Buckinghamshire Healthcare NHS Trust

Agenda for the Trust Board Meeting in Public on Wednesday 29 May 2019 at 9.00am in the Hampden Lecture Theatre, Wycombe Hospital

Guidance on the meeting protocol, opportunities for questions, and Care Awards is shown in the Meeting Guidance item (agenda item 1).

Time	Item	Subject	Lead	Purpose	Enclosure No TB2019/
09.00	**CARE AWARD PRESENTATIONS**				
09.10	**1.**	Chair's Welcome to the Meeting and Meeting Guidance Apologies for absence:	Chair	Open the meeting	Verbal TB2019/45
	2.	Declaration of Interests	Chair	Good governance	verbal
09.15	**GENERAL BUSINESS**				
	3.	Patient Story	Chief Nurse	Information	TB2019/46
	4.	Minutes of last meeting (27 March 2019)	Chair	Note and approve	TB2019/47
	5.	Matters Arising and Action Matrix	Chair	Note and approve	As above Verbal
	6.	Chief Executive's Report	Chief Executive Officer	Assurance	TB2019/48
	QUESTIONS FROM THE PUBLIC				
10.00	**QUALITY AND PERFORMANCE**				
	7.	Integrated Performance Report • Quality • Workforce • Finance	Chief Operating Officer	Assurance	TB2019/49
	8.	Infection Prevention & Control Monthly Report	Medical Director	Assurance	TB2019/50
	9.	Corporate Objectives Implementation Plan	Director of Strategy and Business Development	Approve	TB2019/51
	COMFORT BREAK				
	10.	18/19 Summary financial position	Director of Finance	Assurance	TB2019/53
	11.	Seven Day Services	Medical Director	Approve	TB2019/54
	12.	Quality and Clinical Governance Committee Chair's Report & Terms of Reference for approval	Committee Chair	Assurance Approval	TB2019/55

Safe & compassionate care, every time

Time	Item	Subject	Lead	Purpose	Enclosure No TB2019/
	13.	Finance and Business Performance Committee Chair's Report	Committee Chair	Assurance	TB2019/56
	QUESTIONS FROM THE PUBLIC				
11.00	**RISK AND GOVERNANCE**				
	14.	Audit Committee Chair's Report	Committee Chair	Assurance	TB2019/57
	15.	Organisational Risk Profile & Board Assurance Framework	Director for Governance	Assurance	TB2019/58
	16.	Corporate Risk Register	Director for Governance	Assurance	TB2019/59
	17.	STP planned governance	Director for Strategy and Business Development	Information	TB2019/60
	18.	Self-Certification	Director for Governance	Approve	TB2019/61
	19.	Trust Seal Report	Chief Executive Officer	Information	TB2019/62
	20.	Board attendance record	Director for Governance	Information	TB2019/63
	21.	Private Board Summary Report	Director for Governance	Information	TB2019/64
	22.	Risks identified through Board discussion	Director for Governance	Review	Verbal
	ANY OTHER BUSINESS				
	QUESTIONS FROM THE PUBLIC				
	DATE OF NEXT MEETING				
	Wednesday 31 July 2019, 9am, Florence Nightingale Hospice Charity, Aylesbury				
	The Board will consider a motion: "That representatives of the press and other members of the public be excluded from the remainder of the meeting, having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest" Section 1 (2) of the Public Bodies (Admission to Meetings) Act 1960.				

Papers for Board meetings in public are available on our website www.buckshealthcare.nhs.uk

Safe & compassionate care, every time

Safe & compassionate care, every time

Buckinghamshire Healthcare NHS Trust

Public Board Meeting:
Agenda Item: 1
Enclosure No: TB2019/45

TRUST BOARD MEETINGS

MEETING PROTOCOL

The Buckinghamshire Healthcare NHS Trust Board welcomes the attendance of members of the public at its Board meetings to observe the Trust's decision-making process.

Copies of the agenda and papers are available at the meetings, on our website www.buckinghamshirehealthcare.nhs.uk, or may be obtained in advance from:

Elisabeth Jones, Senior Board Administrator

Stoke Mandeville Hospital

Mandeville Road

Aylesbury

Buckinghamshire HP21 8AL

Direct Dial: 01296 418186

email: Elisabeth.jones@nhs.net

Members of the public will be given an opportunity to raise questions related to agenda items at the beginning of the meeting. Questions are welcome in advance in writing, by email or telephone; or verbally at the meeting. The Board will respond to questions during the content of the meeting.

If members of the public wish to raise matters not on the agenda, then arrangements will be made for them to be discussed after the meeting with the appropriate director.

An acronyms buster has been appended to the end of the papers.

Hattie Llewelyn-Davies
Chair

Safe & compassionate care, every time

Buckinghamshire Healthcare NHS
NHS Trust

THE SEVEN PRINCIPLES OF PUBLIC LIFE

The Committee has set out **'Seven Principles of Public Life'** which it believes should apply to all in the public service. These are:

Selflessness
Holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or their friends.

Integrity
Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.

Objectivity
In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

Accountability
Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

Openness
Holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

Honesty
Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership
Holders of public office should promote and support these principles by leadership and example.

This document should be read in association with the NHS Code of Conduct.

Agenda item: 3
Enclosure no: TB2019/46

Safe & compassionate care, every time

NHS Buckinghamshire Healthcare NHS Trust

PUBLIC BOARD MEETING
29th May 2019

Details of the Paper

Title	Improving chronic wound care outcomes in the community
Responsible Director	Carolyn Morrice
Purpose of the paper	To hear the experience of a patient with a non healing leg injury and the impact on his life
Action / decision required	No decision required – for information/discussion only

IMPLICATIONS AND ISSUES TO WHICH THE PAPER RELATES (PLEASE MARK IN BOLD)					
Patient Quality	*Financial Performance*	***Operational Performance***	*Strategy*	*Workforce performance*	*New or elevated risk*
Legal	*Regulatory/ Compliance*	***Public Engagement /Reputation***	*Equality & Diversity*	***Partnership Working***	*Information Technology / Property Services*

ANNUAL OBJECTIVE	
Which Strategic Objective/s does this paper link to? Quality – specifically improving patient experience of those who can't or find it difficult to communicate People – specifically enabling teams to care for those with a learning disability – providing training and building confidence	
Please summarise the potential benefit or value arising from this paper: Gary's story highlights the importance of expert intervention to manage complex wounds within the community setting. The video also emphasises the impact of non-healing wounds on a persons day to day quality of personal and working life.	
RISK	
Are there any specific risks associated with this paper? If so, please summarise here.	*Non-Financial Risk*:none
	Financial Risk:none
LINK TO CARE QUALITY COMMISSION ESSENTIAL STANDARDS OF SAFETY AND QUALITY	
Which CQC standard/s does this paper relate to?	Regulation 12: Safe care and treatment

Author of paper: Tissue Viability Team and the Communications team
Presenter of Paper: Carolyn Morrice
Other committees / groups where this paper / item has been considered: none
Date of Paper: 21.5.2019

Agenda item: 4
Enclosure number: TB2019/47

Buckinghamshire Healthcare NHS Trust

4

Minutes of the Trust Board Meeting in Public on Wednesday 27 March 2019 at 9.00am in the Hampden Lecture Theatre, Wycombe Hospital

Present:

Voting Members:	Ms H Llewelyn-Davies	Chair
	Mr N Macdonald	Chief Executive Officer
	Mrs N Fox	Chief Operating Officer (Interim)
	Mr G Johnston	Non-Executive Director / Senior Independent Director
	Dr T Kenny	Medical Director / Director of Infection Prevention and Control
	Prof M Lovegrove	Non-Executive Director
	Mrs C Morrice	Chief Nurse
	Ms C Trevena	Director of Finance (interim)
Non-Voting Members:	Mr A Khaki	Deputy Director of Workforce and Organisational Development
	Prof D Sines	Associate Non-Executive Director
	Ms A Williams	Commercial Director
	Mr D Williams	Director of Strategy and Business Development
In Attendance:	Mrs S Manthorpe	Director for Governance
	Mrs E Jones	Senior Board Administrator (minutes)
	Dr M Thornton	Co-Chair, FedBucks (for agenda item 8)
	Dr P Macdonald	Chair FedBucks (for agenda item 8)
	Dr J Drake	Consultant Anaesthetist/ Clinical Lead E.Obs (for agenda item 9).
	Ms K Howsam	Learning Disability Liaison Nurse (for agenda item 3)
	Ms N Edmonds	Learning Disability Liaison Nurse (for agenda item 3).

031/2019	**CARE AWARDS** The Chief Executive Officer presented the Care Awards given to staff nominated by patients and colleagues for demonstrating the Trust's CARE values: Collaborate, Aspire, Respect and Enable. The winners able to be present were: Dr Emily Johns, Stella Jaiyesimi, Carolyn Clarke and Sue Smith.
032/2019	**CHAIR'S WELCOME AND OPENING REMARKS** The Chair welcomed everyone to the meeting in particular those attending to receive a Care Award and the members of the public who were in attendance. In addition the Chair welcomed Emily Carter, NHS management graduate who would be observing the meeting.
033/2019	**APOLOGIES:** Apologies had been received from Mr Jaitly, Mr Roche, Dr Amin and Mrs B O'Kelly.

	The Chair noted that during the course of the meeting various board members would be leaving to attend interviews with the Care Quality Commission (CQC).
034/2019	**DECLARATIONS OF INTEREST** There were no further declarations of interest.
035/2019	**PATIENT STORY** Chief Nurse introduced the patient story around understanding the needs and requirements of patients with a learning disability. Karen Howsam & Nichola Edmonds, Learning Disability Liaison Nurses were introduced to the Board. The film introduced Judy and her carers and showed how liaison with the learning disability nurses, had improved Judy's experience as a patient in hospital. The film highlighted the great work being achieved working in multi-disciplinary teams to improve the patient experience for those with learning disabilities. Ms Howsam and Ms Edmonds stressed the importance of working closely with primary and secondary care colleagues to ensure the patient was supported with their individual needs. Think Twice posters were around the Trust emphasising the need to: **T** – have Time **W** – Where – think of the environment **I** – Include carers in the patient's care **C** – for Communication **E** – for Extra - making reasonable adjustments and observations. Professor Lovegrove commented on developing the role in the wider NHS with support in the acute environment for patients. Training was available at staff induction and there was a training programme in place for other staff to fully understand the needs of those with learning disabilities. The Director of Strategy and Business Development noted the importance of connections with the Council and fostering an inclusion agenda which included employment, community health networks and annual health checks. Professor Sines highlighted that those with a learning disability were living longer and queried how the system was supporting those with complex needs. With regard to younger patients it was explained that work was being undertaken with transitions and making safe decisions. Mr Johnston thanked Ms Howsam and Ms Edmonds for an inspirational and educational presentation. The Deputy Director of Workforce and Organisational Development noted their enthusiasm and would speak with them outside of the meeting regarding how to encourage young people to join their profession. The Chief Nurse concluded by noting the need to build the service and encourage others to join. The Chair passed on thanks for sharing the patient story.
036/2019	**MINUTES OF THE MEETING HELD ON 30 JANUARY 2019** The minutes were accepted as an accurate record of the meeting.
037/2019	**MATTERS ARISING AND ACTION MATRIX** Updates were shown on the action matrix. There was no further comment.

038/2019	**CHIEF EXECUTIVE OFFICER'S REPORT** The Chief Executive Officer presented his report asking the Board to focus on the following during the course of the meeting; the risks the Trust was facing, moving out of deficit and testing the robustness of the finances and financial recovery plan, agreeing the objectives for the coming year, the integrated performance report, and in particular the nurse vacancy rate. The staff survey results were welcomed, showing a changing culture. The results were above average and were testimony to the hard work of staff working to improve this. The Chief Executive thanked staff for managing at a very busy time of year and for welcoming the Care Quality Commission inspectors who had reviewed several acute and community services. The Chair also expressed thanks on behalf of the Board. Professor Sines queried the amount of intake from Bucks New university. The Deputy Director of Workforce explained that a partnership was being formed with Bucks New University and Bedfordshire looking at around 100 nursing students which was an aspirational number. The Chief Executive Officer noted that the Strategic Workforce Committee would monitor this and ensure this happened. Nurse associates would be in addition to this number. The Chief Nurse noted that 9 would be qualified by the Summer and Professor Sines thanked the Chief Nurse for her ambition and trailblazing. Professor Lovegrove commented that it was important to understand the opportunities for the local Sustainability and Transformation Partnership (STP) and Integrated Care System (ICS) workforce plan and working with the council and other organisations. Professor Sines noted that the STP was working well across four counties and was important to recruit and retain local staff, to have a balance. The Chief Nurse commented on the opportunity for shaping the workforce. Mr Johnston highlighted the uptake of flu vaccinations noting that nearly a third were unvaccinated which was disappointing. There had been a good campaign but the motivations of those who weren't vaccinated needed to be understood so that this could be addressed for next year. The Chief Nurse noted that it was important to understand from a patient safety point of view and query what could be done differently for next year. The Board **noted** the Chief Executive's report.
039/2019	**QUESTIONS FROM THE PUBLIC** • Cllr David Peplar, South bucks District Councillor questioned if the Trust performed elective surgery at the weekends. The Chief Executive Officer explained that surgery did occur at the weekends although it was not the most economical model or efficient use of taxpayer's money. However there were lots of other services which were run over weekends. • Mr Alan Barnard, Vice Chair of the Marlow Bottom plus Older People's Action Group raised concern that some staff were not taking up the flu jab and therefore how could the public be expected to. It was explained that 68% of staff have received their flu jab however the Trust would aim for more next year.
040/2019	**TRUST CORPORATE OBJECTIVES** The Deputy Director of Strategy and Business Development presented the corporate objectives for 2019/20 following detailed discussion at the Trust Board Seminar in February 2019 for approval. Corporate objectives are the goals set by the Board that provide a link between the Trust's mission, vison and strategies and delivery. Following discussions with the Board and

