University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Finance Report 2023-24 Month 12**			
Agenda item:	**8.5**			
Sponsor:	**Ian Howard – Chief Financial Officer**			
Author:	**Philip Bunting – Director of Operational Finance** **David O'Sullivan – Assistant Director of Finance – Financial Performance**			
Date:	**25 April 2024**			
Purpose:	**Assurance or reassurance**	**Approval**	**Ratification**	**Information** **X**
Issue to be addressed:	The finance report provides a monthly summary of the key financial information for the Trust.			
Response to the issue:	**M12 Financial Position** UHS delivered a full year deficit of £29.1m, a £3.1m deterioration on our planned £26m deficit. This position was however an improvement on our previous forecast. As a result of this delivery, NHS England granted UHS additional one-off cash support of £24.6m, resulting in a final deficit position of £4.5m. **Narrative of the year** *The financial environment has remained extremely challenging through the closing months of 2023/24. Continued periods of industrial action, coupled with increasing service demand, has put a significant strain on the organisation and its finances. Particularly industrial action has not only had a direct financial impact of increased backfill costs (particularly for consultants needing to cover junior doctor rota gaps) and lost income (due to supressed elective activity) but there has been an opportunity cost of clinical and management time whereby significant planning has been required to ensure the hospital could continue to function safely.* *Surge capacity (unfunded extra beds) has been required across all months of the financial year which has been particularly driven by non-criteria to reside numbers increasing to peaks of 250. The level of Mental Health demand has also increased noticeably from 2022/23 for which patients require enhanced levels of support often at a significant cost premium to the trust utilising agency staff.* *Despite these pressures however the trust has reduced its previously forecasted deficit to £29.1m (£3.1m worse than the planned deficit of £26m) mitigating the risk of further financial deficit. One off funding to offset the impact of industrial action has helped maintain this trajectory. Financial improvement actions across the final months have also helped stabilise the rate of pay expenditure growth and deliver increased levels of efficiencies. This has enabled £63m of savings to be achieved in 2023/24 particularly focused on transforming services under the three workstreams of theatre optimisation, outpatients and inpatient flow. This work will continue on into 2024/25 supporting continued improvement.* *The trust also continues to overperform on the elective recovery target which supports financial sustainability via increased tariff income and also helps supports waiting list reduction targets. 118% of 2019/20 levels of elective, daycase and outpatient first attendances has been delivered in 2023/24*			

compared to an original target of 113%. This target was subsequently reduced to 109% as an offset for industrial action pressures. YTD this has generated over £19m of additional income for the trust.

In part due to the successful delivery of the improvement to our forecast position, NHS England has granted UHS one off cash support of £24.6m that will mean the reported deficit for 2023/24 is now forecast to close at £4.5m. This one-off cash injection will enable continued investment in capital in future years although does not remove the trusts underlying challenge which will continue into 2024/25.

Further to this the trust remains on target to spend its full capital allocation for 2023/24 totalling £75m. This continued investment in capacity, digital and infrastructure helps support continued ongoing financial sustainability and efficiency improvements that provide foundations for the future.

Underlying Position

Throughout the year the Trust has been operating at an underlying monthly deficit ranging between £4m - £5m. Since the recovery actions started in November, the overall underlying deficit has reduced to an average of £4.1m (down from the previous £4.5m average).

In M12, the underlying position was a £4.2m deficit. Additional temporary staffing in March linked to annual leave and increased sickness is however not expected to continue and may therefore reduce this position further.

For the full year, the underlying position for the Trust was a £51.3m deficit, with the overall position supported by substantial levels of one-off benefits.

Financial Recovery

In October, UHS set itself a £5.5m financial recovery plan in order to deliver an improvement in its forecast position.

An update on progress is outlined in appendix 2. Overall, whilst some of the measures have been extremely challenging within the organisation, we have been able to identify £7.4m of benefits delivered, £1.9m above the original target.

The additional control measures have ensured pay costs remaining broadly flat over the period, significantly altering the trajectory. They have also controlled non-pay costs and increased our anticipated income position.

ERF

In month ERF performance was above target at 120%, with full year performance ending at 118%. This was against a revised target of 109% following a 4% reduction linked to industrial action. This overperformance has generated an additional £19.6m income for the Trust, offsetting the additional cost of treating more patients waiting for our care.

The ERF income received as a Trust has been fixed at a figure extrapolated from M9 performance. It has been confirmed that any over-performance against this figure to be adjusted for in our final 24/25 target.

Our performance is the 7th highest in the country (of Trusts earning >£100m ERF) and circa 13% higher than the average performance.

Deficit Drivers

The drivers of our financial deficit continue to be:

- Further growth in the number of patients with no criteria to reside (NCTR). Our plan submission was based on an assumption that the HIOW ICS discharge transformation programme would support a 50% reduction in NCTR patients from 200 to 100. However, numbers have spiked since January and are regularly 220 – 250. The Trust has additional surge capacity open and has utilised additional bed capacity intended to support the elective programme to manage this growth, resulting in a significant unfunded cost pressure. It is estimated the Trust could save £13m should this reduce to 100.
- Further growth in the number of patients presenting with mental health conditions only who would be better cared for in an alternative care setting. It is estimated to be costing the Trust £6m per year in providing agency nursing & care assistants to support these patients safely within the hospital. This has grown by circa £2.5m in 23/24 alone.
- A shortfall in additional funding for nationally negotiated pay awards has added a £5.2m pressure to the Trust. That is set to grow to £6.5m once non-recurring funding is removed in 24/25. It is thought this shortfall has arisen due to the Trust having a higher proportion of medical staff than the average Trust.
- The Trust is continuing to face funding pressures in managing NEL and ED activity above block funded levels.
- The Trust is continuing to deliver outpatient follow-up activity above block funded levels – including in areas such as cancer and managing long-term conditions in Ophthalmology.
- We also entered the year with an underlying deficit from the previous year, with pressures outlined above plus non-pay inflation pressures, particularly in relation to energy prices. High-cost drugs spend was also significantly above block funded levels.

We continue to raise these financial pressures, particularly those linked to unfunded levels of additional activity, with our commissioners and hope to resolve these issues in 2024/25.

Cost Improvement Plans

We have reported delivery of CIP plans of £63m, including the financial recovery plan outlined above. That equates to 5% of our overall income level, or 7% of our addressable income level (excluding hosted functions / pass-through funding items).

This level of CIP delivery is a record for UHS, £18m higher than delivered in the previous year.

Whilst we have made good progress with CIP performance, it is heavily supported by non-recurrent delivery that cannot be relied upon for underlying financial improvement. Recurrent delivery is £28m, or closer to 3%.

The non-recurrent delivery forms part of the financial challenge outlined in our underlying position and into our financial planning for 2024/25.

