% |
| UT33-N | % of Patients waiting over 6 weeks for diagnostics<br>UHSFT<br>Teaching Hospital average (& rank of 20)<br>South East Average (& rank of 18) |  | | | | | | | | | | | | | | | ≤1% | 24.7% |

| **Outcomes** | | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Monthly target | YTD | YTD target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| UT1-N | HSMR - **UHS**<br>HSMR - **SGH** |  | | | | | | | | | | | | | | | ≤100 | 93.2 | ≤100 |
| UT2 | HSMR - Crude Mortality Rate |  | | | | | | | | | | | | | | | <3% | 2.7% | <3% |
| UT1-N / UT2: At time of IPR publication, the latest information available in Doctor Foster was from Oct 2022. Metrics are 12 month rolling. YTD target is for UHS for financial year | | | | | | | | | | | | | | | | | | | |
| UT3 | Percentage non-elective readmissions within 28 days of discharge from hospital |  | | | | | | | | | | | | | | | - | 11.5% | |
| | | Q3 21-22 | | Q4 21-22 | | | Q1 22-23 | | | Q2 22-23 | | | Q3 22-23 | | | Q4 22-23 | Quarterly target | | |
| UT4-L | **Cumulative Specialties** with Outcome Measures Developed (Quarterly) |  | | | | | | | | | | | | | | | +1 Specialty per quarter | | |
| UT5 | Developed Outcomes RAG ratings (Quarterly)<br>Red<br>Amber<br>Green |  | | | | | | | | | | | | | | | | | |
| UT5 - | Red : below the national standard or 10% lower than the local target<br>Amber : below the national standard or 5% lower than the local target<br>Green : within the national standard or local target | | | | | | | | | | | | | | | | | | |

| Safety | | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Monthly target | YTD | YTD target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| UT6-N | Cumulative Clostridium difficile<br>Most recent 12 Months vs. Previous 12 Months | | | 55 64 | 57 71 | 63 74 | 7 9 | 16 11 | 21 18 | 25 24 | 33 28 | 39 35 | 44 47 | 49 55 | 56 65 | 64 67 | ≤5 | 67 | ≤50 |
| UT7 | **Healthcare-acquired COVID infection**: COVID-positive sample taken >14days after admission (validated) | 11 | 21 | 20 | 14 | 42 | 36 | 23 | 45 | 45 | 2 | 29 | 87 | 2 | 34 | 15 | - | 318 | - |
| UT8 | **Probable hospital-associated COVID infection**: COVID-positive sample taken >7 days and <=14 days after admission (validated) | 11 | 14 | 17 | 10 | 31 | 35 | 12 | 32 | 37 | 4 | 15 | 49 | 6 | 14 | 4 | - | 208 | - |
| UT9 | Pressure ulcers category 2 per 1000 bed days | | | 0.39 | | | | | | | | | | | | 0.48 | <0.3 | 0.34 | <0.3 |
| UT10 | Pressure ulcers category 3 and above per 1000 bed days | | | 0.55 | | | | | | | | | | | | 0.25 | <0.3 | 0.40 | <0.3 |
| UT11-N | Medication Errors (severe/moderate) | | | 2 | | | | | | | | | | | | 3 | ≤3 | 21 | ≤30 |

| | | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Monthly target | YTD | YTD target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| UT12 | Watch & Reserve antibiotics, usage per 1,000 adms<br>Most recent months vs. 2018*95.5% | 2,749 | 2,786 | | | | | | | | | | | 2,749 | 3,042 | | 2,749 | 22,541 | 21,447 |
| UT12 - For 2022/23, a new requirement is applied: Reduction of 4.5% from calendar year 2018 usage in combined WHO/NHSE AWaRE subgroups for "watch" and "reserve" agents. The performance data relate to successive FINANCIAL years, however the comparator denominator remains CALENDAR year 2018 (we are not using 2020 or 2021 due to the disruptive effect of COVID on both usage and admissions). Data is reported 3 months in arrears. | | | | | | | | | | | | | | | | | | | |
| UT13 | Serious Incidents Requiring Investigation (SIRI) (based upon month reported as SIRI, excluding Maternity) | | | 5 | | | | | | | | | | | | 3 | - | 94 | - |
| UT14 | Serious Incidents Requiring Investigation - Maternity | | | 0 | | | | | | | | | | | | 0 | - | 8 | - |
| UT15 | Number of falls investigated per 1000 bed days | | | 0.25 | | | | | | | | | | | | 0.10 | - | 0.14 | - |
| UT16 | % patients with a nutrition plan in place (total checks conducted included at chart base) | 444 | 397 | | | | | | 53 | 742 | 572 | 750 | 719 | 676 | 669 | 711 | 812 | ≥90% | 94% | ≥90% |
| UT16 - monthly audit was paused due to pressure on all ward areas between Dec 2021 to May 2022. The audit was partially restarted in some ward areas in May 2022, and fully restarted in June 2022. | | | | | | | | | | | | | | | | | | | |
| UT17 | Red Flag staffing incidents | | | 21 | | | | | | | | | | | | 28 | - | 352 | - |