	Senior Leadership Team it was agreed to focus objectives for 2019-2021 on key areas that would transform culture, workforce and clinical services. Areas related to the performance of the Trust would be reported and monitored separately through the Integrated Performance Report. Following input from the senior leadership team and information gathered from engagement sessions the following three corporate objectives were agreed at the February Board seminar: 1. Continue to improve our culture 2. Implement new workforce models 3. Tackle inequalities and variation The following points were noted: • Work in Bucks to treat patients • Clinical variation • Standardised approach • Integrated care system • Looking at supporting vulnerable patients The Medical Director highlighted the importance of a joint clinical and financial plan with Mr Johnston commenting on activity levels and an efficiency plan which was good to have. The Chief Nurse commented on enabling strategies which were helpful and would line up with the patient voice. The Chair thanked the Executive Team and commented that it was good to see such focus this year. The Board **approved** the Corporate Objectives.
041/2019	**PRIMARY CARE NETWORKS (PCN) IN BUCKINGHAMSHIRE** Local GPs, Dr Martin Thornton and Dr Penny Macdonald, Co-Chairs of FedBucks updated the Board on the development of Primary Care Networks in Buckinghamshire which were part of the NHS long term plan. 30-50 thousand patients would be cared for by each primary care network; which would comprise groups of GP practices but also involving community teams and social care to ensure patients got the right care at right time in the right place. Primary care networks would employ social prescribers and clinical pharmacists enhancing medication reviews, helping patients to manage long term conditions. GPs would be monitoring and managing a wider variety of health and care professionals to provide the range of support the population required. The networks would also aim for earlier cancer diagnosis at stage 1 or 2 rather than 3 or 4. Primary care networks would meet more regularly with the Trust, community colleagues, social care and the voluntary sector to increase integrated working, using technology like shared patient records to help facilitate joint working for the benefit of patients. Professor Lovegrove queried how PCNs would find the additional workforce such as community paramedics considering the challenges across the health service to recruit. One of the solutions would be secondment, keeping people employed within the Bucks integrated care system. It was important to get the right people in post, with the right skills set, focusing on a collaborative leadership style, bringing people and networks together and involving patient

	focussed groups. There would be a medicine optimisation model, career support, training hubs and forums for shared learning. It was noted that there were different patterns of need across the county and it was important to consider this rather than a standardisation approach, supporting areas most in need. The Chair thanked Fe~~b~~dBucks for their presentation. A comment was raised by Alison Lewis about patient involvement in creating PCNs. Assurance was provided that the patient voice played a huge role, the head of health watch was part of the steering group and the networks had formal representation from current patient groups. The Board **noted** the update.
042/2019	**E OBSERVATIONS PRESENTATION** Dr Jeremy Drake, Consultant anaesthetist and informatics lead presented on electronic observations (e-obs) and the use of technology to improve patient care. There had been a £1.3m investment in technology to improve how clinicians make observations and provide patient care. The benefits of the e-obs system seen so far were improving patient handover, escalation, adult psychological measurement and increased contact time with patients, reduction in ICU length of stay and reduction in cardiac arrest. Clinical personnel have been very involved with IT for this project. The next steps for i-care and e-observations going digital includes rolling out to more areas and upgrades to other IT systems, include nursing assessments, access to imaging and pathology information on the one system. Professor Lovegrove stressed the importance of engaging staff of different generations~~.~~ It was explained that it would enable staff to move around to match staffing levels to acuity around the wards. The Medical Director noted her excitement at the developments and asked Dr Drake to explain to the Board the future drivers and the need for digital champions to take this forward. It was noted that digital healthcare had a massive impact on delivering and receiving care and new digital leaders needed to be identified to achieve this. Thanks were expressed to Dr Drake for his presentation.
043/2019	**INTEGRATED PERFORMANCE REPORT** The Director of Finance presented the Integrated Performance Report for Finance providing assurance that the Trust could hit the planned £35m deficit for year end with most divisions achieving their control totals. The following points were noted: • Year to date deficit was £28.6m - £35.9m from the plan • Drivers of the adverse position were income, not achieving the sustainability funding, under delivery of the cost improvement programme and activity from specialist commissioning • Increased medical staffing • The Trust was in discussion with NHSI regarding the likely forecast outturn. • Trust had confidence it would deliver the 35m deficit. • There had been improvements in the run rate, agency rate was low The Board **NOTED** the financial position.

The Interim Chief Operating Officer provided the Board with an update on the integrated performance reports.

Constitutional Standards:

- A&E 4 hour standard had increased with 95% of patients being seen, admitted or discharged within four hours. The Trust was among the top quartile across the county.
- A&E attendances were up on January figures. The number of people arriving in A&E in February 2019 was 12,472 which was higher than in February 2018 when it was 11,146.
- The GP streaming service had seen an average of 50 patients daily.
- The conversion rate (rate of attendance to admission) increased due to the acuity of patients and cases of suspected flu and Noro-virus.
- The Cancer 62 day target rate was 85% with some breaches.
- The refer to treatment time (RTT) performance was improved with the number of people on the waiting list reduced. The Trust was compliant with diagnostic standards and was looking to improve pathways.
- There had been discussions at STP level on capacity particularly for ophthalmology and trauma and orthopaedics.
- There had been delay with PET scans.

Professor Lovegrove commented on the delays in PET scanning. It was explained that the Trust was going to another provider. Work was also being undertaken with cancer alliance.

The Chief Executive Officer congratulated the teams on the cancer targets. It was noted that the RTT trajectory would be reviewed by the Finance and Business Performance Committee.

Quality:

- There had been an increase in CDIFF
- There had been no medication errors, MRSA bacteraemia or never events
- There had been a reduction in pressure ulcers
- 89% of complaints had been responded to in 25 days
- There had been an increase in line infections

Professor Lovegrove as Chair of the Quality and Clinical Governance Committee thanked the Trust on the improved reporting information. The Medical Director noted that the May Board meeting would include a paper on line infections. The Chief Executive Director asked for the Quality Improvement Programme (QIP) around outpatients to be brought to the Quality and Clinical Governance Committee.

The Chief Nurse noted the patient and staff survey had recognised an improvement around discharge and A&E which showed improved dignity and respect.

People:

- There had been improvements in shifts in agency gaps.
- The NHS staff survey results show continued improvement with statistically significant improvement in staff engagement and safety culture.
- In 6 out of 10 themes the Trust was above the national average
- Nursing vacancy rate increased from 17.1% to 17.6%
- There had been domestic fairs and a school leavers event to attract staff
- There had been an EU recruitment event
- There were new starters from the Philippines
- Trust turnover rate was 14.1% against a target of 12%.

	• There was variation in turnover rates for different staff groups seeing significant reductions on turnover. • There was a 50+ retire and return initiative • There was a recruitment training roll out – ensuring the Trust was appointing the right people • Nursing vacancy had increased. Work was being undertaken to improve the trajectory. Professor Sines noted that staff sickness rates were on the increase for HCA and nurses. The Chief Operating Officer explained that a deep dive would be undertaken and would report back to the Strategic Workforce Committee. The Chair commented on the nursing vacancy and queried if there was a quality issue with those areas and whether these areas had been examined. Assurance was provided that this was looked at by the Quality and Clinical Governance Committee looking at the correlation between sickness and vacancy rate. The Chief Executive Officer noted that for the Public Board Meeting in May a paper would be provided showing staffing and triangulation between quality, money and people. The Chief Executive Officer noted the challenge on shifting the nurse vacancy number. The Board **NOTED** the Integrated Performance Report.
044/2019	**INFECTION PREVENTION AND CONTROL REPORT** The Medical Director presented the Board with the Infection Prevention data for February 2019. It was noted that community numbers will be included in future and was a key signal for the year ahead. The Chief Executive Officer requested context and stretch for the next Board report. The Board **NOTED** the Infection Prevention Control report for February 2019.
045/2019	**LEARNING FROM DEATHS** The Medical Director presented the Board with information on the impact of the Medical Examiner Service on improving Patient Safety. The Board **NOTED** the Learning from Deaths report.
046/2019	**GENDER PAY GAP** The Deputy Director of Workforce and Organisational Development presented the Trust's gender pay gap report. It was noted that staff awards were now included. The Board **APPROVED** for the report to be published.
047/2019	**FLU VACCINATION REPORT 2018/2019** The Deputy Director of Workforce and Organisational Development presented the Flu Vaccination report to the Board. The report was a requirement from NHS Improvement and noted the following points: • Total flu vaccination uptake and opt-out numbers and rates • A list of areas designated higher-risk and the uptake and opt-out rates for each • Details of actions taken to deliver the 100% uptake ambition • A breakdown of the reasons that staff have given for opting-out of the vaccine It was explained that the Trust was near the top regionally for staff vaccinations with 68% having received their jab. However the Trust had learned more this year from those who

	opted out of being vaccinated which will help to increase the uptake next year. The Board **NOTED** the Flu Vaccination Report.
048/2019	**QUALITY AND CLINICAL GOVERNANCE COMMITTEE CHAIR'S REPORT** The Board **noted** the Quality and Clinical Governance Committee Chair's report.
049/2019	**FINANCE AND BUSINESS PERFORMANCE COMMITTEE CHAIR'S REPORT** In the absence of the Chair of the Finance and Business Performance, the Chair who had chaired the meeting the previous day gave a verbal update to the Board on the top risks discussed at the meeting: • Financial year end • Capacity to manage activity • Regeneration of A&E programming and timing • Lack of capital funds for next year • Cost improvement for next year • Run rate for next year The Board **NOTED** the Finance and Business Performance Committee Chair's report.
050/2019	**STRATEGIC WORKFORCE COMMITTEE CHAIRS REPORT** The Chair of the Strategic Workforce Committee commended the report of the Freedom to Speak Up Guardian which had been received. The Board **NOTED** the Strategic Workforce Committee Chair's report.
051/2019	**QUESTIONS FROM THE PUBLIC** There were no further questions from the Public.
052/2019	**ORGANISATIONAL RISK PROFILE** The Director for Governance presented the organisational risk profile which highlighted the top risks around the vacancy rates, financial position including the capital position, and the challenge of managing the demands of the urgent care pathway and how they were being managed. The Board Assurance Framework (BAF) would be presented at the May Board Meeting. The Executive Management Committee (EMC) would recalibrate the risks noting that some needed to revaluated and rescored. The Board **NOTED** the Organisational Risk Profile.
053/2019	**STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS** The Director for Governance presented the Standing Orders and Standing Financial Instructions. The Board **NOTED** the changes resulting from the review of the document.
054/2019	**AUDIT COMMITTEE CHAIRS REPORT** The Audit Committee Chair recognised that the Finance Department were going into the busy end of year period and highlighted the tight timetable which would take president over any other commitments. The Board **NOTED** the Audit Committee Chair's Report.
055/2019	**PRIVATE BOARD SUMMARY REPORT** The Board **NOTED** the summary of the private board held in January 2019.

056/2019	**BOARD ATTENDANCE RECORD** The Board **NOTED** the attendance record.
057/2019	**RISKS IDENTIFIED THROUGH BOARD DISCUSSION** The Director for Governance set out the risks identified through Board discussion as follows: • Finance • Workforce • PCNs and the impact these will have in working with the Trust • E-observations – workforce and maternity and paediatrics inclusion (as these are still paper based) • Outpatients appointments • Patient capacity and flow • A&E project and timing • Capacity and activity
058/2019	**ANY OTHER BUSINESS** There was no other business.
059/2019	**QUESTIONS FROM THE PUBLIC** There were no further questions from the Public.
060/2019	**DATE OF NEXT MEETING** Wednesday 29 May 2019, 9am, Hampden Lecture Theatre, Wycombe Hospital There being no further business the Chair recited the motion to bring the meeting in public to an end.
	Signed ……..... Trust Chair Dated……......

ACTION MATRIX

Minute		Lead	Timescale	Update May 2019
134/2018	Board Seminar to discuss Nursing Workforce to be scheduled	Director for Governance	31 March 2019	This will be included in the Board Development Programme for 19/20.
165/2018	The role of the Medical Examiner to be brought to the Board as a patient story.	Chief Nurse / Medical Director	By 31 July 2019	Not due
014/2019	Statement on progress with anti-microbials to go to Board in March following discussions at Quality and Clinical Governance Committee	Medical Director	31 March 2019	
024/2019	Improved reporting from BHPL to F&BP and Board	Director for Governance / Medical Director /	31 May 2019	

Minute		Lead	Timescale	Update May 2019
		Commercial Director		
043/2019	RTT trajectory to be reviewed by the Finance and Business Performance Committee.	Chief Operating Officer	31 May 2019	
043/2019	Paper on line infections to come to Board.	Medical Director	31 May 2019	
043/2019	QIP around outpatients to be brought to the Quality and Clinical Governance Committee.	Chief Nurse	31 May 2019	
043/2019	Deep Dive into HCA / Nurse sickness rates to be brought to Strategic Workforce Committee	Director of Workforce and Organisational Development		
044/2019	The Chief Executive Officer requested context and stretch for the next Board report on Infection Prevention and Control.	Medical Director	31 May 2019	

Agenda Item: 6
Enclosure No: TB2019/48

Buckinghamshire Healthcare NHS Trust

TRUST BOARD MEETING IN PUBLIC
29 MAY 2019
CHIEF EXECUTIVE'S REPORT

This report aims to highlight to Board members areas that will benefit from focused discussion, and to recognise the developments and achievements of the Trust since we last met. Appended to this report is a summary of the Financial Recovery Board and Executive Management Committee meetings to provide the Board with oversight of the significant discussions of the senior leadership team over the past two months. The Buckinghamshire Integrated Care System (ICS) Managing Director's Report is also appended to this report to provide an overview of our activities together with our ICS partners.

1. Learning

As I will introduce later in my report, being an organisation that learns is one of the programmes of work identified to deliver our corporate objective around continuing to improve our culture over the next two years. This reflects the importance we place on continuously reviewing, understanding and learning from our data, feedback from staff and patients, and colleagues in other organisations.

We recorded 422 and 406 births in our care in March and April respectively. There were two cases of *clostridium difficile* infection in March and two in April. I am disappointed to report there was one case of MRSA in April, which occurred in a complex patient case. This has been investigated thoroughly to ensure we learn from this incident, and has been deemed to be an unavoidable case. I am, however, pleased to update that we had zero reports of never events, and no patient falls resulting in severe harm. We recorded five and three Trust-attributed grade three/four pressure ulcers in March and April respectively. 102 patients passed away in our care in March and 80 in April.

We received 61 formal complaints in March and 71 in April. We continue to exceed the Trust target of 85% of cases responded to within 25 days, recording 89% in February and 90% in March. We received 919 accolades in March, bringing the 2018/19 total to 14,504.

In March and April we received 62 and 69 excellence reports respectively. I would like to highlight the following example, illustrating the importance of quick thinking and working together to deliver timely patient care:

> "*** recognised that a patient was deteriorating and scoring for sepsis. Immediate escalation to the Doctor who attended immediately to the patient. *** communicated with Nurses and Doctors to ensure the patient received the best care possible in a timely manner. Well Done!"

We strive to learn from best practice at other NHS organisations, and in the past two months we have been fortunate to have two highly informative opportunities to do this. In May we were delighted to welcome Simon Worthington, Director of Finance at Leeds Teaching Hospitals NHS Trust, who kindly agreed to visit us at Wycombe General Hospital to share his experience and advice. Effective management of our financial positions is of significant importance for us this year, as I detail further later in my report. Simon has an excellent track record in this area, and offered many interesting insights into our organisation and our approach moving forwards.

In April I also visited Deborah Lee, the Chief Executive of Gloucester Hospitals NHS Foundation Trust. I was fortunate to gain a deeper understanding of their successful approaches to financial management and building a learning organisation. A key component to the latter is quality improvement and as outlined below, this forms a priority focus of our corporate objectives over the next two years.

Our quality improvement (QI) team continue to work hard with staff across our services, and this month I would like to share an example developing a therapy and nursing led unit (TNLU) at Stoke Mandeville Hospital to improve patient flow on this site. There is a cohort of adult patients who are medically fit for discharge but who require additional rehabilitation before it is safe for them to go home. These patients were based in wards across the site, making it harder for therapists to provide the necessary care and support. A project delivery group worked with the QI team to develop a sustainable model for the new service, employing a number of QI tools and techniques, particularly stakeholder engagement and sustainability. Transition to the TNLU began in December 2018; by 24 April 2019, 202 patients had been transferred to TNLU from a range of medical and surgical wards. The average length of stay of patients on the TNLU was 11.1 days, although this was lower for patients who were discharged home without further care, with a restart of a package of care, or input from the reablement team (7, 8.9 and 8.7 days respectively). Importantly, the TNLU has improved patient flow, freed

beds for acutely unwell patients, and released consultant and other doctors' time. A nurse who was allocated to the TNLU as part of her return to practice placement made the following comment: "In particular I would like to commend you on the new TNLU… On arrival at the ward I was sceptical on the outcome expected of the patients and the aim to rehabilitate them sufficiently in order to allow them to go home or into care in a similar condition prior to pre-admission. After spending 2 weeks on the wards I was amazed at the progress that many of the patients had made enabling them to return home, able to mobilise, deal with their own personal hygiene and managing to eat independently. All the while being cared for by a team of supporting and encouraging nurses and therapists, enabling the patients to regain as much independence as possible."

Quality and performance

Regarding our cancer performance, following a period of reduction since November, we recorded four patients waiting more than 104 days in February, and this reduced to three in March. Our cancer performance in February against the 62 day standard was 79.4%, but returned above target (85%) in March to 86.2%; indeed, I am pleased to recognise that for the first time since 2017, the Trust has met all of its cancer targets. There is always more to do, but it is important to recognise the efforts of staff across the Trust in achieving this milestone, and the impact that meeting these targets has on patient care.