Capital

We spent our full capital allocation for the year of £75m, with £15m grant / donated income mainly linked to our decarbonisation programme, £6m of NHSE funded schemes, £3m of leases and £51m of Trust-funded capital.

In year:

- We finalised the staff wellbeing programme, with the Wellbeing hub and PAH roof garden opened.
- We completed the sky bridge and opened 2 new wards.

	• We completed and opened 2 new theatres and started work on the next 2 theatres to open in 2024/25. • We secured funding for a Neonatal Unit expansion, expected to complete in 2024/25. • We began construction of a new Sterile Service and Aseptics facility at Adanac Park. • We completed refurbishment of G3 ward. • We spent £8m on improvements to infrastructure to reduce our highest backlog maintenance risks. • We spent £8m on investments to our digital infrastructure. • We delivered the first year of the Trusts £33m decarbonisation programme, spending £12m. • We commenced the Community Diagnostics Centre programme, to be delivered in 2024/25 and 2025/26. • We added new equipment including MRI and CT scanners to an overall value of circa £12m. **Cash** We ended the year with a cash balance of £79m, an in-year reduction of £26m linked to our underlying financial position. This was however significantly higher than previously projected, with cash receipts linked to cash support and other income previously accrued. We are however anticipating our cash position deteriorating early in the new financial year, linked to underlying financial pressures and payment of payables balances to suppliers, particularly linked to our capital programme. Moving into 2024/25 additional vigilance will be applied and early warning systems maintained in order to assess the ongoing viability of the capital programme and also ensure the NHS England draw down process is ready if and when required.
Implications:	• Financial implications of availability of funding to cover growth, cost pressures and new activity. • Organisational implications of remaining within statutory duties.
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. • Investment risk related to the above • Cash risk linked to volatility above • Inability to maximise CDEL (which cannot be carried forward) and the risk of a reducing internal CDEL allocation for 2024/25 due to the forecast deficit for 2023/24.
Summary: Conclusion and/or recommendation	Trust Board is asked to: • Note the finance position.

University Hospital Southampton NHS Foundation Trust

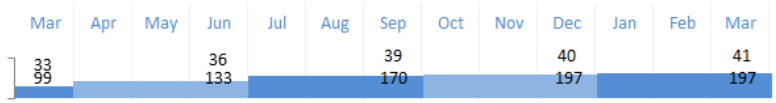
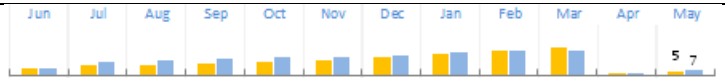
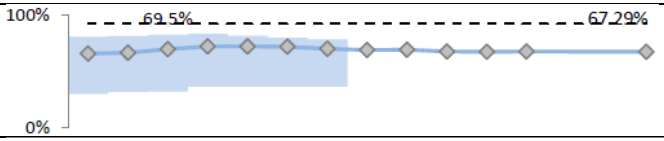
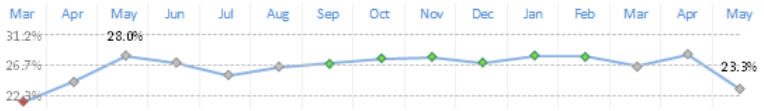
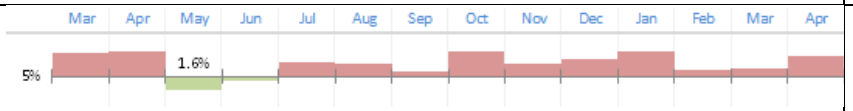
Report to the Trust Board of Directors				
Title:	**Performance KPI Report 2023-24 Month 12**			
Agenda item:	**8.2**			
Sponsor:	**David French, Chief Executive Officer**			
Author	**Sam Dale, Associate Director of Data and Analytics**			
Date:	**25 April 2024**			
Purpose:	**Assurance or reassurance** **Y**	**Approval**	**Ratification**	**Information**
Issue to be addressed:	The report aims to provide assurance: • Regarding the successful implementation of our strategy • That the care we provide is safe, caring, effective, responsive, and well led			
Response to the issue:	The Performance KPI 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 performance metrics. 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.			

Performance KPI Board Report

Covering up to
March 2024

Sponsor – David French, Chief Executive Officer
Author – Sam Dale, Associate 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 is 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 Performance KPI Report is presented to the Trust Board each month 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.

Due to the timing of the April 2024 Board meeting, the following referral to treatment data points were not validated for March 2024 and are therefore excluded: -

- **31** - Patients on an open 18 week pathway (within 18 weeks)
- **33** - Patients on an open 18 week pathway (within 52 weeks)
- **34** - Patients on an open 18 week pathway (within 65 weeks)
- **35** - Patients on an open 18 week pathway (within 78 weeks)
- **35a** - Patients on an open 18 week pathway (within 104 weeks)
- **32** - Total number of patients on a waiting list (18 week referral to treatment pathway)

Changes of note withing the report itself: -

- **13a –** the report now includes a metric reporting the number of never events in the month. This is an addition following our recent alignment of incident reporting with the Patient Safety Incident Response Framework (PSIRF).

Summary

This month's spotlight report explores UHS recent performance within the Emergency Department.

The ED spotlight highlights that:

- March 2024 performance for patients spending less than four hours in ED was 71.7% for Type 1 attendances and 73.5% for all types. This represents a 7% improvement on the February 2024 position. The performance for Type 1 attendances ranks UHS second when compared to other teaching hospitals and fourth against all hospitals within the South East Region.
- Throughout the 2023/24 financial year, Type 1 attendance volumes have averaged at 375 per day. This is a 1.4% increase on 2022/23 and an 18% increase on 2019/20.
- The Emergency Care Improvement Support Team (ECIST) recently visited the department and the feedback has highlighted four key workstreams which the senior team have agreed to prioritise over the next six months.
- The Trust's Transformation Team are also supporting the ED team by reviewing the current pathways into pitstop to improve ambulance handover delays and to support the ECIST actions agreed.

Areas of note in the appendix of performance metrics include: -

1. The Trust continues to make further improvements against the national Cancer waiting time targets. In February 2024, the Trust performance increased to 82.2% for the 62 day standard metric (urgent referral to first definitive treatment) and to 89.0% for 28 day faster diagnosis. This reflects an improvement on the January position for both standards and ranks the Trust in first place when compared to peer teaching hospitals across the country. Whilst performance increased to 87.6% for 31 day cancer targets (decision to treat to first definitive treatment) this lowers the organisation into the third quartile when compared to peer organisations. A series of actions are constantly reviewed and discussed to maintain progress across all tumour sites.
2. The percentage of patients waiting over 6 weeks for diagnostics has continued to reduce month on month through 2023/24, reaching just 7.8% in March 2024 (8.2% in February). In the latest comparison data available, the organisation ranked in the top quartile against peer teaching hospitals.
3. As noted above, the validated referral to treatment waiting times for March 24 were not available at the time of writing. However, it should be acknowledged that the February 2024 metrics rank UHS in the top quartile for all wait time categories associated to an open 18 week pathway.
4. The volume of inpatients in the hospital who do not meet the criteria to reside has remained at the same high levels throughout quarter four. The March 2024 average is 238 patients – this compares to a quarterly average of 236 and a year to date average of 204.
5. In March 2024, there were improvements across several metrics measuring patient experience. The FFT negative scores for inpatients (0.3%) and maternity postnatal ward (3.3%) are both within the monthly target. This success is also echoed in the % of patients involved in decisions about care and treatment (90%).