| **Patient Experience** | | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Monthly target | YTD | YTD target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| UT18-N | FFT Negative Score - Inpatients |  | | | | | | | | | | | | | | | ≤5% | 1.0% | ≤5% |
| UT19-N | FFT Negative Score - Maternity (postnatal ward) |  | | | | | | | | | | | | | | | ≤5% | 2.6% | ≤5% |
| UT20 | Total UHS women booked onto a continuity of carer pathway |  | | | | | | | | | | | | | | | ≥35% | 43.8% | ≥35% |
| UT21 | Total BAME women booked onto a continuity of carer pathway |  | | | | | | | | | | | | | | | ≥51% | 80.5% | ≥51% |
| UT22 | % Patients reporting being involved in decisions about care and treatment |  | | | | | | | | | | | | | | | ≥90% | 88.2% | ≥90% |
| UT23 | % Patients with a disability/ additional needs reporting those needs/adjustments were met (total number questioned included at chart base) |  | | | | | | | | | | | | | | | ≥90% | 87.9% | ≥90% |
| UT23 - Performance is a scored metric with a "Yes" response scoring 1, "Yes, to some extent" receiving 0.5 score and other responses scoring 0. | | | | | | | | | | | | | | | | | | | |
| UT24 | Overnight ward moves with a reason marked as non-clinical (excludes moves from admitting wards with LOS<12hrs) |  | | | | | | | | | | | | | | | - | 514 | - |

| **Access Standards** | | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Monthly target | YTD | YTD target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| UT25-N | Patients spending less than 4hrs in ED - (Type 1)<br>UHSFT<br>Teaching hospital average (& rank of 16)<br>South East average (& rank of 16) | 69.1% | | | | | | | | | | | | | | 61.5% | ≥95% | 61.5% | ≥95% |
| | | 4 | 5 | 8 | 10 | 6 | 4 | 8 | 7 | 7 | 4 | 5 | 7 | 6 | 6 | 7 | | | |
| | | 3 | 3 | 4 | 4 | 4 | 4 | 4 | 3 | 4 | 3 | 4 | 4 | 4 | 4 | 3 | | | |
| UT26 | Average (Mean) time in Dept - non-admitted patients | 03:02 | | | | | | | | | | | | | | 03:46 | ≤04:00 | 03:21 | ≤04:00 |
| UT27 | Average (Mean) time in Dept - admitted patients | 05:03 | | | | | | | | | | | | | | 06:37 | ≤04:00 | 05:59 | ≤04:00 |
| UT28-N | % Patients on an open 18 week pathway (within 18 weeks )<br>UHSFT<br>Teaching hospital average (& rank of 20)<br>South East average (& rank of 17) | 67.2% | | | | | | | | | | | | | | 64.0% | ≥92% | 65.4% | ≥92% |
| | | 10 | 9 | 8 | 6 | 5 | 5 | 3 | 4 | 4 | 5 | 6 | 5 | 5 | 5 | | | | |
| | | 8 | 8 | 8 | 8 | 7 | 7 | 7 | 6 | 6 | 6 | 6 | 5 | 5 | 5 | | | | |
| UT29 | Total number of patients on a waiting list (18 week referral to treatment pathway) | 44,551 | | | | | | | | | | | | | | 54,254 | - | 54,254 | - |
| UT30 | % Patients on an open 18 week pathway (waiting 52 weeks+ )<br>UHSFT<br>Teaching hospital average (& rank of 20)<br>South East average (& rank of 17) | 2,171 | | | | | | | | | | | | | | 2,156 | 2,011 | 2,156 | 2,011 |
| | | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 5 | 5 | 5 | 5 | | 5 | 5 | 5 | | | |
| | | 15 | 14 | 14 | 14 | 14 | 14 | 12 | 12 | 13 | 13 | 13 | 12 | 12 | 12 | | | | |

| | | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Monthly target | YTD | YTD target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| UT31 | Patients on an open 18 week pathway (waiting 104 weeks+ )<br>UHSFT<br>Teaching hospital average (& rank of 20)<br>South East average (& rank of 17) | 8 | 8 | 8 | 8 | 6 | 8 | 5 | 6 | 6 | 6 | 7 | 5 | 1 | 1 | 0 | 0 | 0 | 0 |
| | | 150 | | | | | | | | | | | | | | | | | |
| | | 17 | 17 | 17 | 17 | 17 | 17 | 13 | 13 | 13 | 14 | 14 | 10 | 1 | 1 | | | | |
| UT31a | Patients on an open 18 week pathway (waiting 78 weeks+ )<br>UHSFT<br>Teaching hospital average (& rank of 20)<br>South East average (& rank of 17) | 7 | 7 | 8 | 8 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | | | 271 | |
| | | 564 | | | | | | | | | | | | | | 271 | | | |
| | | 15 | 15 | 15 | 15 | 15 | 15 | 13 | 13 | 14 | 15 | 15 | 15 | 15 | 15 | | | | |
| UT32 | Patients waiting for diagnostics | 10,421 | | | | | | | | | | | | | | 10,525 | - | 10,525 | - |
| UT33-N | % of Patients waiting over 6 weeks for diagnostics<br>UHSFT<br>Teaching hospital average (& rank of 20)<br>South East average (& rank of 18) | 7 | 6 | 7 | 8 | 9 | 8 | 9 | 9 | 9 | 9 | 11 | 11 | 8 | 10 | 28.7% | ≤1% | 24.7% | ≤1% |
| | | 7 | | 24.6% | | | | | | | | | | | | | | | |
| | | 13 | 12 | 13 | 12 | 13 | 13 | 11 | 8 | 8 | 7 | 9 | 8 | 11 | 12 | | | | |
| UT34-N | Cancer waiting times 62 day standard - Urgent referral to first definitive treatment (Most recently externally reported data, unless stated otherwise below)<br>UHSFT<br>Teaching hospital average (& rank of 19)<br>South East average (& rank of 17) | 15 | 13 | 13 | 11 | 12 | 7 | 11 | 14 | 10 | 10 | 16 | 14 | 14 | 17 | | ≥85% | 64.0% | ≥85% |
| | | 71.9% | | | | | | | | | | | | | 12 | | | | |
| | | 5 | 3 | 4 | 4 | 2 | 3 | 4 | 6 | 3 | 4 | 10 | 11 | 7 | 55.6% | | | | |
| UT35-N | 31 day cancer wait performance - decision to treat to first definitive treatment (Most recently externally reported data, unless stated otherwise below)<br>UHSFT<br>Teaching hospital average (& rank of 19)<br>South East average (& rank of 17) | 9 | 96.8% | 12 | 14 | 16 | 14 | 16 | 15 | 15 | 17 | 16 | 16 | 16 | 16 | | ≥96% | 90.1% | ≥96% |
| | | 11 | | | | | | | | | | | | | 12 | | | | |
| | | 3 | 2 | 5 | 6 | 14 | 9 | 12 | 8 | 10 | 16 | 12 | 13 | 13 | 89.5% | | | | |
| UT36-N | 31 day cancer wait performance - Subsequent Treatments of Cancer (Most recently externally reported data, unless stated otherwise below)<br>UHSFT<br>Teaching hospital average (& rank of 19)<br>South East average (& rank of 17) | 16 | 15 | 11 | 14 | 15 | 13 | 9 | 12 | 13 | 13 | 13 | 14 | 14 | 7 | 95.3% | ≥96.0% | 91.2% | ≥96.0% |
| | | 15 | 87.8% | 8 | 11 | 8 | 15 | 10 | 10 | 13 | 13 | 13 | 9 | 13 | 6 | | | | |