The Trust went live with Careflow Vitals our Electronic Observations (eObs) on 26 February 2019 with phase one rollout of the core observations module. Currently, all wards in Stoke Mandeville Hospital and the community hospitals are live. The deployment in Wycombe General Hospital commenced on 13 May 2019. Recent analysis shows that we have recorded 70,000 observations with only 0.003% (197) delayed by fifteen minutes. Evidence shows that eObs is already influencing practice from the way patient handover is conducted by our medical and nursing teams, to the ability to have Trust-wide visibility of patient acuity. Phase two development will introduce the ability for our nursing staff to carry out assessments at the bedside moving from a paper-based system to a digital one. We envisage the eObs system linking with our Careflow Communication system later on in the year allowing activation of automatic escalation functionality. I am really pleased to see this system now up and running and the impact it is already having on the quality and timeliness of patient care.

In my recent reports I have commented on our winter performance, and it is now timely to reflect on our Trust's winter performance for 2018/19 as a whole. We saw significant improvements in performance compared to previous years, with A&E performance between November and March at least 2% better every month than 2017/18. We saw more patients in our A&E and Urgent Treatment Centre (UTC) every month compared to the previous winter, an average of 6691 Buckinghamshire residents each month, compared to 6234 in 2017/18. BHT continues to be one of the top A&Es in the region in reducing ambulance handover delays for SCAS. The standard of ambulance handovers taking less than 15 minutes is indicative of this, with average handover time of 14.02 minutes in winter 2018/19 compared to 17.18 minutes in winter 2017/18.

A national area of focus for 2019/20 is reducing patient length of stay. There is a national ambition that 33% of all patients will have a hospital length of stay less than 24 hours. Analysis shows that this is already being delivered in BHT, and 45% of all admissions have a length of stay under 24 hours – a fantastic achievement. We are working to review our clinical pathways to ensure that only patients requiring admission are admitted, and that services are configured to deliver patient care in an ambulatory way.

There is also a national focus on reducing length of stay for patients who have been an inpatient for over 20 days. This is a challenging measure for BHT because our patients' reported length of stay continues if they move between an acute hospital and community hospital bed; however, our robust processes to clinically review all patients with a length of stay over seven days each week has delivered a 5% reduction of patients with a length of stay over 20 days compared to 2017/18. There is considerable national and local focus on long length of stay reductions for 2019/20, with an ambition to deliver a total reduction of 40% by March 2020.

Money

The pre-audit year-end out-turn was £31.6m deficit, including £3.3m Provider Sustainability Fund (PSF). As previously described, there were five key drivers to this position: our 2017/18 exit run rate was higher than accounted for in our plan; our contract income was lower than our costs; income from the PSF was less than anticipated; cost pressures largely from staff vacancies and estates costs; and under-delivery of our cost-improvement plan. Our regulator (NHS England and NHS Improvement) has submitted to the Trust a Proposed Enforcement Action under the National Health Service Act 2006, moving us from segment 2 to segment 3 under the Single Oversight Framework.

Recognising that the year-end out-turn for last year is disappointing, it is important that we also recognise that the additional efforts focused on minimising further spend did mitigate a worse position. We recorded a delivery of the 2018/19 cost improvement programme of £6.9m at the end of March 2019. In addition, expenditure of a further £6m was curtailed from the expenditure predictions made in November 2018.

We are working more closely than ever before with our system partners, particularly Buckinghamshire CCG, as we enter 2019/20. We are working together to understand what is causing our deficit, as well as developing a long term financial model (to predict the potential challenges ahead). Outputs from these workstreams will inform our medium and longer term planning. We also continue to work jointly to develop a detailed Efficiency Plan across clinical and corporate services. Our regulator requires that the Trust and Buckinghamshire CCG deliver a single financial target this year.

In my last report I referred to the requirement for BHT to produce a financial recovery plan and the ongoing development of a joint approach to local healthcare provision together with our system partners. It has become increasingly clear that the successful management of our finances is dependent upon cooperation through joint decision making and joint working. Our ability to address the increasing demand for our services through the short, medium and long term is reliant upon new ways of working (which will require investment e.g. digital) and new pathways for patients (involving primary, acute and community care). These pressures are as much an issue for our GP and primary care colleagues as they are for BHT, whether this in our acute or community based services. We will now need to build upon the initial draft of our financial recovery plan to include our plans for 2019/20 and beyond.

Within the Trust, our Financial Recovery Board (FRB) continues to meet weekly to maintain the focus and pace required to manage the Trust's financial position. The FRB reports on savings plan progress, facilitating early decision making and oversight of risks, issues and barriers to delivery (please see the appendix for further detail from the last two months). With our colleagues at Buckinghamshire CCG, we have also set up a joint System Efficiency Group, chaired by me, to increase the pace and address the system financial challenges in 2019/20. This group will oversee specific savings plans and ensure the wider transformation work across the integrated care system is effectively addressing our financial challenges.

People

The nursing workforce remains a key priority for the Trust this year. Led by the Chief Nurse and Director of Workforce & Operational Development, substantial work to recruit well, retain staff at all stages of their career, and enable development through flexible career pathways and the implementation of new roles, continues this year. This work is making an impact: nurse turnover reduced overall during 2018/19; this trend has been maintained into 2019/20, with turnover at the end of April 2019 at 13.4%, the lowest for over two years. I am also pleased to welcome 23 registered nurses who joined the Trust in April. In addition, 17 existing staff gained their NMC registration, including newly qualified graduates from one of our partner universities, the University of Bedfordshire, nurses who qualified overseas including the EU, and a colleague who has returned to practice. All of these individuals have received professional support from the Trust's clinical education team.

There remains much more to do to tackle our nursing vacancy rate. I am pleased to share that we are working with Bucks New University to support the recruitment of an additional 40 first year students to their nurse undergraduate programmes in 2019/20 who will be based at BNU's newly refurbished campus building in Aylesbury; the Trust will provide a range of placements across both acute and community sites during students' studies. We are really excited to be working with BNU as a partner to support the growth of the nursing workforce across Buckinghamshire.

Employment of temporary staff ensures the provision of safe and high quality care across all services. Our aim is to fill vacancies with bank staff wherever possible and during the latter half of 2018/19, we reduced levels of spend on agency staff through robust control and strong clinical leadership and involvement; total agency spend during the full year was £10.7m (£200k above the ceiling set by NHS Improvement).

Equality, Diversity and Inclusion is a key priority for 2019/20; four staff networks (BAME, Disability, LGBT+, VIBES (values, identity, belief, ethical and spirituality) will develop and grow from the foundations set last year. I am delighted that more colleagues (including non-executive directors and executive directors) are involved in the Trust's BAME reciprocal mentoring programmes.

Strategic view
In 2019/20, we remain dedicated to our Trust vision (we want to be one of the safest healthcare systems in the country) and mission (safe and compassionate care, every time). Our three priority areas of Quality, People and Money are embedded within the organisation, and to focus our future direction we have developed three corporate objectives with input from staff engagement events, the Board and the senior leadership team, as follows: 'continue to improve our culture'; 'implement new workforce models'; and 'tackle inequalities and variation'. Each has 4–5 clear programmes of work owned by Executive Directors. We have also identified four distinct enabling strategies supporting the delivery of the corporate objectives. Further detail will be shared later in the Board agenda.

These corporate objectives span 2019–21; our commitment to the next two years is designed to provide a level of stability and direction to build a sustainable organisation, and reflect the large scale of the programmes of work involved.

We launched our corporate objectives in April 2019 at our flagship engagement event, the BHT Way. This dedicated half-day event provided team leaders protected time to think about how what the objectives mean for their teams and services, and workshop ideas for immediate actions that their teams could implement relating to the corporate objectives. Individuals from across our services shared their experiences of implementing projects linked to each of the objectives, to inspire and share their learning. The next three BHT Way events will focus on the three areas of the objectives, to further support implementation and facilitate change in these priority areas. We have a quarterly reporting schedule planned through Executive Management Committee and the Board committees, and we will be reporting to Trust Board biannually on the progress against these objectives; I look forward to sharing an update later in the year.

Earlier this month we held our first strategy conference of the year in collaboration with Bucks HSC Ventures. Focusing on 'spreading innovation', this event showcased innovations already underway within the Trust and across Buckinghamshire, and provided delegates with insights into the support available to help teams get projects off the ground.

I am delighted to report that we have appointed two new members of the Executive team. Barry Jenkins will join at the end of July as Director of Finance. Whilst initially Barry will be Director of Finance only for the Trust, as from April 2020 he will also be Director of Finance for the CCG. Barry has a wealth of experience gained in acute, mental health, community and social care settings. He has a strong track record of building and motivating high performing teams, most recently at North East London Foundation Trust where he has led in developing new ways of working, quality improvement and transformation. Wayne Preston will be acting Director of Finance until Barry joins us.

Joining us as Chief Operating Officer in September is Dan Gibbs. Dan is an experienced health care operations director, specialising in the leadership of operations in complex clinical networks, developing leadership capability as well as improving quality and efficiency. He has worked for a number of London hospitals including The Kings College Hospitals and University College Hospital NHS Foundation Trust and is currently working as Director of Operations for the Royal London and Mile End Hospitals. Dan will also sit on the Executive Committee and the Trust Board.

I'd also like to take this opportunity to congratulate and thank Natalie Fox, our interim COO, who will shortly be joining Barnet, Enfield and Haringey Mental Health NHS Trust as Chief Operating Officer.

Finally, I would like to formally welcome Julie Hoare, who joined as Managing Director of the Buckinghamshire Integrated Care System in April 2019.

2. Outstanding practice
I am delighted to recognise that three of our pharmacy staff have been selected to join the Chief Pharmaceutical Officer Global Health Fellowship programme funded by Health Education England. This is a significant achievement both for the individuals themselves and for the Trust pharmacy team as a whole.

I am also pleased to share news from Public Health England that our Trust in the smokefree NHS survey, which we participated in last year. This means the Trust has been considered to 'have demonstrated positive steps towards comprehensive smokefree status'. There is always more to do to support both staff and patients and ensure the environment across all our sites is the best it can be, but I am pleased that our continued efforts in this regard have been recognised in this survey.

Well done to our chaplaincy team who won the 'Putting People First' award at the Bucks County Council Dignity in Care Awards on 14 March.

3. Proud to be BHT

- Two of our staff visited the Kampala region in Uganda to help shape antimicrobial stewardship in resource settings, and then back in the UK – I wish them very well and recognise the support that the whole team is providing to enable them to go.
- Our midwifery team held a number of events to mark International Day of the Midwife (05 May), including a bake-off competition.
- We also celebrated International Nurses Day earlier this month with a number of activities, including a pot luck lunch in Stoke Mandeville hospital, tea parties and coffee mornings. It was fantastic to celebrate all of our hard-working nurses and recognise those working across the NHS.
- Our staff's excellence, dedication and hard-work continues to be recognised:
    - Congratulations to Frances Taylor, one of our specialist dietitians, who has been shortlisted for paediatric nutrition professional of the year in the 2019 CN Awards.
    - Congratulations also to the team shortlisted for the second year running for the Children and Family award for Antibiotic Guardian 2019.

Neil Macdonald
Chief Executive

Appendix 1 – Financial Recovery Board and Executive Management Committee

Financial Recovery Board (FRB)

Between mid-March and mid-May, the FRB has continued to develop plans to deliver a £15m savings target. Our planning processes started later than we would have liked, mainly due to the focus on mitigating the financial position in 2018/19. However, we have identified projects to meet £11m of our £15m target. These plans necessarily impact across all of our services, requiring productivity improvement as well as the need to reduce our costs and increase value for money. Despite challenging ourselves, this clearly falls below where we need to be, and so measures are in place to avoid costs until full plans are in place. These measures cover delaying, where possible, investment proposals around cost pressures and service developments; applying stricter protocols around vacancies and recruitment of new staff. Clearly, these are actions we would ideally wish to avoid, and all measures are subject to quality and safety impact scrutiny, but we deem these necessary to minimise the risk of repeating the results in 2018/19. In the meantime, we continue to work up further plans to manage our financial position overseen by FRB.

Executive Management Committee 22 March 2019 to 10 May 2019

The Executive Management Committee meets formally on a weekly basis and covers a range of subjects including early strategy discussions, performance monitoring, consideration of business cases and moderation of risk documentation. The meeting is chaired by the Chief Executive Officer and attended by Executive Directors, Director for Governance, and other key leaders within Divisions and Corporate services. The following provides a brief overview of some of the key areas considered at the Executive Management Committee since 22 March 2019.

Quality

Acuity dependency
Infection Prevention Control report
Quality Accounts
Chaplaincy strategy
Rehabilitation and remediation policy & procedure for medical staff
Epilepsy 12 audit report
Non-elective performance weekly update
Rapid Emergency Assessment and Care Team review
Capacity Governance reports for quarter 1 & 2
New performance standards and capacity alerts
Review of NHS Access Standards
Pathology network
Diabetic eye screening programme
Maternity safety quarterly report
Outpatients
Integrated Board Report
Reducing long hospital stays

Money

Financial recovery plan
2019/20 activity and finance plans
Monthly cash report
Monthly Income & Expenditure report
Capital
The following business case appraisals:

- Cath lab
- Digital technologies

People

Pensions
Developing workforce safeguards
CARE value awards

Governance

Corporate Risk Register
Board Assurance Framework
Annual Governance Statement
Trust Board planner 2019-20
Performance and governance framework
Summary of internal audit work
The following policies have been approved:

- Clinical coding process & audit policy
- Management of corporate and local induction policy
- IT network security policy
- Clinical excellence awards policy

Meeting minutes of the following:

- Risk & Compliance Monitoring Group
- Human Resources and Workforce Group
- Caldicott and Information Governance Committee

Strategy

Buckinghamshire Integrated Care System
Operational Plan 2019/20
Proposal for future planning of population health and care needs
High voltage and low voltage infrastructure project
Energy contract update
Health & Safety monthly update
Estates strategy quarterly update
Endoscopy service
Medical gases
Emergency Preparedness, Resilience and Response assurance report
EU Exit plans
Staff car parking

Buckinghamshire Integrated Care System (ICS)
Managing Directors Update Report **11 April 2019**

1. Introduction

The purpose of this paper is to provide an update on the development of the Buckinghamshire Integrated Care System. It aims to provide a clear narrative which links the vision and strategy of the ICS, the set-up of the ICS operating model, the development of the care model and the forward look. Comments on usefulness and content are welcomed to enable further refinement of the report for future meetings.

2. ICS/NHSE Assurance Meeting

This meeting was postponed from original date due conflicting schedules; the revised date is 22nd May at 1200. The draft agenda below has been developed in line with NHSE feedback. Once confirmed, the portfolio office will circulate a time line to collate content for the meeting slides. The slides will require submission to NHSE by the 15 May.

Item	Agenda Topic
1	**Welcome and Introductions**
2	**New Regional Ways of Working**
3	**3a Executive Summary** **3b Financial Update** **3c Performance Update** **3d Quality and Patient Safety Update**
4	**4a Strategy & Transformation, including response to Long Term Plan** **4b Non-Elective Demand Management** **4c Elective Care Transformation** **4d Meds Management** **4e Continuing Healthcare** **4f Mental Health** **4g PCN development** **4h System Governance Arrangements to support delivery**
5	**5a Next Steps** **5b Summary of agreed bipartite support** **5c Approach to system assurance during 2019/20**
6	**Closing Summary**

3. System Priority: Elective Care and Capacity

We have completed the first wave of the pilot MDT clinics for our new MSK service, the analysis of this work shows that 84% of patients rate their experience of the service as excellent and that as a result of the MDT clinics clinical decisions were changed for over 50% of patients reducing the number of interventions and hand offs experienced by patients on the MSK pathway.