6. An area of concern remains the percentage of women booked onto a continuity of care pathway. The metrics for all UHS women has consistently been below the target of 35% and performance specifically for BAME women has declined to 9.1% in March 2024 against a target of 51%. The service recognises the position, understands the problems and has already adopted a series of steps to drive improvement. These include enabling a more inclusive approach to recruitment, the employment of a Band 7 lead to improve pastoral support and a more robust protection of caseloads and workstreams. Further interventions within the current self-referral team are being considered to ensure earlier signposting and onward referral for vulnerable clients. Medium to longer term steps will also include utilising digital tools and aids to capture patients at the first point of contact, ensuring all people with any vulnerability factor are fast tracked into the correct pathways of care sitting within a CoC framework.
7. The trust reported two PSIIs for Maternity in March 2024
8. There are eight medication errors reported for March 2024 all of which were categorised as moderate.

Ambulance response time performance

The latest unvalidated weekly data is provided by the South Coast Ambulance Service (SCAS) and the position is further explored in the spotlight report. For all weeks commencing in March 2024, we averaged 7.5 handovers per week taking over 60 minutes and 40 handovers per week taking over 30 minutes. This compares positively to the concerning position in January 2024, when we averaged 32 handovers taking over 60 minutes per week and 67 taking over 30 minutes. We will continue to highlight the position to gain assurance that long term, consistent improvements result from the agreed actions plans.

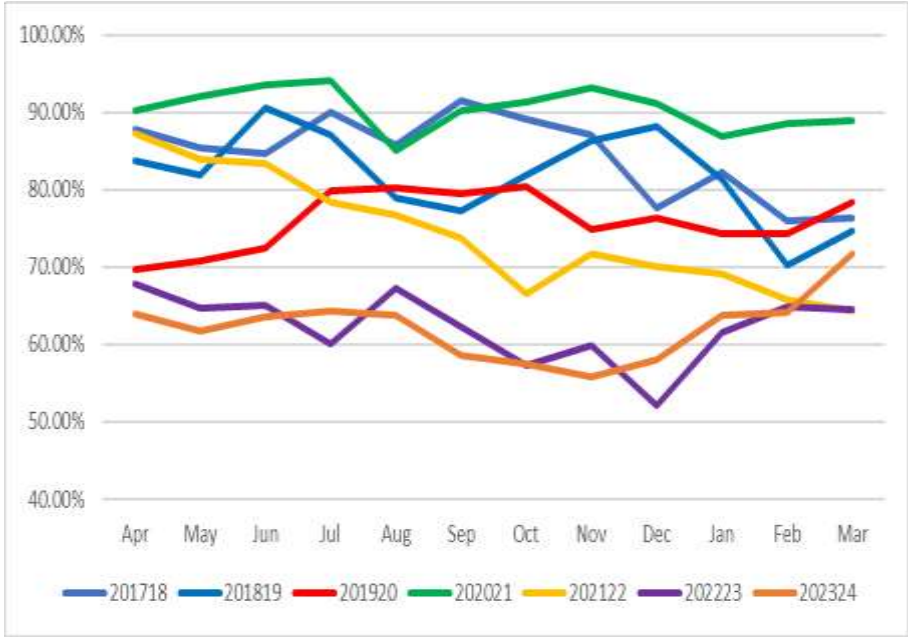
Spotlight: Emergency Department (ED) Performance

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

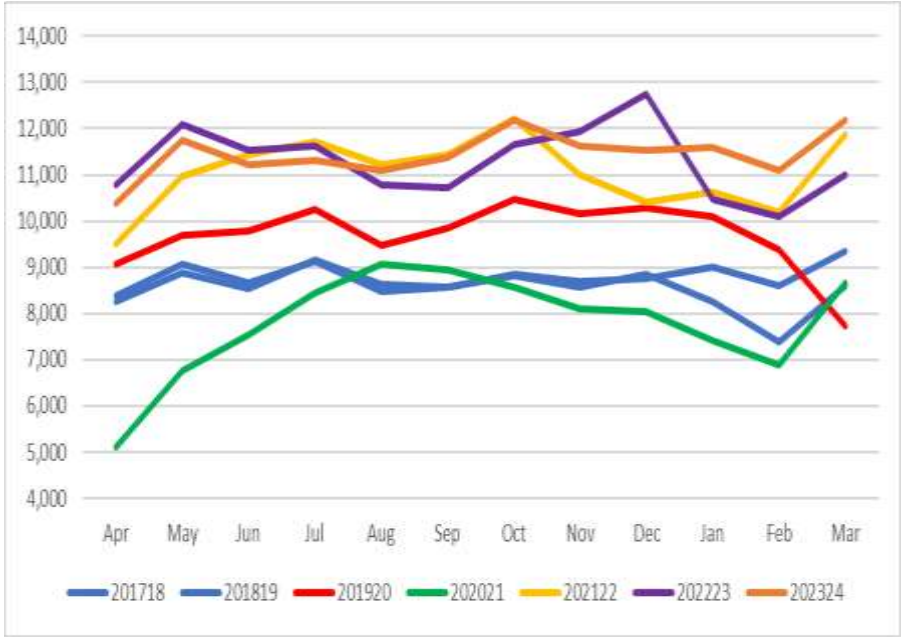
UHS is not currently meeting the national ED target and stood at 71.70% (Type 1) of patients seen within 4 hours in March 2024 (graph 1). Annual type 1 4hr performance was 62.20% for the full 2023/24 year which mirrors the performance achieved in 2022/23.

From April 2023 to March 2024 UHS averaged over 375 attendances per day (graph 2), compared to an average of 318 per day for the same time period in 2019/20, reflecting an 18% increase. Type 1 attendance growth was 1.4% in 2023/24 when compared to 2022/23.