| R&D Performance | | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Monthly target | YTD | YTD target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| PN1-L | Comparative CRN Recruitment Performance - non-weighted | 9 | 8 | 9 | 8 | 9 | 1 | 1 | 3 | 4 | 5 | 6 | 7 | 7 | 14 | 15 | Top 10 | - | - |
| PN2-L | Comparative CRN Recruitment Performance - weighted | 3 | 3 | 4 | 4 | 3 | 6 | 8 | 11 | 7 | 7 | 7 | 8 | 10 | 10 | 10 | Top 5 | - | - |
| PN3-L | Comparative CRN Recruitment - contract commercial | 7 | 7 | 8 | 9 | 10 | 2 | 1 | 3 | 2 | 3 | 4 | 4 | 8 | 8 | 8 | Top 10 | - | - |
| PN4-L | Achievement compared to R+D Income Baseline<br>Monthly income increase %<br>YTD income increase % | 0.0% | 29.0% | 49.0% | -234.0% | 143.0% | 359.0% | 63.0% | 74.0% | 56.0% | 177.0% | 94.0% | 48.0% | 23.0% | 71.0% | 79.0% | 166.0% | 85.0% | ≥5% | - | - |
| PN4-L | Note – Monthly and YTD Income are affected by a permanent change in accounting treatment implemented in M10 (Jan) 2021/22 in order to improve accuracy. Prior to M10, R+D open and ongoing studies/ grants in credit had anticipated future costs accrued. From M10 onwards, income received is deferred where costs have not yet been incurred/ invoiced. This change results in an adjustment of -£5m to monthly and YTD income which has been applied in M10. (An equivalent adjustment to the costs accounted for means that the balance of income and expenditure is not affected). | | | | | | | | | | | | | | | | | | |

| **Thrive** | | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Monthly target | YTD | YTD target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| WR1-L | Substantive Staff - Turnover<br>**-R12M turnover %**<br>**-Leavers in month (FTE)** | 16% 10% 13.7% 129 14.2% 124 200 0 | | | | | | | | | | | | | | | R12M <= 12.0% | 14.7% | - |
| WR2-L | Staff Vacancies<br>**-Nursing vacancies** (registered nurses only in clinical wards)<br>**-All Staff vacancies** | 20% 0% 13.2% 7.3% 11.9% 8.3% | | | | | | | | | | | | | | | - | - | - |
| WR3-L | Workforce Numbers<br>**-Planned substantive WTE**<br>**-Actual substantive WTE**<br>*-Including - Month-end contracted staff in post (ESR), Consultant APAs, Junior doctors Extra Rostered Hrs*<br>*-Excluding - Bank and agency; honorary contracts; career breaks; secondments; hosted services; WPL; Chilworth; Vaccination Hub* | 13,000 11,000 11,570 11,570 12,163 11,834 | | | | | | | | | | | | | | | 11,900 WTE by March 2023 | - | - |
| WR4-L | Staff - Sickness absence<br>**-R12M sickness %**<br>**-Sickness in month %** | 7% 0% 5.9% 4.2% 4.5% 3.7% | | | | | | | | | | | | | | | R12M <= 3.4% | 4.8% | - |
| **Excel** | | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Monthly target | YTD | YTD target |
| WR5-L | Non-medical appraisals completed<br>**-R12M appraisal %**<br>**-Appraisals in month** | 100% 50% 73.9% 385 75.8% 477 725 325 | | | | | | | | | | | | | | | R12M >= 92.0% | 73.4% | - |
| WR6-L | Medical staff appraisals completed - Rolling 12-months | 95% 50% 64.2% 86.7% | | | | | | | | | | | | | | | - | - | - |

| | | Q3 21-22 | Q4 21-22 | Q1 22-23 | Q2 22-23 | Q3 22-23 | Q4 22-23 | Quarterly target | | |
|---|---|---|---|---|---|---|---|---|---|---|
| WR7-L | Staff recommend UHS as a place to work score:<br>National Quarterly Pulse Survey (NQPS)<br>**National NHS Staff Survey** | 7.1 | 7.24 | 7.05 | 6.96 | | | - | - | - |
| WR8-L | Staff survey engagement score<br>National Quarterly Pulse Survey (NQPS)<br>**National NHS Staff Survey** | 7.2 | 7.17 | 7.08 | 7.03 | | | - | - | - |