Next month sees the launch of the revised clinical pathways and preparations continue for the roll out of First Contact practitioners working in primary care from July 2019.

On 8th April we held a system wide ophthalmology workshop developing community based pathways across our service for glaucoma and cataract patients. This was a fantastic example of collaborative working with colleagues from BHT, independent sector, charities and the local optical committee working together to develop service for patients that provide care closer to home and reduce attendances at hospital.

We are working as a system to transform our outpatient services and the first steering group of this programme of work took place on 9th April focusing on reducing cancellations, use of digital technology and development of alternative pathways to meet the needs of our population.

4. Enabler: ICS Portfolio Office

The ICS Portfolio Office has submitted the ICS Operations Plan for 2019/20 on 11 Apr, and is now working on development and socialisation of the associated delivery plan. The aim is to develop a draft delivery plan by the end of April which will be reported against on a quarterly basis. However, there is a necessity to triangulate the content and deliverables within the operations plan with the financial recovery scheme commitments. Identification of risks and assurance on deliverability will support the system to effectively transform the system this year.

As reported previously, the ICS Portfolio Office drafted a system QIA that has now been socialised, and amended with the feedback. The PO will then coordinate with system partners for final agreement.

The ICS Portfolio Office is working to establish a system efficiency group, the purpose is to prioritise financial recovery working to scale to manage efficiencies as a system and ensuring effective use of resources. The system efficiency group will start with the following operating principles and scope as defined below:

- Controlling the cost of system delivery
- Transparency and full open book approach to Costs, Risks, Reserves and Mitigations across partners
- Full Sharing of System Risks and Opportunities
- Joint investment decisions
- Developing and monitoring a revised regulatory approach which concentrates on the system

Scope

- Strategic – Activity outside the control of a single organisation but within control of the system as a whole
- Structural – Activity that is considered outside the control of the system
- Operational - Activity that is broadly within the control of a single organisation

Additionally, the Portfolio Office is working with system partners to establish an Oxfordshire and Buckinghamshire Mental Health Delivery Board, establish a care homes programme, build a more robust CHC programme and support development of the digital transformation programme.

5. Enabler: Clinical and Care Leadership

Clinical and Care Forum (CCF) membership was reviewed at the last meeting (March), and each organisation within the ICS has a nominated lead who will have delegated responsibility and regularly attend the Forum meetings, both locally and at STP level.

The CCF is due to meet on 2nd May, to elect a Chair and agree dates for the ongoing forum meetings. They will also describe how the first objective will be achieved and what the priority clinical areas are over the next 12 months, so a plan can be put together for future meetings. This includes an update on the integrated children's work; to develop a case for change; led by Sarah Creighton, an update from the newly established Care Home Steering group and End of Life.

Bucks ICS Digital Transformation project held its first event on 12th March 2019. The event was very well attended, with participants from all partners across the ICS with a mixture of clinicians, carers and managerial staff.

The aim was to demonstrate the level of engagement and interoperability we have achieved in the digital transformation space over the past year or so. There was an emphasis on the fact that many parts of these systems are live and are being rolled out. System providers were on-site in market stall style to provide live demonstrations. The presenters gave the audience a flavour of what is currently achievable so that we see the benefits to patient care and population health being enhanced by the IT.

6. Enabler: Communications and Engagement

Health and Social Care Staff Roadshows

The staff roadshow started on Monday 1 April. If any directors are available to support any dates, please let Kim Parfitt know – kparfitt@buckscc.gov.uk

VENUE	DATE	TIME
North & South lift lobbies, County Hall, Walton St, AYLESBURY, HP20 1UA	Mon 1 April	11:00 – 14:30
Foyer, Chiltern Education Centre, Wycombe Hospital, Queen Alexandra Rd, HIGH WYCOMBE, HP11 2JT	Tues 2 April	11:00 – 15:00
Seminar Room 1,Education Centre, Amersham Hospital, Whielden St, AMERSHAM, HP7 0JD	Weds 3 April	10:00-14:00
The Street, AVDC, The Gateway, Gatehouse Rd, AYLESBURY, HP19 8FF	Thurs 4 April	11:00 – 15:00
Marlow Community Hospital, Victoria Rd, MARLOW, SL7 1DJ	Mon 8 April	12:00 – 16:00
Consultation Room 3, Buckingham Community Hospital, High St, BUCKINGHAM, MK18 1NU	Thurs 11 April	12:00 – 16:00
Dining Room, Chalfonts & Gerrards Cross Community Hospital, Hampden Rd, CHALFONT ST PETER, SL9 9DR	Mon 15 April	10:00 – 14:00
Lounge, Post Grad Education Centre, Stoke Mandeville Hospital, Mandeville Rd, AYLESBURY, HP21 8AL	Weds 17 April	10:00 – 14:00
Meeting Room 5, Chiltern District Council Offices, King George V Rd, AMERSHAM, HP6 5AW	Weds 24 April	12:00 – 16:00
Conference Room, Whiteleaf Centre, Bierton Rd, AYLESBURY, HP20 1EG	Thurs 25 April	12:00 – 16:00
Stoke Mandeville Ambulance Station, Mandeville Road, AYLESBURY, HP21 8BD	Mon 29 April	
Meeting Room A5, BCC Area Office, Easton St, HIGH WYCOMBE, HP11 1NH	Tues 30 April	11:00 – 15:00

In week 1, we have attended County Hall, Wycombe Hospital, Amersham Hospital and AVDC. The roadshows have been very well attended especially at the hospitals. We have been receiving good suggestions from staff including:

- Change the requirement to pick up a prescription written at a Hub from a Hospital. (**Trainee GP**)
- Show mental health medication on the shared care record (**PreOp Nurse**)
- GPs to provide detail of the severity of dementia diagnosis (**PreOp Nurse**)
- Removal of Catheters and treatment of UTIs to take place in Community Hubs (**Urology Consultant**)

Getting Buckinghamshire Involved Steering Group

During the second meeting, a full list of all ICS engagement activities was presented to the group as well as a presentation on the Adult Social Care Better Lives Strategy and the Community Asset Tool and the GP Improved Access Communications Plan. Recommendations were provided by the group on changes to the plan although there were some concerns that the service is not being offered consistently by GPs.

It was agreed that at the next meeting, the following would be presented for review:

- NHS Long Term Plan
- Digital Transformation
- Updates on Short Breaks, Future of Thrift Farm and Early Years

Agenda item: 7
Enclosure no: TB2019/49

Safe & compassionate care, every time

NHS Buckinghamshire Healthcare NHS Trust

TRUST BOARD
WEDNESDAY 29TH MAY 2019

Details of the Paper

Title	Integrated Performance Report (IPR)
Responsible Director	Natalie Fox, Interim Chief Operating Officer
Purpose of the paper	To brief the Board on the Trust's performance across People, Quality and Money
Action / decision required (e.g., approve, support, endorse)	For information and review

7

IMPLICATIONS AND ISSUES TO WHICH THE PAPER RELATES (PLEASE MARK IN BOLD)					
Patient Quality	*Financial Performance*	***Operational Performance***	*Strategy*	*Workforce performance*	*New or elevated risk*
Legal	*Regulatory/ Compliance*	***Public Engagement /Reputation***	*Equality & Diversity*	*Partnership Working*	*Information Technology / Property Services*

ANNUAL OBJECTIVE	
Which Strategic Objective/s does this paper link to?	
Please summarise the potential benefit or value arising from this paper: To provide an update to the meeting on the operational performance of the constitutional standards, eceptions and action to be taken going forward.	
RISK	
Are there any specific risks associated with this paper? If so, please summarise here.	*Non-Financial Risk*: Delays in patient pathways
	Financial Risk:
LINK TO CARE QUALITY COMMISSION ESSENTIAL STANDARDS OF SAFETY AND QUALITY	
Which CQC standard/s does this paper relate to?	Safety, responsiveness and well led *(if you need advice on completing this box please contact the Director for Governance)*

Author of paper: Natalie Fox, Interim Chief Operating Officer
Presenter of Paper: Natalie Fox, Interim Chief Operating Officer
Other committees / groups where this paper / item has been considered: **EMC, F&BPC, Quality Committee**

Date of Paper: 22.05.2019

Buckinghamshire Healthcare NHS Trust

Integrated Board report

April 2019

Safe & compassionate care, every time

Executive summary

This summary outlines the operational performance of the Trust for the month of March 2019 and identifies key successes and risks for the organisation in its agreed operational indicators against People, Quality and Money.

Emerging/Emerging Risks

Performance against the A&E four hour standard improved from 87.67% in March to 89.73% in April, the daily average of patients for the month decreased from 457 to 449. Performance achieved >95% on four occasions. The number of Emergency admissions has increased substantially compared to last year of approximately 20%, this is related to same day emergency care cases. This is due to increasing use of observation/assessment wards and enables BHT to improve performance at a time of rising demand.

Cancer performance improved against the 62 day standard, rising from 79.4% in February to 86.2% (target 85%). 104 day waits increased from 2.5 to 3 (5 patients)

RTT Open Pathway performance decreased from 88.8% in March to 88.6% in April with a growth in waiting list size from 29,225 to 29,550. 71 more patients were waiting over 18 weeks.

Quality

Harm free care continues to improve from Feb, to 92.3%; FTT showed a marginal fall to 95.5%. 25 day complaint response rates show a continued improvement, whilst 90 day response rates remain unchanged and represent complex complaints. There was 1 case of MRSA Bacteraemia. This was attributed to a complex patient, with a clinical condition which made blood sampling challenging. On review it was unavoidable. There has been a 30% decrease in avoidable grade3/4 pressure damage in 2018/19. From April 2019 the national reporting of pressure damage has changed. Pressure damage is referred to as deep tissue damage and the avoidably rating has been removed The quality committee will receive quarterly reports on progress against reduction in harm against the national guidelines .

New complaints have continued to increase from January with 71 received for April, significantly one of the highest totals within a rolling twelve months, with ED receiving 15. Themes were delays and cancellations; behaviour of staff; discharge; diagnosis and treatment/procedure. Work is currently underway to understand and target specific s areas of poor experience.

Workforce

Our focussed work to support the retention of nurses is delivering results nurse turnover in April was 13.4%, the lowest level for over two years. We continue to recruit and develop the nursing workforce; 23 registered nurses joined the Trust in April and 17 existing staff gained their registration. Existing controls to safely manage temporary staffing ensure that agency spend in M1 was below the NHSI agency cap. All temporary staffing is now managed through a platform – NHS Professionals for non-medical staffing; Liaison for medical staff – ensuring timely reporting and transparency of usage.

Finance

The Trust reported delivery of £1.1m deficit at Month 1 in line with Operating Plan. A revised plan was submitted to NHSI on the 15th May and the budgetary implications will be finalised for Month 2 reporting. The Trust drew down £10.7m cash in May as previously approved at Finance Committee. Efficiency delivery is circa £0.2m behind plan, but this does include some non-recurrent items early in the year to offset lead in times for some of the recurrent schemes.

Content of the Integrated Board report

The Integrated Board report consist of two components

- **Charts that show the Trust's performance across a large number of important areas, known as Key Performance Indicators (KPI's)**
- **Commentary on these charts together with other reports about key aspects of the Trust's performance, strategy and financial position**

Most of the charts are derived from data taken from the Trust's internal sources. However, there are also charts that show information taken from external sources. These enable a comparison to be made between the Trust's performance and that of other, similar NHS providers

The charts are divided into four types

- **The Floodlight – which shows those KPI's that are considered to be the most significant in identifying the Trust's performance in the key areas of Quality, Efficiency and People. Where applicable, these show the current value for a KPI, how it meets the Trust's targets (based on a "traffic light" system) and an SPC analysis (more information about SPC analysis is given on the following page)**
- **Leading Indicators – which show those KPI's that are considered to be significant in giving an early warning of possible areas of concern, or equally, of possible areas of successful improvement. Again, these charts contain an SPC analysis**
- **Trend indicators – which show the remaining important KPI's, how they currently meet the Trust's targets (also based on a "traffic light" system) and also indicate how these KPI's have changed over time**
- **Other charts – which include those taken from the comparison data shown on NHSI Model Hospital and other reference sites, together with some that reflect summarised information about key Trust activities.**

Trust operational Floodlight report

To help to provide greater insight into the Trust's performance in key areas, the Floodlight section of this report and also the Leading Indicators section make use of SPC charts.

SPC charts are considered to be effective where a situation or process occurs regularly. However, they are not appropriate when a situation arises only infrequently. Therefore, the following four pages show Key Performance Indicators (KPI's) for the Floodlight based on SPC charts and these are then followed by two pages that show charts, in a different style, for those KPI's for the Floodlight where SPC analysis is not appropriate

Statistical Process Control (SPC) charts

The main aim of Statistical Process Control is to understand what is the norm and what is different. It does this by looking at the performance of a KPI over time and applying a statistical analysis technique to calculate an "upper control limit" and a "lower control limit". Then, if the performance in the current period lies within these "limits", it is considered to be within "normal statistical fluctuation" and does not require special attention.

By contrast, if the performance in the current period has either risen above the "upper control limit" or fallen below the "lower control limit", then this represents a situation that does require special attention.

The notation used on the following SPC charts is

Blue line	–	Trust actual performance
Green line	–	Mean Trust performance over the period shown on the chart
Red lines (dotted)	–	Upper Control Limit and Lower Control Limit

In addition, the following symbols are used to indicate the result of the statistical analysis

Within normal statistical fluctuation

Above Control Limit – shows significant deterioration

Below Control Limit – shows significant deterioration

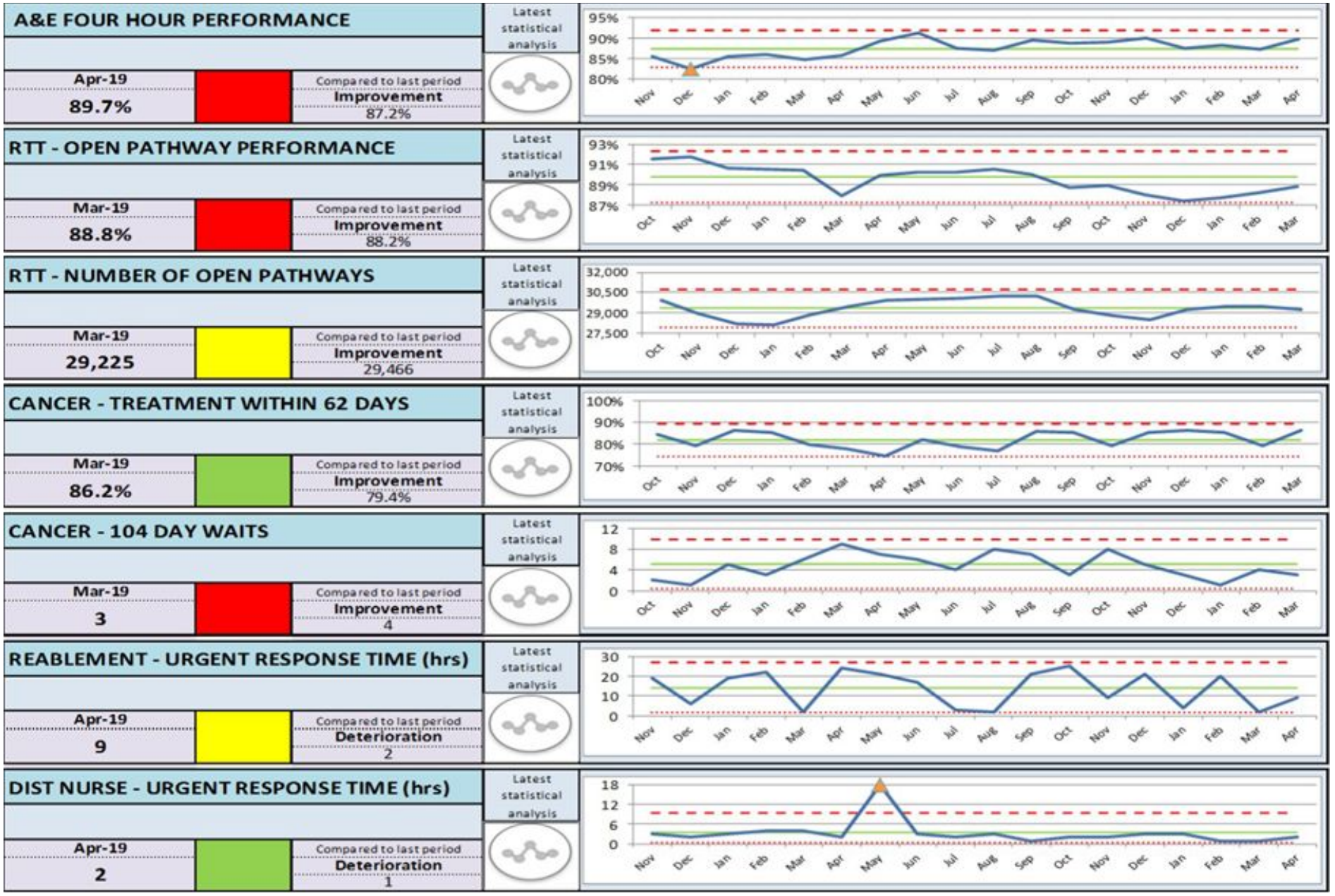
Above Control Limit – shows significant improvement