Graph 1: Trended ED 4 hour performance – Type 1



Graph 2: Trended ED attendance – Type 1

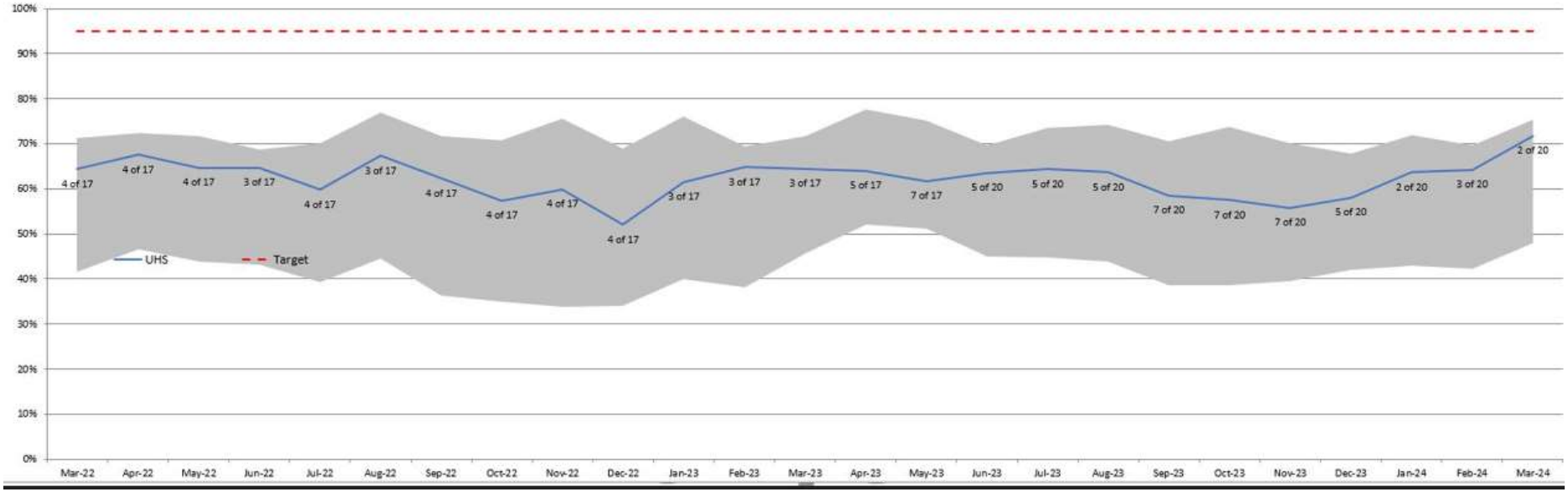


With type 2 performance (eye casualty) included, our March 2024 4hr performance was 73.5% compared to the national target of 76%. With type 3 (Urgent Treatment Centres at RSH & Lymington) our combined (unvalidated) UEC performance was above the national target achieving 79.90%.

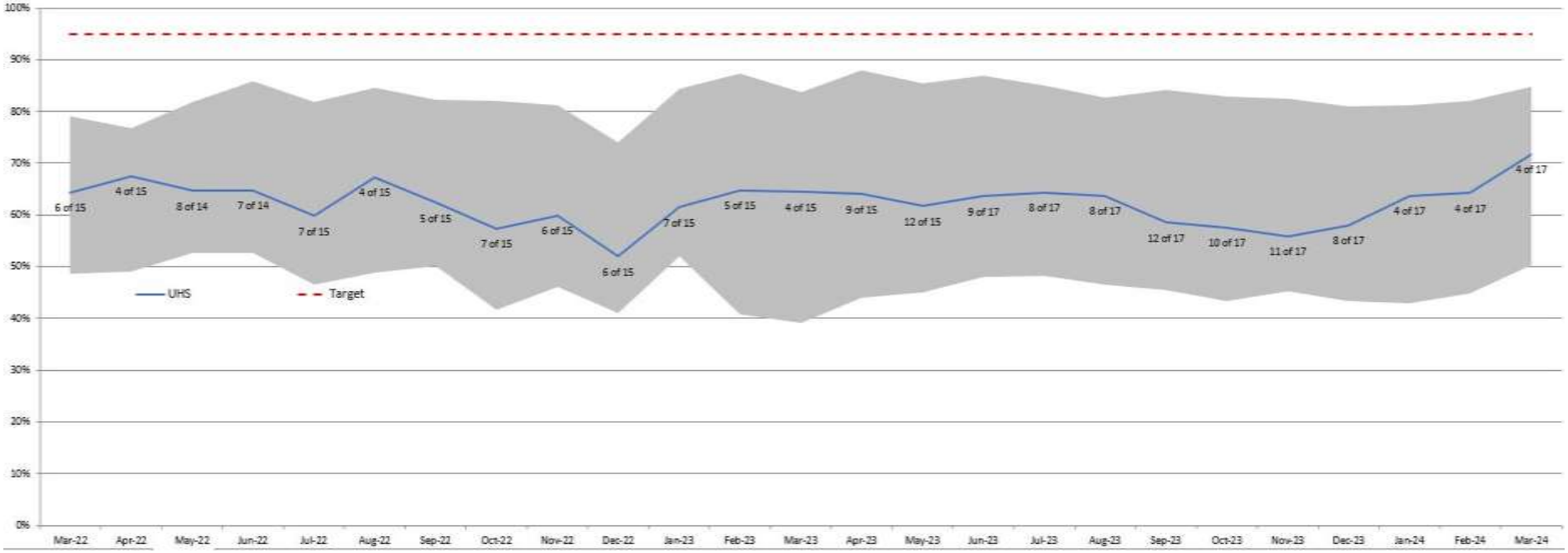
Our March 2024 position improved on February 2024 by 7%, despite an increase in daily attendances. This improvement can be attributed to a number of factors including the support from having a GP presence in the waiting room supporting with triage and early assessment of appropriate patients, nurse-led triage moving the patients to the appropriate place in the Emergency Department more quickly, additional focus from workload prioritisation by the Emergency Medicine Care Group Management Team and constant oversight Trust wide to support flow out of the ED.

This recent improvement can be seen in the teaching hospital and regional performance comparison graphs below.

Graph 3: Teaching Hospital Performance Comparison (2/20 at Mar24, was 7/20 at Oct23)



Graph 4: South-East Region Performance Comparison



Pressures raised in previous reports to Trust Board remain the same and in summary are:-

- Attendance growth – 18.2% compared to pre-covid, now 375 daily average compared to 318 pre-covid.
- Rise in patients with enhanced care needs and mental health attendances and the associated length of stay in the ED but also the knock-on impact on assessment areas and downstream wards.
- Flow through the Emergency Department. Whilst the % of admissions remains relatively flat at 30% in 23/24 (slight increase on 22/23 average of 29%) patients with no criteria to reside has now increased to 270 at times over this winter. This is an additional 50 patients and beds being occupied compared to previous years.

Emergency Care Improvement Support Team (ECIST) recently visited our ED based on an invite from our Deputy Medical Director and Director of Urgent and Emergency Care. Post this visit, the ED and Trust are continuing to work on improvements in areas within the ED and as part of a wider whole hospital response.

The inpatient flow programme continues to focus on a reduction in length of stay, increase timeliness of discharge (home before lunch) and an increase weekend discharge rates. Plans across the local system are also being developed, to support admission avoidance or improved discharge. However, the number of patients not meeting the criteria to reside continues to remains high.