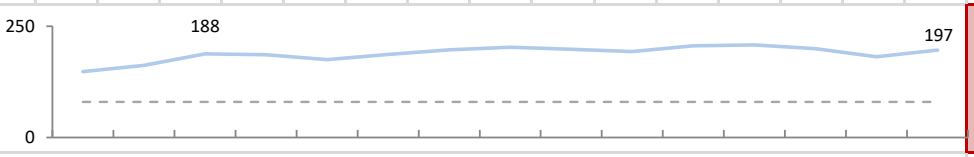
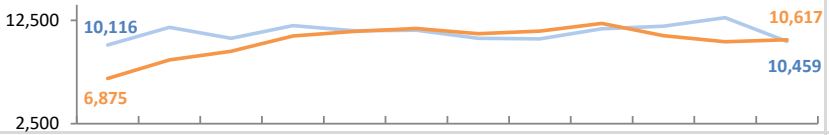
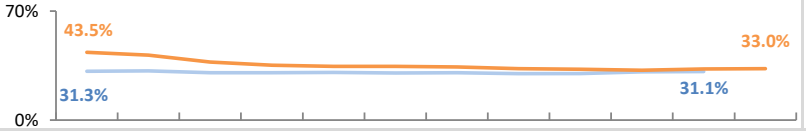
WR7-L , WR8-L: National NHS Staff Survey results under **embargo** until 9th March 2023.

| **Belong** | | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Monthly target | YTD | YTD target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| WR9-L | % of Band 7+ staff who are Black and Minority Ethnic | 10.4% | | | | | | | | | | | | | | 11.0% | 19% by 2026 | 10.7% | - |
| WR10 | % of Band 7+ Staff who have declared a disability or long term health condition | 13.4% | | | | | | | | | | | | | | 13.1% | - | - | - |

| | | Q3 21-22 | Q4 21-22 | Q1 22-23 | Q2 22-23 | Q3 22-23 | Q4 22-23 | Quarterly target | | |
|---|---|---|---|---|---|---|---|---|---|---|
| WR11 | Staff recommending UHS as a place to work: White British staff compared with all other ethnic groups combined<br>-White British<br>-All other ethnic groups combined | 7.36 | 7.44 | 7.3 | 7.14 | | | - | - | - |
| | | 7.14 | 7.12 | 7.02 | 6.97 | | | | | |
| WR12 | Staff recommending UHS as a place to work: Non disabled /prefer not to answer compared with Disabled<br>-Non disabled /prefer not to answer<br>-Disabled | 6.9 | 7.02 | 6.9 | 6.91 | | | - | - | - |
| | | 7.3 | 7.18 | 7.09 | 7.06 | | | | | |
| WR13 | Staff recommending UHS as a place to work: Sexuality = Heterosexual compared with all other groups combined<br>-Sexuality = Heterosexual<br>-All other groups combined | 7.00 | 6.87 | 6.81 | 6.62 | | | - | - | - |
| | | 7.2 | 7.19 | 7.08 | 7.05 | | | | | |

WR11, WR12,WR13: National NHS Staff Survey results under **embargo** until 9th March 2023.

| | | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Monthly target | YTD | YTD target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FN6 | Percentage of staff living locally (inside the Southampton City boundaries) | 53.1% | | | | | | | | | | | | | | 55.1% | - | - | - |
| FN7 | Percentage of staff residing in deprived areas (lowest 30% - national Index of Multiple Deprivation) | 23.4% | | | | | | | | | | | | | | 25.5% | - | - | - |

| **Local Integration** | | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Monthly target | YTD | YTD target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| NT1 | Number of inpatients that were medically optimised for discharge (monthly average) |  | | | | | | | | | | | | | | | ≤80 | 197 | - |
| NT2 | Emergency Department activity - type 1<br>This year vs. last year |  | | | | | | | | | | | | | | | - | 114,118 | - |
| NT3 | Percentage of virtual appointments as a proportion of all outpatient consultations<br>This year vs. last year |  | | | | | | | | | | | | | | | ≥25% | 30.4% | ≥25% |

| **Digital** | | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Monthly target | YTD | YTD target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FN1 | My Medical Record - UHS patient accounts (cumulative number of accounts in place at the end of each month) | 150,000<br>0<br>101,577<br>144,668 | | | | | | | | | | | | | | | - | 144,668 | |
| FN2 | My Medical Record - UHS patient logins (number of logins made within each month) | 32,000<br>15,000<br>21,560<br>30,515 | | | | | | | | | | | | | | | - | 262,338 | |
| FN3 | Patients choosing digital correspondence<br>- Total choosing paperless in the month<br>- Total offered but not yet choosing paperless in the month<br>- % of total My Medical Record service users who have chosen paperless (cumulative) | 15%<br>0%<br>12,000<br>0<br>1941<br>7,294<br>2.0%<br>10.7%<br>690<br>2,756 | | | | | | | | | | | | | | | - | | |