Below Control Limit – shows significant improvement

As a general rule, within the SPC charts, a "blue" symbol shows an improved situation and an "orange" symbol shows one that needs attention

Trust operational Floodlight report – SPC chart section

QUALITY



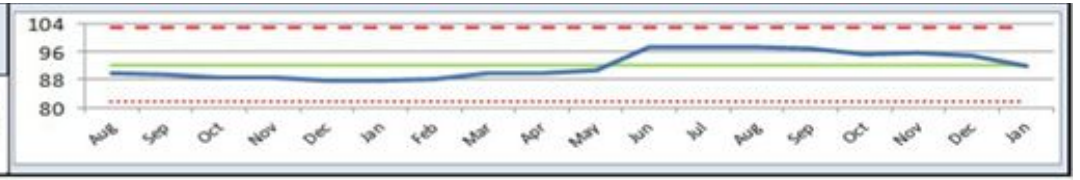
Trust operational Floodlight report – SPC chart section

QUALITY

HSMR (Hospital Standardised Mortality Ratio)

Jan-19		Compared to last period
92.1		Improvement 94.7

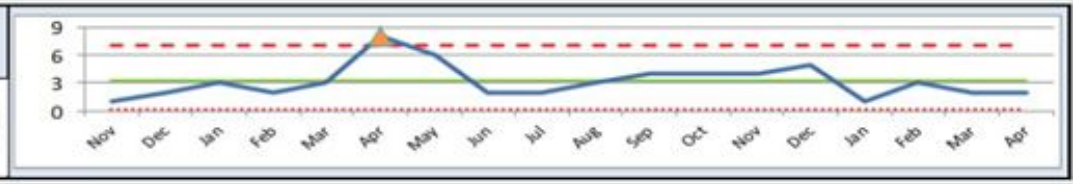
Latest statistical analysis



C DIFF (Clostridium Difficile)

Apr-19		Compared to last period
2		No change 2

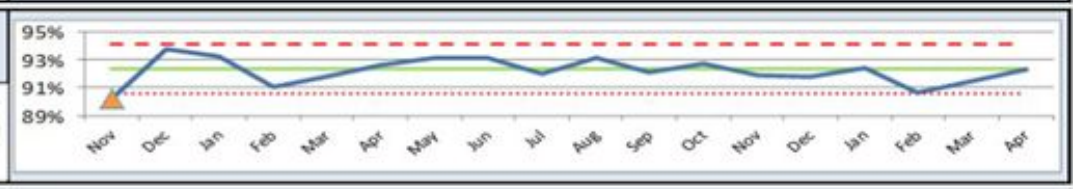
Latest statistical analysis



HARM FREE CARE

Apr-19		Compared to last period
92.3%		Improvement 91.5%

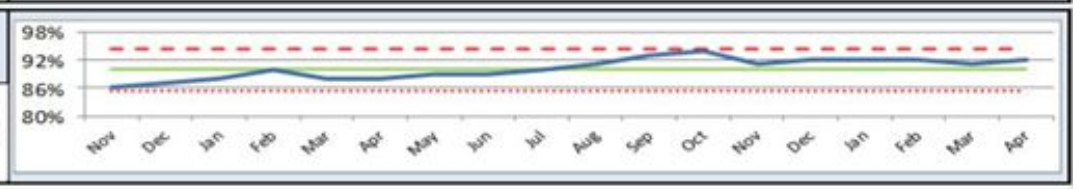
Latest statistical analysis



STATUTORY TRAINING

Apr-19		Compared to last period
92%		Improvement 91%

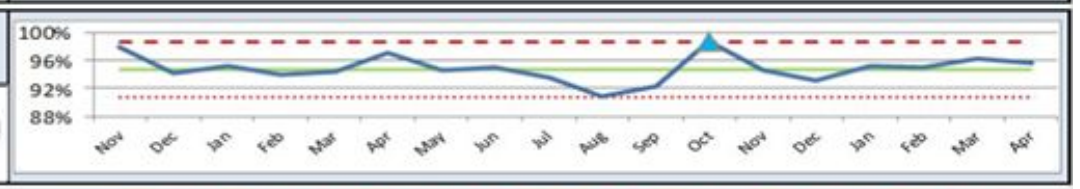
Latest statistical analysis



FFT - INPATIENT POSITIVE RESPONSE

Apr-19		Compared to last period
95.5%		Deterioration 96.3%

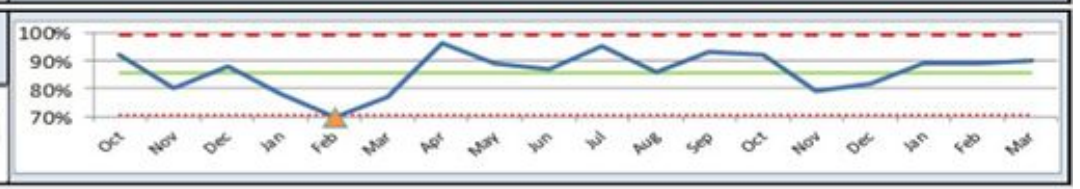
Latest statistical analysis



COMPLAINTS - RESPONSE IN 25 DAYS

Mar-19		Compared to last period
90%		Improvement 89%

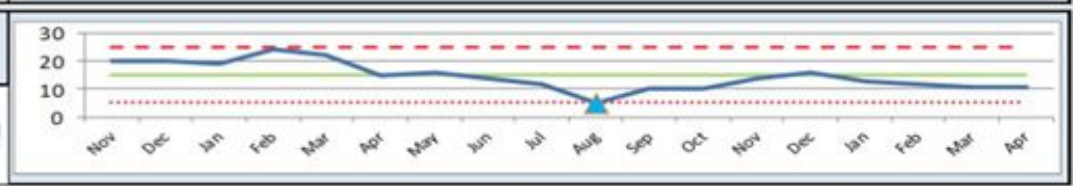
Latest statistical analysis



COMPLAINTS - RESPONSE O/S - 90 DAYS

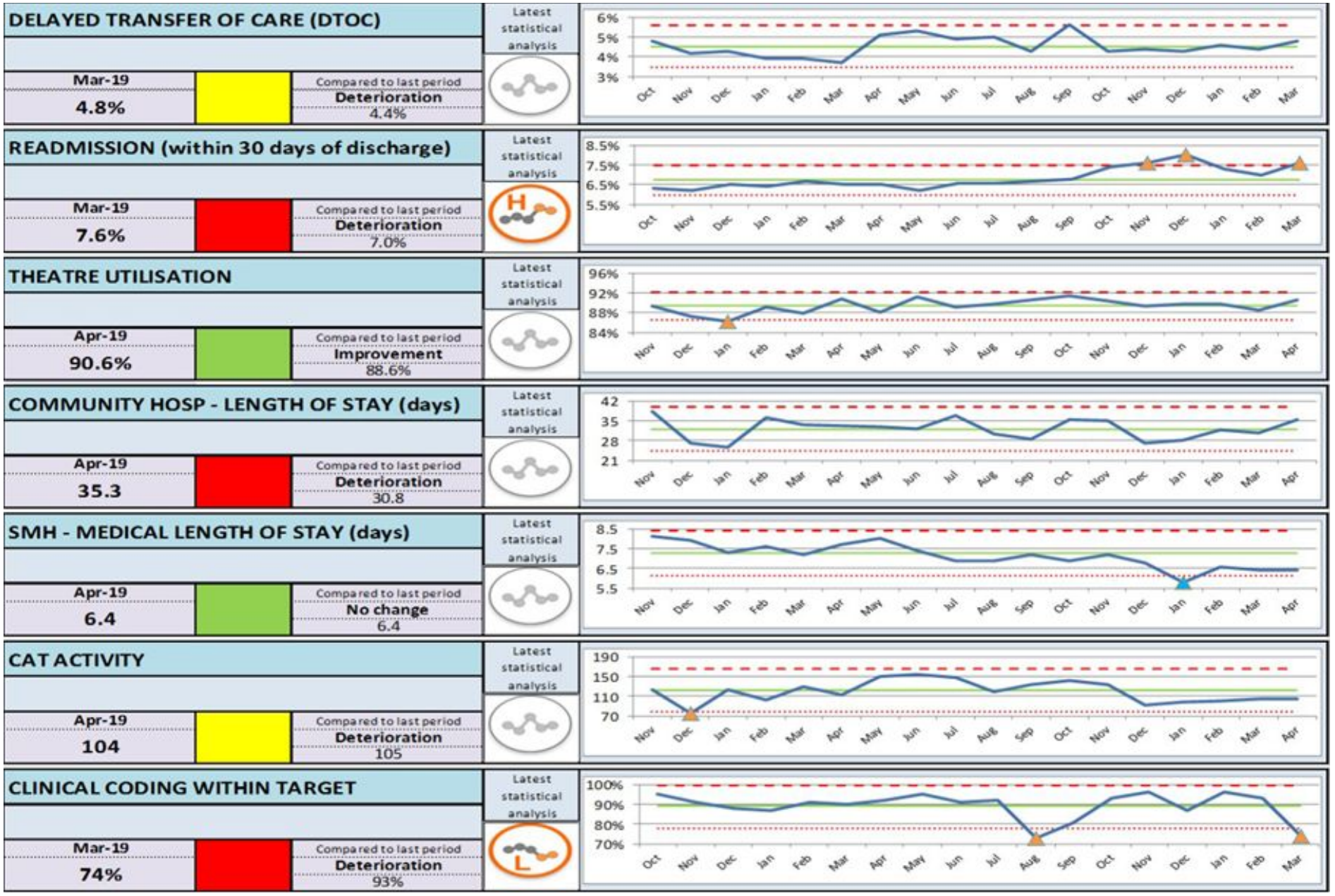
Apr-19		Compared to last period
11		No change 11

Latest statistical analysis



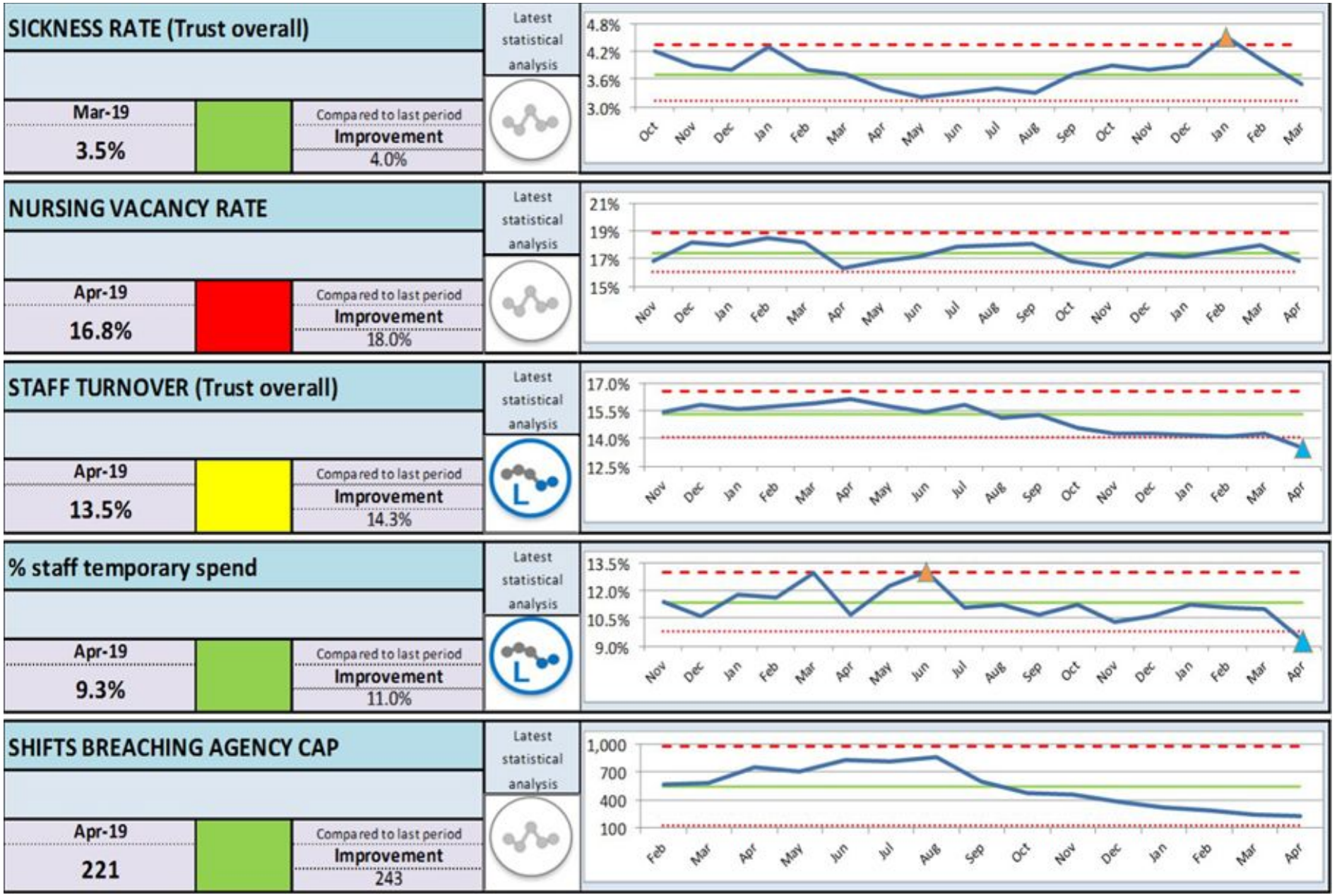
Trust operational Floodlight report – SPC chart section