In 2024-25 the inpatient flow programme will be focusing on delivering a 5% reduction in length of stay, which will not only support the Emergency Department and non-elective flow, but also access to elective services. The programme will focus on:-

1) Ward based improvements, including embedding and achieving 25% of patients being discharged before midday, improving the use of discharge lounges and rolling our criteria led discharge to more teams.
2) Supporting the medical model, including reducing the amount junior doctors need to do to complete the healthcare management record through a combination of auto-populating key fields and reducing the length where possible. We will also be undertaking a significant piece of cultural change, trying to encourage clinical teams to see prolonged length of stay as an act of potential harm, and challenge themselves 'why not home today?'
3) Embedding the use of digital systems, particularly eWhiteboards, to support flow across the hospital and better using Apex to support daily reviews of patients, particularly those being discharged on Pathway 0.
4) Expanding the use of existing same day emergency care facilities, and encouraging direct access from community or primary care, and exploring the possibility of a multi-speciality surgical same day emergency care space.
5) Working to standardise the role of bed managers and the care group single points of contact, and improving induction, education and training.
6) Work to further reduce delays for medication needed for patients to leave hospital, and to ensure transport is appropriately booked and where possible booked in advance

These actions, combined with initiatives being undertaken at a local level, will support the reduction in length of stay, creating beds for those patients who need admission from the emergency department.

Through the Urgent and Emergency Care Board we are also focussed on embedding the internal professional standards that have been supported by the Chief Medical Officer and clinical leaders across the organisation, which will reduce the time patients wait in the emergency department because of delays in a speciality accepting, or disputes between specialities about which is the most appropriate.

None of these things are silver bullets, and many require significant and ongoing cultural change. The aim is to create a culture where when a patient needs admission this is done swiftly and without dispute, delays in discharge are not tolerated and the concept of home first, and as soon as safely possible is

embedded. It is also important to note that these changes are necessary but not sufficient to improve performance against the emergency access target and to reduce corridor care and ambulance delays. Changes, outlined below, to how the emergency department itself works are also necessary.

An equal focus on timeliness of decisions from senior decision makers at the front door of the hospital is ongoing via recruitment programmes, support from other specialties (AMU, MOP & Cardiology) and help with ambulatory care pathways.

The senior ED team have prioritised four main workstreams from the ECIST feedback to focus on in Q1 & Q2 of 24/25 related to:

1) Consultant of the Day (COD) leadership – the aim of this workstream is to clarify and where appropriate standardise the role of the COD, focusing on how the department is run, how escalation takes place and what are the 'must do' actions in any shift. While recognising there will be acceptable levels of variation in any team, the goal is to codify what the minimum standards are. It will also review the ECIST recommendation about zoning to help alleviate the pressure on the consultant of the day.
2) Flow – front door, ambulatory & minors – ECIST feedback highlighted that there was a lack of clear definitions in key areas such as pitstop and ambulatory majors, leading to an inconsistent approach at times. This workstream will review pathways and clarify and codify the purpose and role of each zone, and those working in it.
3) Use of clinical decisions unit (CDU) - ECIST questioned the need for a CDU, and whether the space would be better repurposed for another use. There are a number of potential options for the space, but there is also potential risk as the current CDU provides additional capacity for patients who otherwise might wait in majors. This workstream will review that recommendation and come up with a series of options to respond to the feedback.
4) Flow in and out of Pitstop – At times pitstop can delay offloading of ambulances even when there is space in majors, because of the need to triage patients. A new triage model has, while reducing risk in the waiting room, also potentially increased the pressure on ambulance holds. This workstream will review flow into and out of pitstop, to agree a process that provides appropriate triage, reduces risk in the waiting room but also reduces ambulance delays.

The clinical leaders in the ED, supported by the Care Group Management Team are taking forward these workstreams via weekly oversight meetings and regularly sessions with the wider ED workforce. An initial brainstorming session was held at the end of March with the senior ED team led by the ED clinical leads to discuss these topics and assign actions and owners.

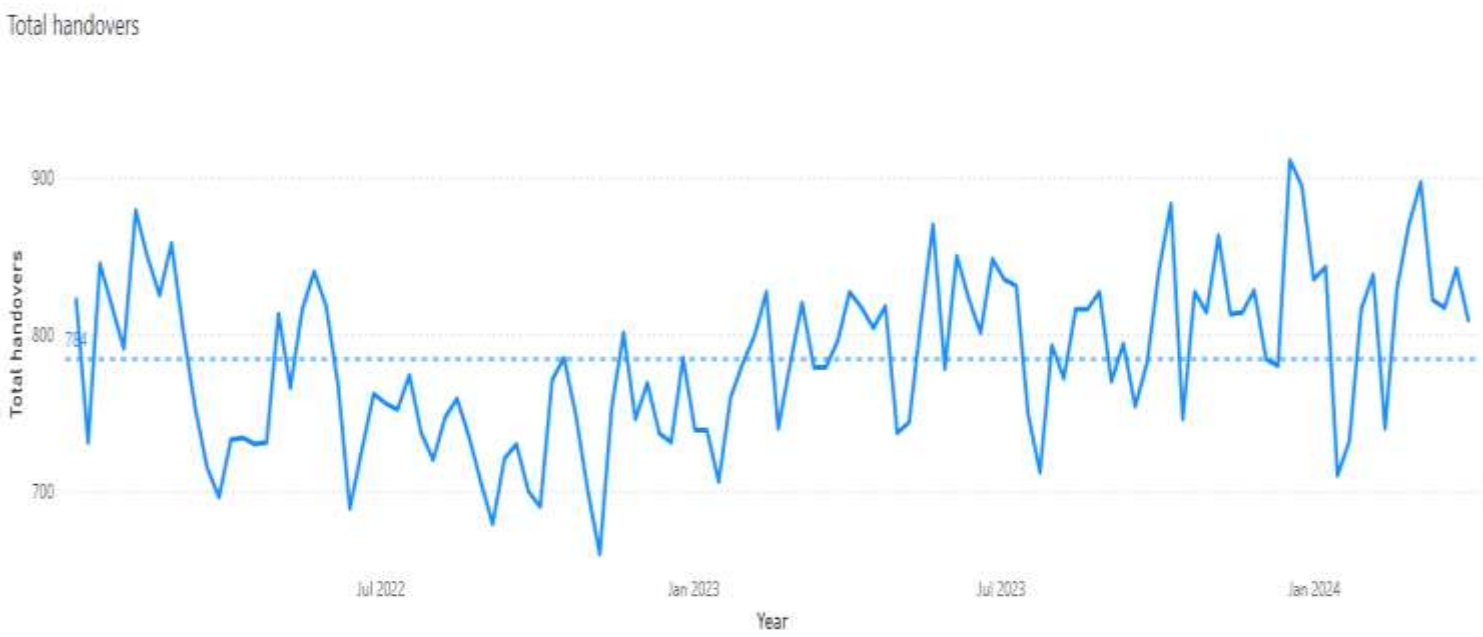
The Transformation Team have started to support in developing these work streams and have done some initial observations.

The COO led Urgent & Emergency Care (UEC) Board continues to meet to discuss feedback on the ED and trust wide workstreams to support performance against the 4hr emergency access target with two clear aims and objectives of the next 12 months to eradicate corridor care and have zero ambulance handover delays above the 15mins allowance.

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

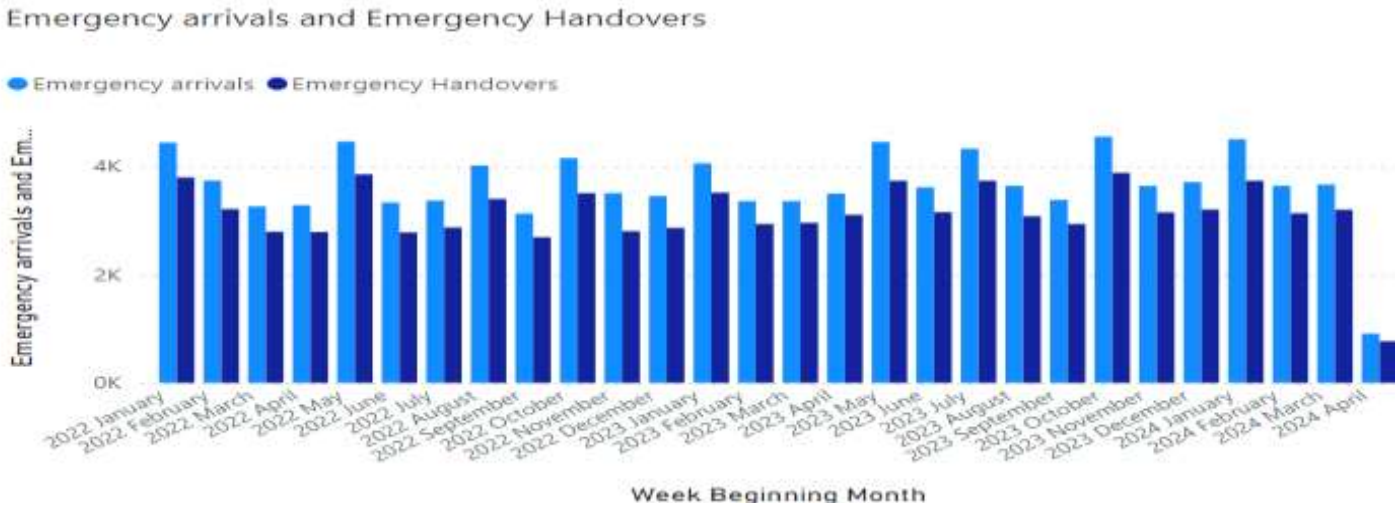
Ambulance Handovers are a current focus area for NHS England and is also one of the key priority areas within the national priorities for 2023/24.
UHS has constantly performed very well in relation to measures of timely ambulance handover and continues to do so compared to peers.

Graph 5: Total Ambulance handovers (unvalidated):-



Graph 6: Ambulance handovers to the ED - Volumes over 30 & 60 minutes

Graph 7: Emergency Ambulance Arrivals & Handovers Volume December 2021 to March 2024



Graph 6 highlights the increasing trend in ambulances conveyed to UHS being held over 30 & 60mins. Discussions are ongoing between COO team and SCAS reps to support improving ambulance delays. This involves better implementation of dual sign off with the emergency department, to ensure more accurate data quality, agreeing a 'capacity full' protocol with SCAS and the wider system, and work between SCAS and the emergency department to review best practice and ensure we are following it (e.g. how patients are managed when they are in a queue, and any potential escalation areas should immediate handover need to be implemented).

It is worth noting, whilst the handover delays appear to be on the rise this does not directly link with held ambulances at UHS waiting to handover patients into the ED. This is due to how those patients are being looked after by an onsite SCAS crew following the standing up of a SCAS HALO and then enacting our agreed cohorting policy at times of extreme pressure in the ED but also with ambulance calls. The cohorting policy allows patients to be handed over into ED but looked after temporarily by a SCAS crew to support ambulances returning to the road to respond to 999 calls. As SCAS report in line with National Reporting Standards the data does not recognise our actual lost ambulance hours when we enact cohorting.

The Trust's Transformation Team are currently supporting the ED team to review the current pathways into pitstop with one of the measures to review the impact on ambulance handover delays and to support the ECIST action identified above.

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 eleven 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

		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Monthly target	YTD
31	% Patients on an open 18 week pathway (within 18 weeks) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	5	5	4	4	4	4	5	4	4	4	4	4	4	4		≥92%	62.9%
		5	5	6	6	5	5	6	6	6	5	4	4	4				
38	% Patients following a GP referral for suspected cancer seen by a specialist within 2 weeks (Most recently externally reported data, unless stated otherwise below) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	13	15	17	17	17	16	16	16	13							≥96%	79.3%
		11	18	16	19	18	16	13	10	9								

38 - Beginning December 2023, NHSE published Cancer data no longer includes 2 week wait as a cancer standard for benchmarking. Data shown for October 2023 onwards will reflect internally reported UHS position for each month, but will not include Teaching Hospital/South East Hospital data

39	Cancer waiting times 62 day standard - Urgent referral to first definitive treatment (Most recently externally reported data, unless stated otherwise below) UHSFT Teaching hospital average (& rank of 19) South East average (& rank of 17)	14	14	18	9	14	13	10	15	6	11	7	6	4			≥85%	63.3%
		11	7	14	5	9	7	3	6	1	2	3	2	2	1			
28	Patients spending less than 4hrs in ED - (Type 1) UHSFT Teaching hospital average (& rank of 16) South East average (& rank of 16)	7	5	4	9	12	9	8	8	12	10	11	8	4	4	4	≥95%	62.2%
		3	3	3	5	7	5	5	5	7	7	7	5	2	3	2		
37	% of Patients waiting over 6 weeks for diagnostics UHSFT Teaching Hospital average (& rank of 20) South East Average (& rank of 18)	12	12	12	11	11	11	10	10	7	7	6	7	5	5		≤1%	17.6%
		7	8	8	7	7	8	7	9	8	7	7	7	7	5			