E F F I C I E N C Y

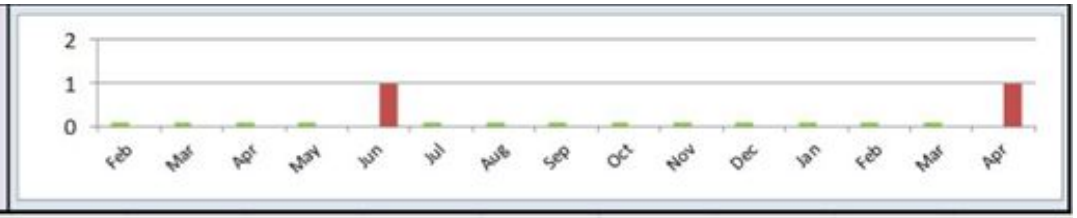
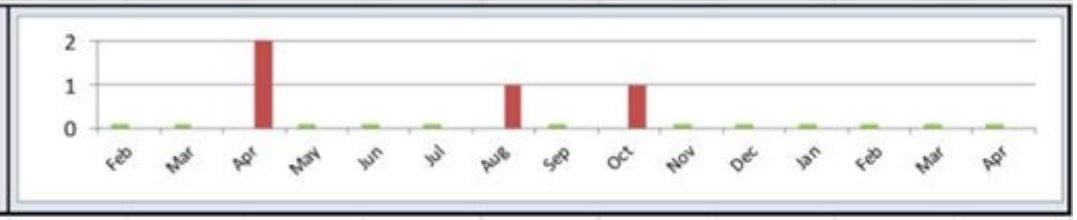
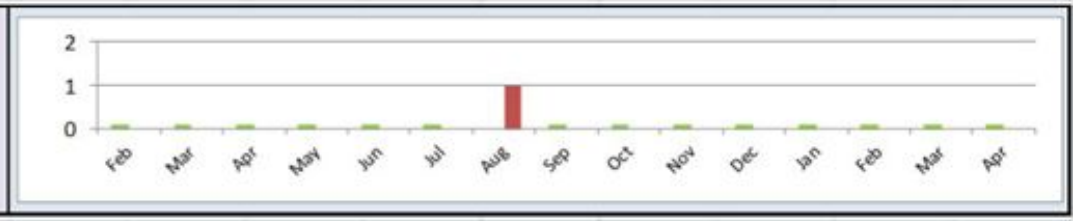
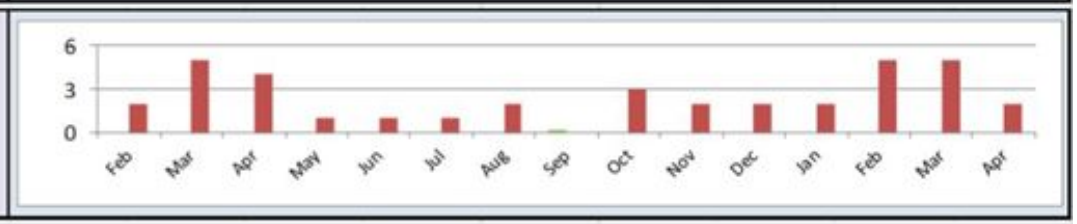
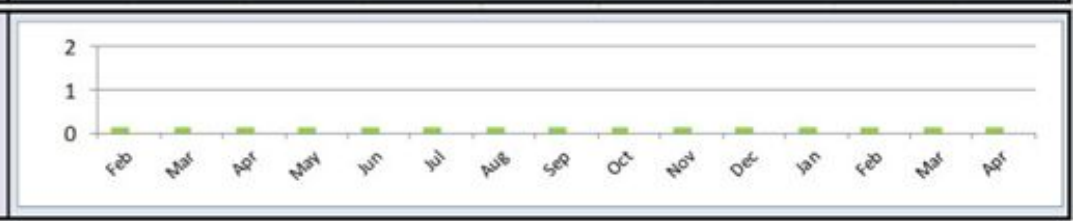


Trust operational Floodlight report – SPC chart section

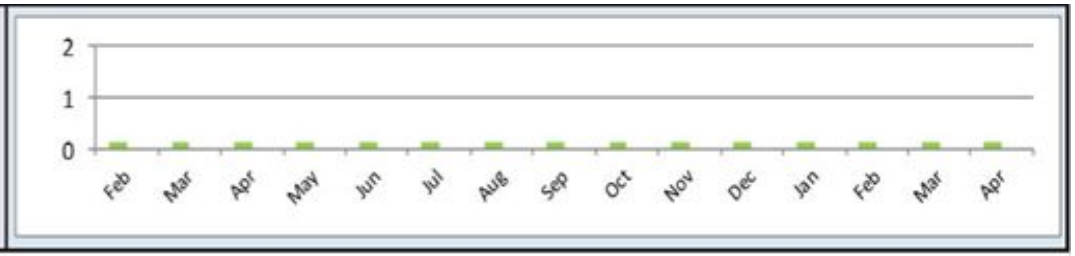
P E O P L E

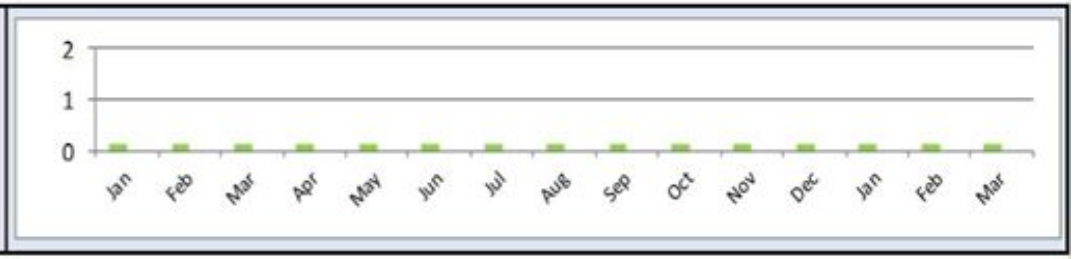


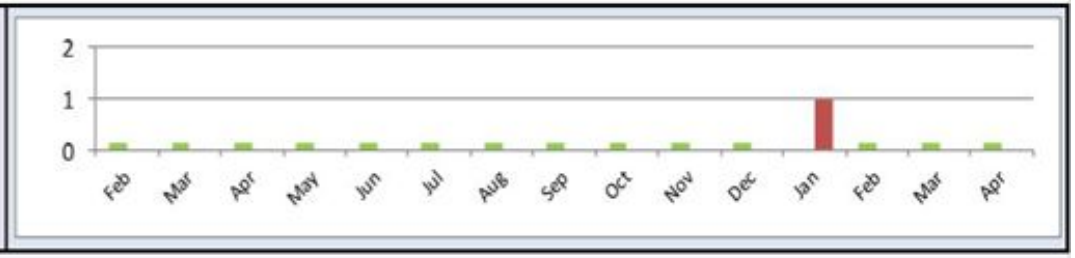
Trust operational Floodlight report – non SPC charts

MRSA BACTERAEMIA			
Apr-19		Compared to last period	
1		Deterioration	
		0	
NEVER EVENTS			
Apr-19		Compared to last period	
0		No change	
		0	
FALLS (causing severe harm)			
Apr-19		Compared to last period	
0		No change	
		0	
MEDICATION ERRORS (with severe harm)			
Apr-19		Compared to last period	
0		No change	
		0	
PRESSURE ULCERS (deep tissue damage)			
Apr-19		Compared to last period	
2		Improvement	
		5	
O/S PATIENT SAFETY ALERTS			
Apr-19		Compared to last period	
0		No change	
		0	

Trust operational Floodlight report – non SPC charts

MIXED SEX BREACHES			
Apr-19		Compared to last period	
0		No change	
		0	

RTT - PATIENTS WAITING 52+ WEEKS			
Mar-19		Compared to last period	
0		No change	
		0	

A&E - 12 HOUR TROLLEY WAITS			
Apr-19		Compared to last period	
0		No change	
		0	

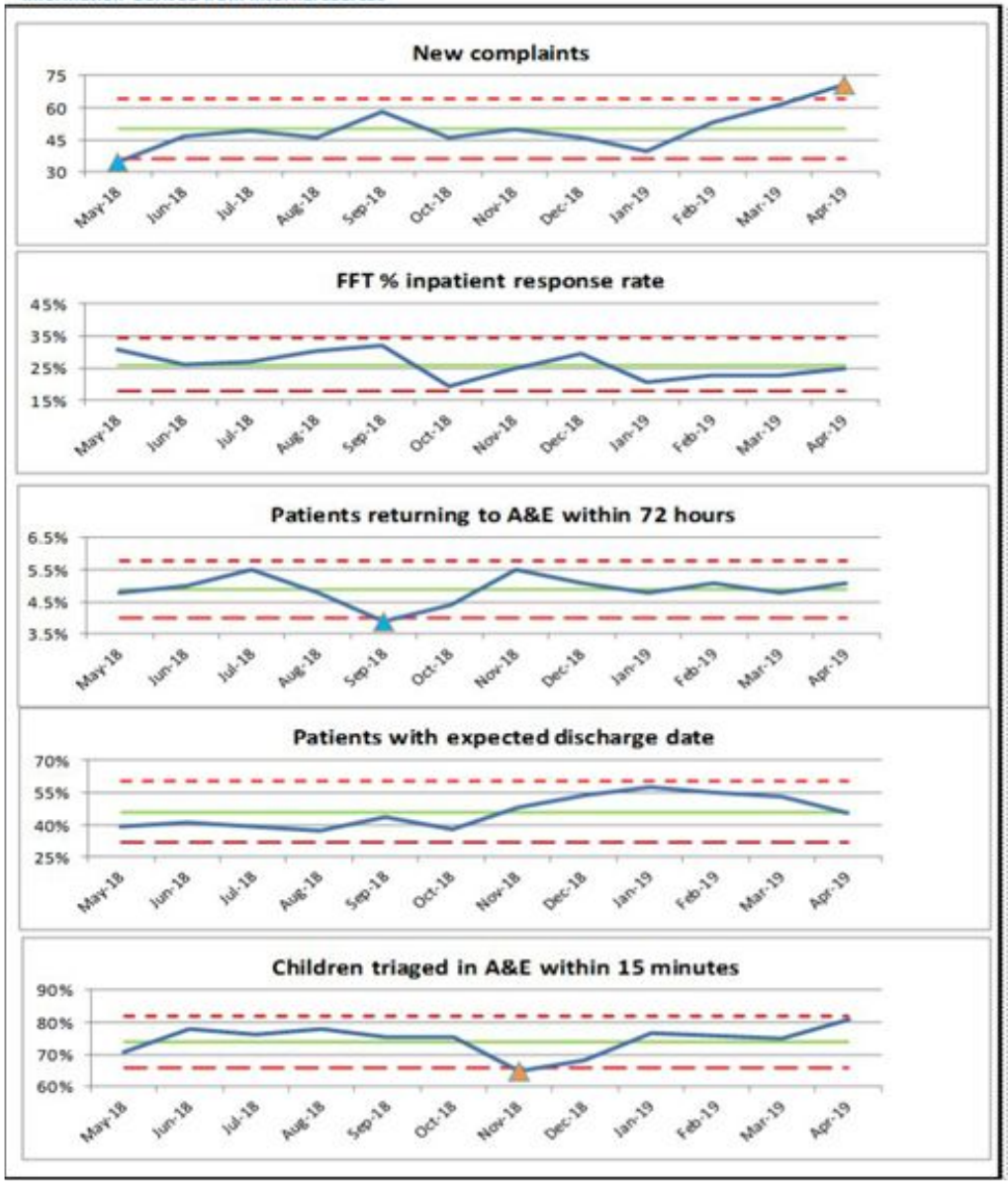
	Jan18 to Mar18	Apr18 to Jun18	Jul18 to Sep18	Oct18 to Dec18	Jan19 to Mar19
STAFF FFT (recommend as place to work)	61%	61%	56%	60%	65%
GO ENGAGE	-	3.89	3.88	-	3.91

Quality: patient experience

PATIENT EXPERIENCE - LEADING INDICATORS (SPC)

Lead - Quality Committee

Information derived from internal sources

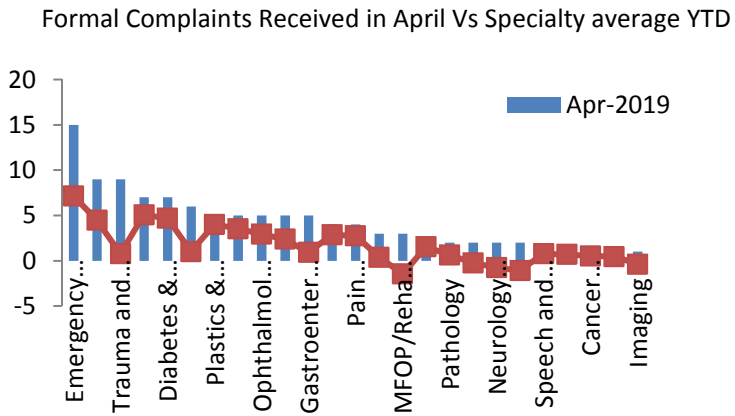


PATIENT EXPERIENCE - TREND INDICATORS

Information derived from internal sources

Diagnostic waits - patient seen within six weeks	This period 96.1% Apr-19		100% 98% 96%
Outpatient appointment disruption	This period 20.7% Apr-19		23% 20% 17%
Outpatient letters to GP within 14 days	This period 66% Apr-19		80% 70% 60%
Elective operations cancelled on the day	This period 47 Apr-19		70 40 10
Friends and Family - % positive (Maternity)	This period 97.5% Apr-19		100% 95% 90%
Friends and Family - % positive (A&E)	This period 85.4% Apr-19		100% 85% 70%
Patients over 12 hours in A&E	This period 323 Apr-19		600 400 200
Cancer - two week wait for first appointment	This period 95.2% Mar-19		100% 95% 90%
Cancer - 31 days to treatment	This period 97.9% Mar-19		100% 95% 90%
Cancer Screening - 62 days to treatment	This period 93.8% Mar-19		100% 80% 60%

Complaint data



	Delays/Cancellations	Behaviour & Attitude of Staff	Discharge/Transfer/Referral	Diagnosis	Treatment/Procedure	Nursing care
Emergency Medicine (incl A&E)	0	2	1	3	2	1
Trauma and Orthopaedics	2	3	1	0	1	0
General Surgery	2	1	3	2	0	0
Diabetes & Endocrinology	0	0	2	1	0	2
Respiratory Medicine	0	1	2	1	0	0
Urology	1	0	1	0	1	2
Dermatology	3	1	0	0	0	0
Gastroenterology	1	2	0	0	1	0
National Spinal Injuries Centre	1	0	2	1	0	0
Ophthalmology	2	1	0	0	1	0
Acute & General medicine	0	0	1	1	0	0
Gynaecology	0	1	0	1	1	0
Clinical haematology	0	0	0	0	0	1
Children and Young People	3	0	0	0	0	0
Pain Management	1	0	0	0	2	0
Paediatrics	0	2	0	0	0	0
Property Services	0	1	0	0	0	0
Neurology /Stroke	0	0	0	1	1	0
Pathology	0	0	0	1	0	0
Cardiology	0	0	0	0	0	0
Community Locality Teams	0	0	1	0	0	0
Imaging	0	0	0	0	0	0
Medicine for Older People/Rehab/Mudas	0	0	0	0	1	0
Oral Surgery & Orthodontics	0	0	0	0	1	0
Totals:	16	15	14	12	12	6

Complaints – April data

New formal complaints received in April was 71, **the highest number YTD**, with medicine receiving the highest proportion:

Specialties: Of the 71 new formal complaints received in April, the greatest number were received for ED (15). This was 7 cases above the average received per month over the last year. The most marked *increases* against averages were spread amongst ED, General surgery, diabetes, urology, plastics and respiratory. Detail on next slide.

Themes Trust wide: Top themes for April cases were delays & cancellations; behaviour of staff; discharge; diagnosis and treatment/procedure. There is work underway currently to target interventions at local level to address.

Speed of response: 90% of 25 day cases in March. Exceeded the 85% trust target. There needs to be a continued focus to reduce complaints over 90 days.

Accolades

June IBR will begin with April and new 2019/20 sheet.