Outcomes		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Monthly target	YTD	YTD target
1	HSMR - **UHS** HSMR - **SGH**	89.02												89.85			≤100	93.1	≤100
		87.29												88.56					
		75																	
2	HSMR - Crude Mortality Rate	3.1%															<3%	2.8%	<3%
		2.8%												2.7%					
		2.5%																	
3	Percentage non-elective readmissions within 28 days of discharge from hospital	15%															-	12.2%	
		11.2%												12.5%					
		10%																	
			Q4 22-23			Q1 23-24			Q2 23-24			Q3 23-24			Q4 23-24		Quarterly target		
4	**Cumulative Specialties** with Outcome Measures Developed (Quarterly)	80															+1 Specialty per quarter		
		70	71			72			72			73			75				
		60																	
5	Developed Outcomes RAG ratings (Quarterly) Red Amber Green	100%	35			34			37			41			42				
		75%	81			82			75			67			65				
		50%	336			340			333			337			338				

Red : below the national standard or 10% lower than the local target
Amber : below the national standard or 5% lower than the local target
Green : within the national standard or local target

Safety		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Monthly target	YTD	YTD target
6	Cumulative Clostridium difficile **Most recent 12 Months** vs. **Previous 12 Months**	9	4	11	12	18	27	24	35	28	49	35	60	47	66	55	72	65	81	73	91	77	97	84	105	≤5	105	≤60
7	MRSA bacteraemia	0	0	0	0	0	0	1	0	0	1	2	1	2	0	1	0	8	0
8	Gram negative bacteraemia	16	17	14	32	14	19	27	16	21	15	25	18	17	20	19	≤18	226	≤209
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Monthly target	YTD	YTD target
9	Pressure ulcers category 2 per 1000 bed days	0.39														0.33	<0.3	0.41	<0.3
10	Pressure ulcers category 3 and above per 1000 bed days	0.29														0.28	<0.3	0.42	<0.3
11	Medication Errors (severe/moderate)	3														8	≤3	33	36
12	Watch & Reserve antibiotics, usage per 1,000 adms **Most recent months** vs. **2018*95.5%**	2,345	2,587												2,927	2,480	2,927	32,894	31,311

12 - For 2022/23 and forward, 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).

Safety		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Monthly target	YTD	YTD target
13	PSII's (based upon month reported, excluding Maternity)			3												1	-	39	-
13a	Never Events															0		6	
14	PSII's- Maternity			1												2	-	6	-
15	Number of falls investigated per 1000 bed days			0.12												0.09	-	0.09	-
16	% patients with a nutrition plan in place (total checks conducted included at chart base)			93.1%												95.2%	≥90%	95%	≥90%
		1624	780	1600	844	871	788	806	798	772	770	894	879	956	930	949			
17	Red Flag staffing incidents			35												41	-	256	-

Maternity		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Monthly target	YTD	YTD target
18	Birth rate and Bookings Birth Rate - total number of women birthed Bookings - Total number of women booked	436 / 453	383 / 432	387 / 513	416 / 449	402 / 477	418 / 450	417 / 382	400 / 424	400 / 442	467 / 446	409 / 469	428 / 392	406 / 483	401 / 429	428 / 409	-	-	-
19	Staffing: Birth rate plus reporting / opel status - number of days (or shifts) at Opel 4.	1	0	2	1	1	4	6	1	3	3	1	4	4	0	6	-	-	-
20	Mode of delivery % number of normal birthed (women) % number of caesarean sections (women) % other	37.2% / 49.3%	36.0% / 54.8%	36.7% / 48.8%	40.6% / 46.9%	32.6% / 53.0%	43.3% / 43.3%	43.7% / 38.6%	44.8% / 44.8%	43.0% / 43.5%	43.5% / 44.3%	43.5% / 45.2%	38.6% / 49.3%	39.2% / 47.3%	38.9% / 50.6%	40.9% / 46.7%	-	-	-

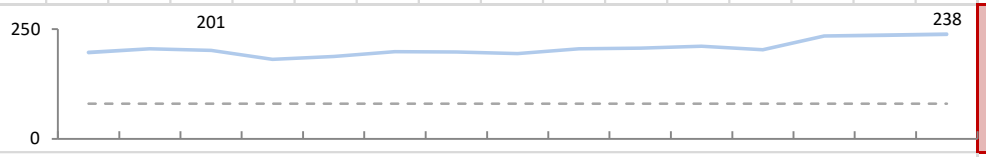
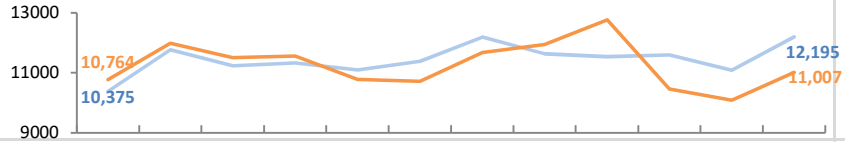
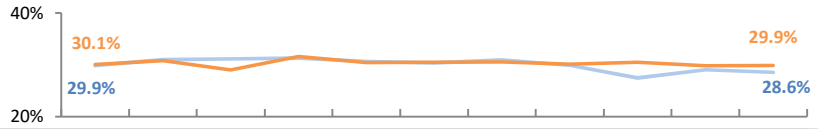
Patient Experience		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Monthly target	YTD	YTD target
21	FFT Negative Score - Inpatients	3%	1.0%													0.3%	≤5%	0.6%	≤5%
		0%																	
22	FFT Negative Score - Maternity (postnatal ward)	10%		0.0%												3.3%	≤5%	2.8%	≤5%
		0%																	
23	Total UHS women booked onto a continuity of carer pathway	30%		13.6%												12.2%	≥35%	13.0%	≥35%
		0%																	
24	Total BAME women booked onto a continuity of carer pathway	80%	44.3%													9.1%	≥51%	25.6%	≥51%
		5%																	
25	% Patients reporting being involved in decisions about care and treatment	100%		87%												90%	≥90%	87.6%	≥90%
		80%																	
26	% Patients with a disability/ additional needs reporting those needs/adjustments were met (total number questioned included at chart base)	100%		90%												91%	≥90%	90.4%	≥90%
		70%	169	290	209	209	300	301	287	249	214	234	336	208	272	304	268		
26 - Performance is a scored metric with a "Yes" response scoring 1, "Yes, to some extent" receiving 0.5 score and other responses scoring 0.																			
27	Overnight ward moves with a reason marked as non-clinical (excludes moves from admitting wards with LOS<12hrs)	200		57												67	-	803	-
		0																	

Access Standards		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Monthly target	YTD	YTD target
28	Patients spending less than 4hrs in ED - (Type 1) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 16)	7	5	64.5% 4	9	12	9	8	8	12	10	11	8	4	4	71.7% 4	≥95%	62.2%	≥95%
		3	3	3	5	7	5	5	5	7	7	7	5	2	3	2			
29	Average (Mean) time in Dept - non-admitted patients			03:09												03:09	≤04:00	03:35	≤04:00
30	Average (Mean) time in Dept - admitted patients			05:50												05:37	≤04:00	06:01	≤04:00
31	% Patients on an open 18 week pathway (within 18 weeks) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	5	5	62.7% 4	4	4	5	4	4	4	4	4	4	4	4	62.1% 4	≥92%	62.9%	≥92%
		5	5	6	6	5	5	6	6	6	5	4	4	4					
32	Total number of patients on a waiting list (18 week referral to treatment pathway)			55,338												58,106	-	58,106	-
33	Patients on an open 18 week pathway (waiting 52 weeks+) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	5	5	4	4	4	4	3	3	3	2	2	2	2	3		≤2,011	1,760	≤2011
		12	12	11	11	11	9	8	8	8	8	8	9	10	9				