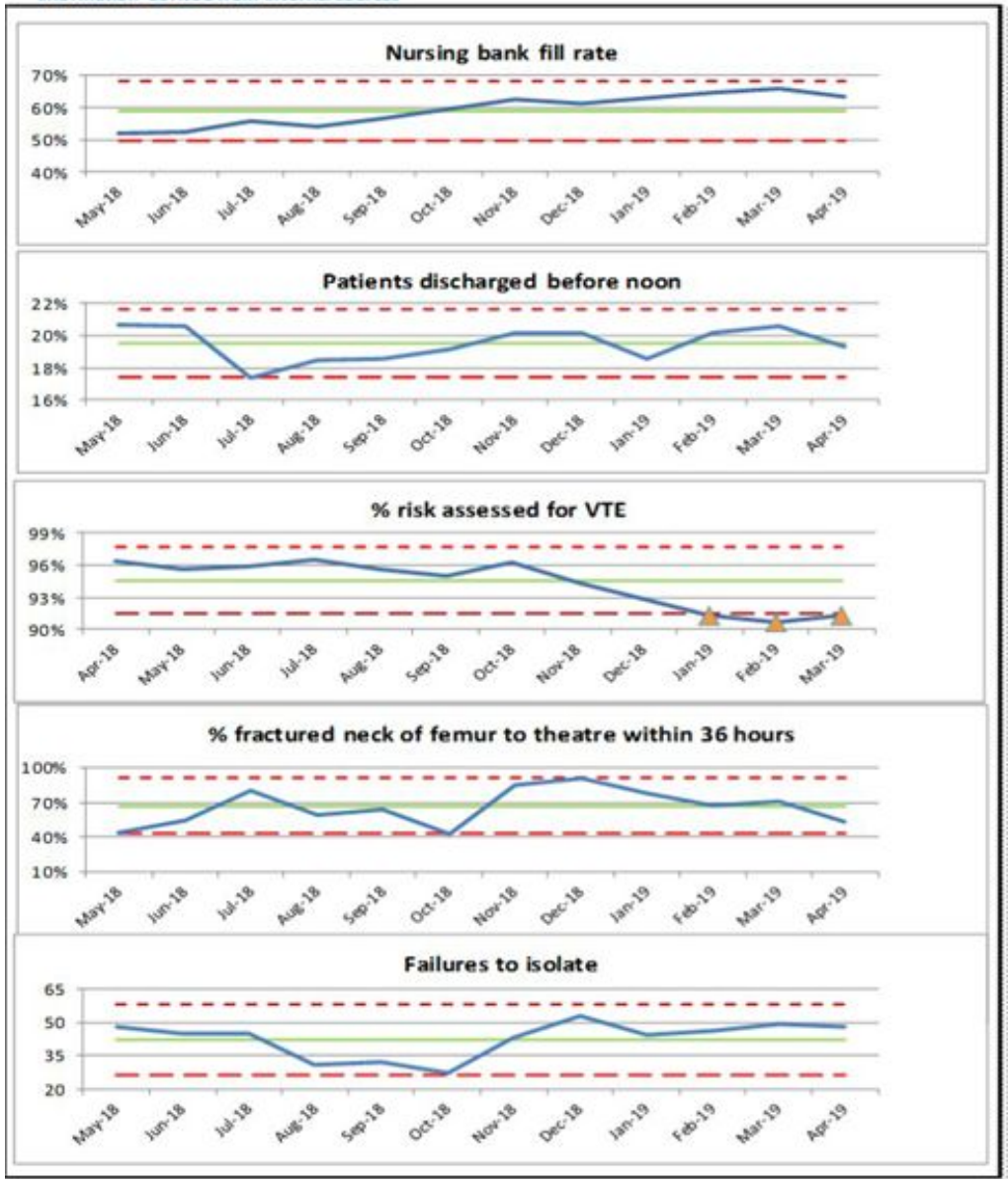
Division	Apr-2018	May-2018	Jun-2018	Jul-2018	Aug-2018	Sep-2018	Oct-2018	Nov-2018	Dec-2018	Jan-2019	Feb-2019	Mar-2019	Grand Total
Corporate/Non-Clinical Support Services	1	1	5	4		6	2	4	3	1	1	1	29
IECC	508	479	497	477	462	488	509	538	573	482	464	425	5902
Integrated Medicine	103	88	109	108	129	168	142	137	271	124	90	105	1574
Specialist Services	275	252	205	277	259	262	246	303	398	116	109	58	2760
Surgery	179	25	231	162	101	174	245	268	122	104	101	122	1834
Women & Children	103	72	132	168	153	113	229	234	451	259	283	208	2405
Grand Total	**1169**	**917**	**1179**	**1196**	**1104**	**1211**	**1373**	**1484**	**1818**	**1086**	**1048**	**919**	**14504**

Quality: patient safety

PATIENT SAFETY- LEADING INDICATORS (SPC)

Lead - Quality Committee

Information derived from internal sources



PATIENT SAFETY - TREND INDICATORS

Information derived from internal sources

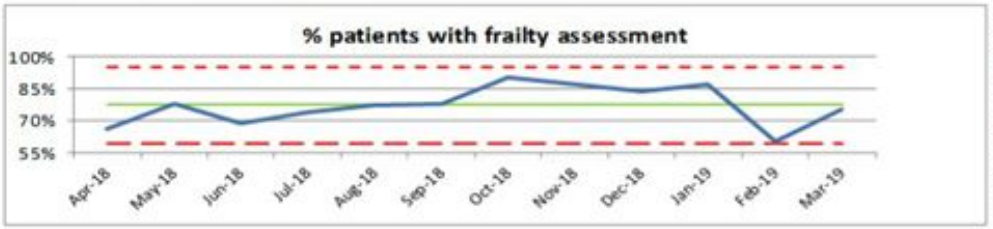
Ambulance handover delays (over 30 minutes)	This period 39 Apr-19		100 50 0
A&E - Median time to triage (minutes)	This period 17 Apr-19		24 18 12
Avoidable cardiac arrests	This period 4 Apr-19		8 4 0
Extended perinatal mortality (per 1000)	This period 3.6 Apr-19		6.0 4.0 2.0
Stillborn babies - at 24 weeks or later (per 1000)	This period 2.2 Apr-19		4.5 3.0 1.5
New mothers visited within 14 days of birth	This period 95% 18/19 Q4		100% 95% 90%
Safeguarding training - children and young people	This period 88% Apr-19		100% 85% 70%
Line infections	This period 1 Mar-19		6 3 0
Crude mortality (rolling 12 month average)	12 month average 1.1% Apr-19		1.4% 1.1% 0.8%
Medical Examiner screens selected for further review	This period 13% Mar-19		20% 10% 0%
Outstanding clinical audits causing concern	This period 6 Apr-19		25 15 5

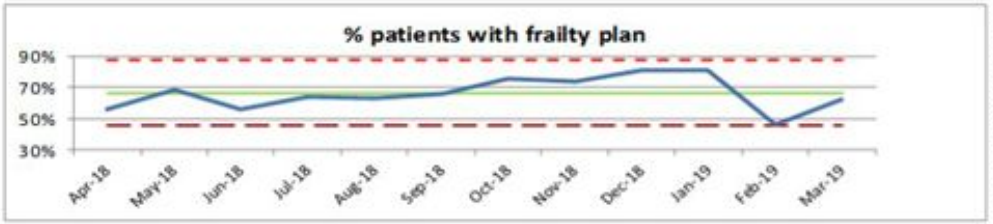
Quality: patient safety

PATIENT SAFETY- LEADING INDICATORS (SPC)

Lead - Quality Committee

Information derived from internal sources



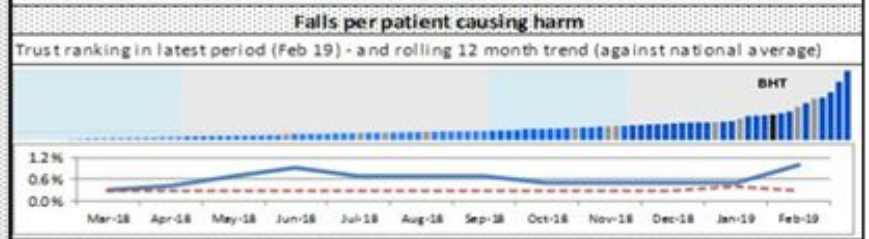


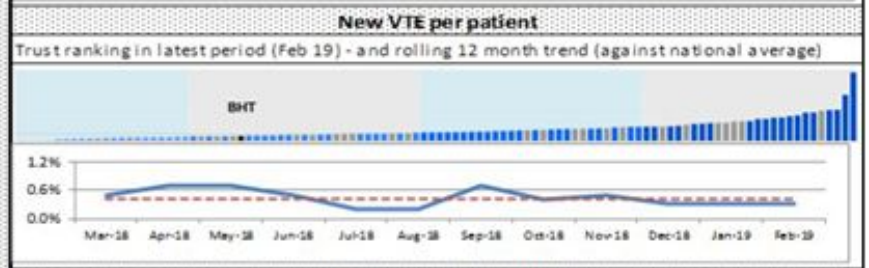
Safety incident reporting

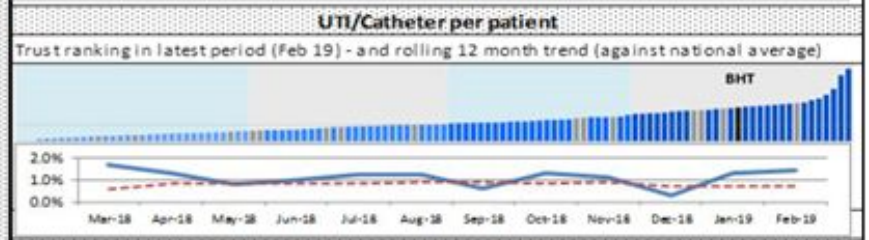
Information source is CQC Insight

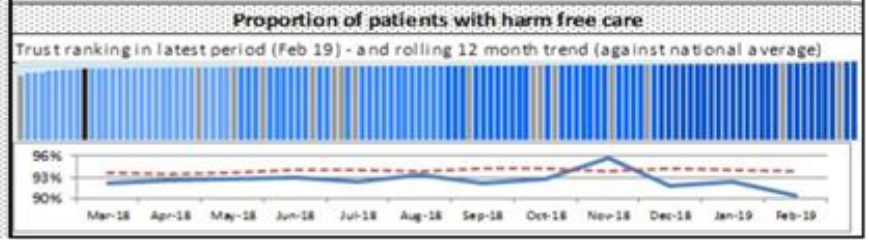
PATIENT SAFETY - TREND INDICATORS

Information source is NHSI Model Hospital - for benchmarking nationally









Quality: Key Issues and Learning

Learning organisation

There is a continued strong focus on the reduction on in-patient falls and a target of no more than 70 falls per month has been set. Learning from incidents have caused harm we will continue to drive the following prevention interventions .

- Effective communication of care patients at high risk
- Fall safe Bundle which has specific recognised, tested interventions
- Completion of Risk Assessments and appropriate care planning
- Awareness and use of appropriate equipment

However recognising we need to do more to reduce harm, a dedicated learning event on **'Learning for sustainable improvements in care and the environment to reduce falls as a harm.'** is taking place this month which will identify 3 high impact actions within higher risk areas to implement 2019/2020.

This session will have multi professional attendance and contributions, led by the trust allied health professions lead. There will be a focus on shared learning from service improvement redesign work, specialist pharmacists and from those working with residents in care.

Quality Improvement

- Bespoke Quality Improvement training patient experience group members
- Monthly drop in clinics for all staff who want to learn more and seeking guidance and support
- Communications launch
- Give it a go week – promoting quality improvement at local level
- Quality improvement at trust induction
- Learning from others – East London foundation Trust

Mortality review and alerts

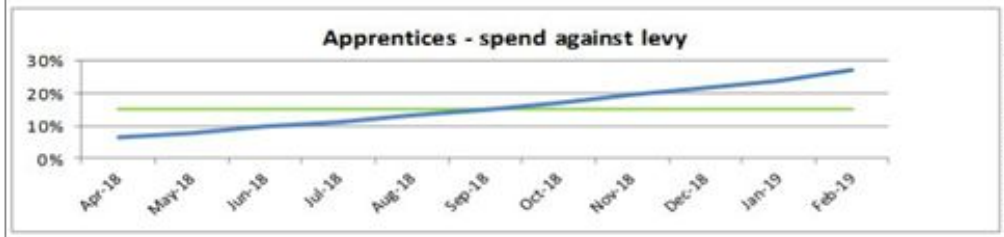
•Total compliance with ME screens **98%**
•**89%** no care problems identified
•**11%** selected for **SJR**
•SJR compliance up to **88% overall**
•**21%** of all compliments led to excellence reporting
•**91%** patients had DNACPR
•**84%** patient had TEP
•**1%** re-admissions with 72 hours - SMH only
•**83%** of applicable calls achieved by medical examiner to bereaved rela ves
•Quarterly meeting with Coroner, Registrar and Local Authority April 2019
•National Medical Examiner roll out from April 1st 2019- initial roll out to secondary care non statutory phase
•BHT representation at National Medical Examiner Conference April 2019
•Poster Presentation accepted for Patient Safety Congress in the category of a culture for learning and change
•Milton Keynes visit planned to Medical Examiner Service May 15th 2019

Workforce indicators

WORKFORCE - LEADING INDICATORS (SPC)

Lead - Workforce Committee

Information derived from internal sources



WORKFORCE - TREND INDICATORS

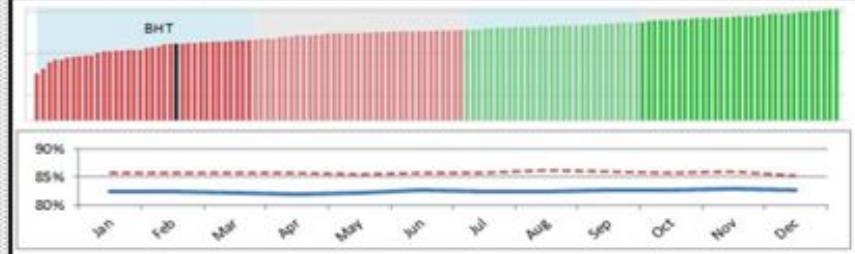
Information derived from internal sources

Agency staff - spend against plan	This period 92% Apr-19	Trend line will become available as financial year progresses
Units with >30% nursing vacancies	This period 15 Mar-19	16, 10, 4
Occupational Health referrals for stress	This period 20 Apr-19	50, 35, 20
Medical locums for longer than one month	This period 11 Apr-19	30, 15, 0
Apprentices - recruitment against plan	This period 138% 18/19 Q4	140%, 100%, 60%
Appraisals completed (2019 cycle)	2019 cycle has just commenced	

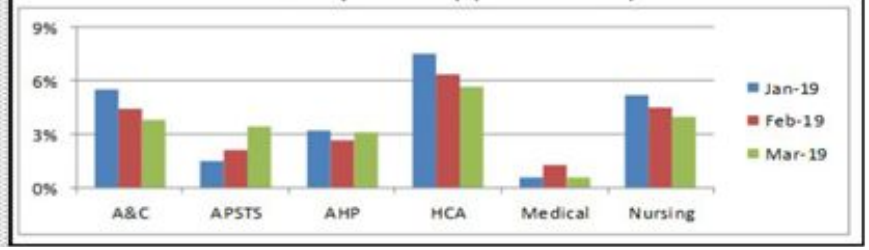
Information source is NHSI Model Hospital - for benchmarking nationally

Staff retention

Trust ranking in latest period (Dec 18) - and rolling 12 month trend (against national average)



Sickness by Staff Group (latest 3 months)



Workforce

Strategic update

- Implementing new workforce models is our key people objective, supported by three programmes: innovate with new models of care; make BHT a great place to work; develop teams, talent and an inclusive workforce
- Key risks and mitigating actions are in place for areas where delivery of floodlight performance indicators is not meeting target and indicators are rag rated red or amber