		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Monthly target	YTD	YTD target
34	Patients on an open 18 week pathway (waiting 65 weeks+) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	6	5	5	4	4	4	4	5	5	3	3	3	3	3		-	198	-
		506													198				
		13	12	12	11	11	10	9	9	9	8	8	8	6	7				
35	Patients on an open 18 week pathway (waiting 78 weeks+) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	7	6	4	4	5	8	8	7	6	5	6	5	5			0	19	0
		14													19				
		15	15	12	10	11	12	11	10	9	9	9	9	8					
35a	Patients on an open 18 week pathway (waiting 104 weeks+) UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 17)	1	1	1	1	8	14	17	15	16	12	13	13	1			0	-	0
		0	0	0	1	4	5	2	2	1	1	1	0	0					
		1	1	1	1	13	13	17	13	14	10	11	9	1					
36	Patients waiting for diagnostics	10,329													8,655		-	8,655	-
37	% of Patients waiting over 6 weeks for diagnostics UHSFT Teaching hospital average (& rank of 20) South East average (& rank of 18)	12	22.0%	12	11	11	11	10	10	7	7	6	7	5	7.8%		≤1%	17.6%	≤1%
		12																	
		7	8	8	7	7	8	7	9	8	7	7	7	5					

		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Monthly target	YTD	YTD target
38	% Patients following a GP referral for suspected cancer seen by a specialist within 2 weeks (Most recently externally reported data, unless stated otherwise below) **UHSFT** **Teaching hospital average (& rank of 20)** **South East average (& rank of 17)**	13	15	17	17	17	16	16	16	13							≥96%	79.3%	≥93%
		11	18	16	19	18	16	13	10	9									
			78.6%												93.6%				
38	Beginning December 2023, NHSE published Cancer data no longer includes 2 week wait as a cancer standard for benchmarking. Data shown for October 2023 onwards will reflect internally reported UHS position for each month, but will not include Teaching Hospital/South East Hospital data																		
39	Cancer waiting times 62 day standard - Urgent referral to first definitive treatment (Most recently externally reported data, unless stated otherwise below) **UHSFT** **Teaching hospital average (& rank of 20)** **South East average (& rank of 17)**	14	14	18	9	14	13	10	15	6	11	7	6	4	3		≥85%	63.3%	≥85%
		11	7	14	5	9	7	3	6	1	2	3	2	2	1				
			57.6%												82.2%				
39	From October 2023 data onwards, the 62 day standard metric published in NHS england data combines Urgent Suspected Cancer and Breast Symptomatic with previously excluded Screening and Upgrade routes.																		
40	Cancer 28 day faster diagnosis Percentage of patients treated within standard **UHSFT** **Teaching hospital average (& rank of 20)** **South East average (& rank of 17)**	8	8	8	7	7	6	3	1	2	3	3	1	2			≥75%	79.3%	≥75%
		9	5	8	7	5	3	2	1	1	1	1	1	1	1				
			80.8%												89.0%				
41	31 day cancer wait performance - decision to treat to first definitive treatment (Most recently externally reported data, unless stated otherwise below) **UHSFT** **Teaching hospital average (& rank of 20)** **South East average (& rank of 17)**	16	18	16	15	17	15	13	13	11	15	12	13	11	14		≥96%	89.1%	≥96%
		14	20	12	10	14	11	5	9	6	15	9	8	9	13				
			81.3%												87.6%				
41	From October 2023 data onwards, the 31 day standard metric published in NHS england data combines First Treatment and Subsequent Treatment routes.																		

R&D Performance		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Monthly target	YTD	YTD target
43	Comparative CRN Recruitment Performance - non-weighted	15	15	13	14	17	19	19	21	17	17	16	15	15	15	15	Top 10	-	-
44	Comparative CRN Recruitment Performance - weighted	10	11	9	9	6	12	14	15	12	11	12	9	11	11	11	Top 5	-	-
45	Study set up times - 80% target for issuing Capacity & Capability within 40 Days of Site Selection					25%	47%	59%	64%	46%	60%	67%	46%	88%	55%	50%	64%	-	-	-
46	Achievement compared to R+D Income Baseline Monthly income increase % YTD income increase %	166.3%	69.5%	35.6%	50.7%	65.2%	84.7%	104.1%	45.8%	133.3%	133.3%	84.7%	65.2%	157.6%	75.0%	6.2%	≥5%	-	-

Local Integration		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Monthly target	YTD	YTD target
47	Number of inpatients that were medically optimised for discharge (monthly average)																≤80	204	-
48	Emergency Department activity - type 1 This year vs. last year																-	137,377	-
49	Percentage of virtual appointments as a proportion of all outpatient consultations This year vs. last year																≥25%	29.1%	≥25%

Digital		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Monthly target	YTD	YTD target
50	My Medical Record - UHS patient accounts (cumulative number of accounts in place at the end of each month)	152,305														195,541	-	195,541	-
51	My Medical Record - UHS patient logins (number of logins made within each month)	31,309														34,470	-	32,526	-
51 - The YTD Figure shown represents a rolling average of MMR logins per month within the current financial year																			
52	Average age of IT estate Distribution of computers per age in years	0	0	25	36	72	119	314	772	1040	1180	2570	3170	1890	849		-	-	-
		14	13	12	11	10	9	8	7	6	5	4	3	2	1				
53	CHARTS system average load times - % of pages loaded under 5s	99.75%	99.72%	99.73%	99.81%	99.77%	99.82%	99.74%	99.79%	99.80%	99.79%	99.77%	99.78%						
53	Data only available from April 2023 onwards																		
		Q4 22-23			Q1 23-24			Q2 23-24			Q3 23-24			Q4 23-24					
54	Cyber attacks / phishing / incidents blocked Average # Malware attempts blocked per month (10s) Average # Phishing emails blocked per month (100s) Average # Ransomware attempts blocked per month	10	61	2	25	71	3	22	40	1	20	26	1	51	33		-	-	-
54	Ransomware attempts have been included within # of Malware attempts as part of changes to Cyber Security reporting data source for Q4 23-24																		
55	Inpatient noting progress Left axis: IP Noting data recorded (100s) IP Noting unique user views Right axis: IP pages scanned (1000s)	CV&T go live			T&O go live			Med go live			Sur go live			Can go live			-	-	-