Nursing workforce

- The work led by the Chief Nurse and Director of Workforce & OD continues to make an impact on the nurse turnover rate, which reduced overall during 2018-19; this trend has been maintained into the new financial year, with turnover at April 2019 at 13.4%, the lowest for over two years
- We are recruiting nurses from within and outside the UK; in April, 23 registered nurses joined the Trust
- We are supporting existing staff in gaining their NMC (Nursing & Midwifery Council) registrations. In April, 17 staff gained their registration: this included newly qualified graduates from one of our partner universities, the University of Bedfordshire; nurses who qualified overseas and a colleague who has returned to practice. All of these individuals have received professional support from the Trust's clinical education team

Temporary staffing

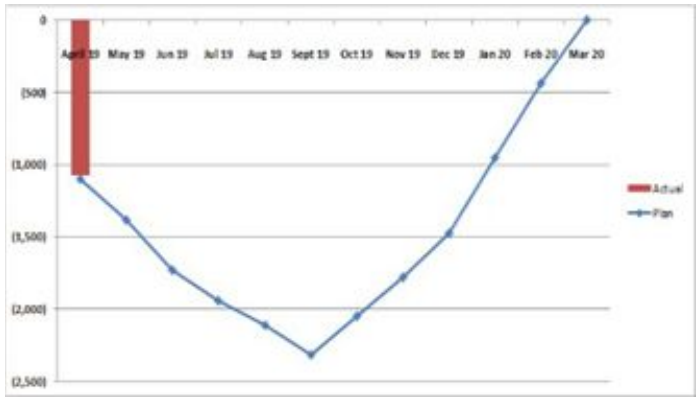
- Temporary staff ensure the provision of safe and high quality care; our aim is to fill with bank staff wherever possible
- Through robust controls and strong clinical leadership and involvement, we reduced levels of spend on agency staff during the second half of 2018-19 and this work continues, with Month 1 agency spend just below 800K

Equality, Diversity and Inclusion

- This is a key priority for 2018-19; four staff networks – BAME (Black, Asian, Minority Ethnic), Disability, LGBT+, VIBES (values, identity, belief, ethical and spirituality network) will develop from the foundations set in 2018/19
- Colleagues (including non-executive and executive directors) are involved in the Trust's BAME reciprocal mentoring programmes

Finance: income and expenditure

Income & Expenditure Positon



Key Highlights

- The Trust delivered a £1.1m deficit position for month 1, April, 2019. This is in line with the financial plan for the month and includes the expected receipt of Performance Sustainability Fund (PSF) and Financial Recovery Fund (FRF) monies totalling £0.7m. MRET is also included at plan, £0.3m. The month 1 position assumes the receipt of £2m non-recurrent ICS risk funding income from Buckinghamshire CCG
- The month 1 pay position includes payment of the agenda for change 1% non-consolidated pay award to all staff on top of scale (£0.7m) and the consultant clinical excellence awards (£0.2m). Both these items are fully funded within the financial plan and Divisional positions
- Agency Spend totals £0.8m for the month, against the £0.9m monthly agency cap. The full year agency cap for 2019-20 is £10.5m
- The Annual Financial Plan is to deliver a breakeven position. The Plan assumes the full delivery of £15m recurrent productivity and efficiency savings, £18.6m non recurrent central funding (PSF/FRF and MRET) and £6.9m ISC Risk funding
- CIP allocation of actuals delivered will be represented through budgets as part of plan finalisation in Month 2
- As previously notified at committee, the Trust has amended its accruals policy and all items are included, irrespective of age

Divisional I&E Performance (£k)

Division	Monthly Plan	Monthly Actuals	Variance	Annual Plan
Integrated Medicine	(6,485)	(6,887)	(402)	(75,119)
Integrated Elderly Care	(3,077)	(3,006)	71	(34,979)
Surgery And Critical Care	(7,575)	(7,743)	(168)	(86,675)
Women & Children	(4,020)	(3,971)	49	(45,508)
Specialist Services	(6,079)	(6,341)	(262)	(69,618)
Total Clinical Divisions	(27,236)	(27,949)	(713)	(311,900)
Chief Executive	(362)	(377)	(14)	(4,324)
Chief Operating Off-Management	(110)	(127)	(17)	(1,259)
Corporate Services	83	6	(78)	1,000
Finance Dept.	(406)	(336)	70	(4,690)
Information Technology	(532)	(503)	29	(6,084)
Performance & Delivery	(309)	(294)	14	(3,567)
Property Services	(4,077)	(4,351)	(274)	(48,241)
Human Resources	127	173	46	1,768
Medical Director	(26)	(28)	(2)	(282)
Nursing Director	(1,378)	(1,376)	2	(16,315)
Pdc And Depreciation	(1,402)	(1,589)	(187)	(16,824)
Bht -Bhpl Sla	0	7	6	4
Strategy And Business Dev.	(48)	(31)	17	(511)
Total Corporate	(8,440)	(8,828)	(388)	(99,324)
Contract Income	33,499	34,521	1,022	401,987
MRET	349	349	0	4,189
Committed Funds	9	0	(9)	(9,324)
Impairment Adjustment	0	0	0	0
Donated Asset Reporting Adj	0	110	110	0
Total before PSF & FRF	(1,819)	(1,797)	22	(14,372)
Performance Sustainability Fund (PSF)	291	291	0	5,816
Financial Recovery Fund (FRF)	428	428	0	8,556
Total Including PSF & FRF	(1,100)	(1,078)	22	0

Run Rate Performance (£k)

Expense Type	2018-19 Average Run Rate	2019-20 M01
Contract Income	31,238	30,221
Total Income From Activities	1,079	5,139
MRET	0	349
Donated Assets Income	127	11
Other Operating Income	2,070	1,748
Total Income	34,514	37,467
Nursing - Total	(8,900)	(9,499)
Medical Staff - Total	(5,819)	(6,002)
Admin & Clerical - Total	(2,942)	(3,091)
Professional & Tech - Total	(3,557)	(3,965)
Other Staff - Total	(514)	(556)
Chairmand,Exec+Non-Exec Dirs.	(93)	(121)
Redundancy/Mars	(1)	0
Total Pay	(21,825)	(23,235)
Drugs	(3,558)	(3,576)
Clin.Supp.Srvs Total(Ex Drugs)	(2,794)	(3,095)
Gen Supp & Servs - Total	(111)	(105)
Establishment Exps - Total	(430)	(487)
Premises & F Plant - Total	(1,617)	(1,695)
Miscellaneous - Total	(1,816)	(1,731)
PFI	(2,110)	(2,174)
CNST	(1,040)	(1,031)
Total Non Pay	(13,476)	(13,894)
Owned Depreciation - Total	(875)	(1,046)
Donated Depreciation - Total	(113)	(120)
Interest Paid And Pdc Div	(1,134)	(1,077)
Interest Receivable	11	(2)
Profit/Loss On Disposal	1	0
Fin11 Impairment Expenditure	299	0
Total Other	(1,711)	(2,295)
Donated Asset Reporting Adj	(14)	110
Remove Impairments	(299)	0
Total Reported Position before PSF & FRF	(2,012)	(1,797)
Performance Sustainability Fund (PSF)	0	291
Financial Recovery Fund (FRF)	0	428
Total Reported Position before PSF & FRF	(2,012)	(1,078)

Trust I&E Performance (£k)

Division	Monthly Plan	Monthly Actuals	Variance	Annual Plan
Contract Income	33,499	34,521	1,022	401,987
Other Income From Activities	926	839	(89)	11,132
MRET	349	349	0	4,189
Other Operating Income	1,559	1,748	190	18,704
Donated Asset Income	83	11	(73)	1,000
Income CIP Underplan	53	0	(53)	1,268
Total Income	36,471	37,467	997	438,281
Nursing	(9,871)	(9,499)	371	(114,396)
Medical Staff	(5,963)	(6,002)	(40)	(69,796)
Admin & Clerical	(3,282)	(3,091)	191	(37,915)
Professional & Tech	(3,780)	(3,965)	(185)	(43,519)
Other Staff	(589)	(556)	33	(6,738)
Exec & Non Exec Dirs	(93)	(121)	(28)	(1,116)
Pay Committed Funds	118	0	(118)	(763)
Pay CIP Underplan	329	0	(329)	7,991
Total Pay	(23,131)	(23,235)	(104)	(266,252)
Drugs	(3,706)	(3,576)	129	(44,470)
Clinical Supp Servs	(2,644)	(3,095)	(451)	(31,733)
Gen Supp & Servs	(93)	(105)	(12)	(1,115)
Establishment Exps	(387)	(487)	(100)	(4,645)
Premises & F Plant	(1,540)	(1,695)	(155)	(18,629)
Miscellaneous	(1,690)	(1,731)	(40)	(20,285)
PFI	(2,084)	(2,174)	(90)	(25,005)
CNST	(1,031)	(1,031)	0	(12,368)
Non Pay Committed Funds	(105)	0	105	(8,327)
Non Pay CIP Underplan	252	0	(252)	5,741
Total Non Pay	(13,028)	(13,894)	(866)	(160,837)
Owned Depreciation	(925)	(1,046)	(121)	(11,096)
Donated Depreciation	(83)	(120)	(37)	(1,000)
Impairment	0	0	0	0
Interest Paid And Pdc Div	(1,130)	(1,077)	53	(13,555)
Interest Receivable	7	(2)	(9)	87
Profit/Loss Disposal of Assets	0	0	0	0
Total Other	(2,130)	(2,245)	(114)	(25,564)
Donated Asset Reporting Adj	0	110	110	0
Total before PSF & FRF	(1,819)	(1,797)	22	(14,372)
Performance Sustainability Fund (PSF)	291	291	0	5,816
Financial Recovery Fund (FRF)	428	428	0	8,556
Total Including PSF & FRF	(1,100)	(1,078)	22	(0)

Finance: business performance

USE OF RESOURCES - TREND INDICATORS

Lead - Finance and Business Performance Committee

Information source is NHSI Model Hospital - for benchmarking nationally

CAPITAL SERVICE CAPACITY

12 months from April 18

LIQUIDITY (days)

12 months from April 18

I&E MARGIN

12 months from April 18

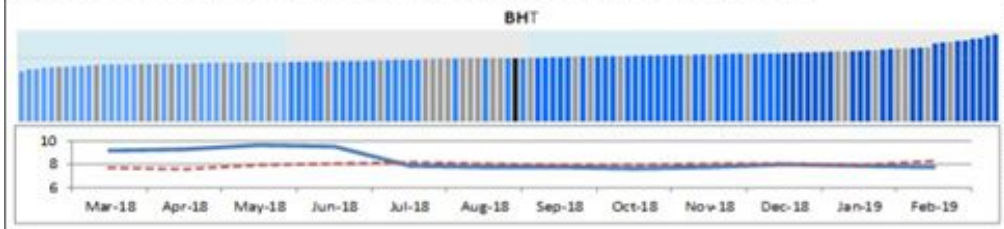
DISTANCE FROM FINANCIAL PLAN

12 months from April 18

Information source is NHSI Model Hospital - for benchmarking nationally

NURSING CARE HOURS PER PATIENT DAY

Trust ranking in latest period (Feb 19) - and rolling 12 month trend (against national average)



USE OF RESOURCES - TREND INDICATORS

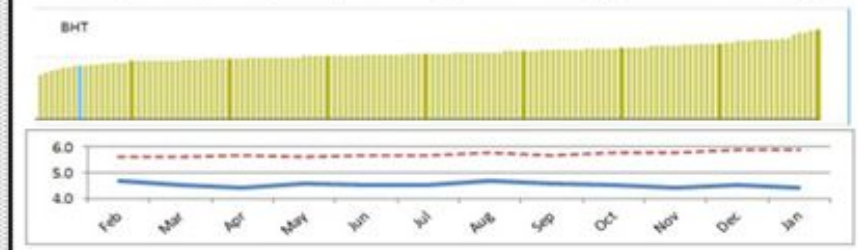
Information derived from internal sources

Outpatient appointments - cashing up within target	This period 97.2% Apr-19	
Outpatient appointments - DNA's	This period 5.3% Apr-19	
Job Plans completed (current cycle started Oct 18)	This period 57% Apr-19	
Impact of non compliance with Best Practice Tariff (potential lost income)	This period £51K Mar-19	
LoS > 21 days - patients in acute hospitals	This period 96 Apr-19	
LoS > 21 days - patients in community hospitals	This period 30 Apr-19	
Temporary shifts requested	This period 5,708 Apr-19	
Receipts without a purchase order	This period 302 Apr-19	
GP referrals	This period 9,253 Apr-19	

Information source is CHKS

AVERAGE DIAGNOSES PER CODED EPISODE

Trust ranking in latest period (Jan 19) - and rolling 12 month trend (against national average)



Finance: cash & Accounts Payable / Receivable

Cash Position (£k)

	Apr Actual	May Forecast	Jun Forecast	Jul Forecast
	£'000s	£'000s	£'000s	£'000s
Opening Balance	2,191	2,497	2,091	2,075
Receipts	32,825	39,072	39,176	35,218
Service Level Agreements	29,309	31,729	31,729	28,729
Other Income	3,516	7,343	7,647	6,489
Payments				
Payroll	(21,288)	(24,545)	(23,575)	(24,210)
Monthly pay	(20,769)	(21,465)	(21,915)	(21,930)
Nhs Professionals - Agency	(309)	(1,500)	(800)	(1,100)
Nhs Professionals - Bank	(117)	(1,500)	(800)	(1,100)
Temporary Medical	(93)	(80)	(60)	(80)
Creditors	(14,782)	(25,632)	(15,817)	(15,808)
Pharmacy	(2,593)	(3,850)	(3,050)	(3,650)
Other Revenue Creditors - AP	(7,755)	(10,651)	(8,570)	(7,961)
Bunzl - Supplies	(234)	(200)	(200)	(200)
PFI - Enterprise	(1,343)	(1,370)	(1,370)	(1,370)
PFI - United Health	(1,840)	(1,827)	(1,827)	(1,827)
Capital creditors	(1,017)	(7,734)	(800)	(800)
Borrowings	1,551	10,700	0	4,800
DH - Revenue Loan drawdown	2,504	10,700	0	4,800
DH - MRET	1,047			
Closing Balance	2,497	2,091	2,075	2,075

Cash – Key Highlights

- The Trust drew down £10.7m in May in support of the final 2018-19 deficit and in advance of incentive payments (PSF,FRF)
- The Trust is not anticipating any cash draw down for June
- Future cash need will be dependant on the profile of I&E performance. NHSI capital and cash have indicated that any very short term support accessed in relation to this will need to be repaid as soon at the Trust achieves a breakeven position
- The most significant cash outflow in May is the South Buckinghamshire PFI lifecycle payment of £4.5m
- The Trust also has a £3m credit note with NHS Buckinghamshire CCG which will be repaid in June

Accounts Payable & Accounts Receivable

INVOICED RECEIVABLES AS AT 30 APR 2019

	Current	30-60 days	60-90 days	90-120 days	> 120 days	Total
NHS	2,245	1,860	1,267	554	2,947	8,873
NON NHS	1,481	1,667	244	215	2,575	6,182
% of Total	25%	23%	10%	5%	37%	

INVOICED RECEIVABLES AS AT 31 MAR 2019

	Current	30-60 days	60-90 days	90-120 days	> 120 days	Total
NHS	1,733	1358	582	447	2,402	6,522
NON NHS	2,176	563	277	338	2,727	6,081
% of Total	31%	15%	7%	6%	41%	

INVOICE PAYABLES AS AT 30 APR 2019

	Current	30-60 days	60-90 days	>90 days	Total
NHS	6	0	-	87	93
NON NHS	1,111	- 119	2	390	1,383
% of Total	76%	-8%	0%	32%	

INVOICE PAYABLES AS AT 31 MAR 2019

	Current	30-60 days	60-90 days	>90 days	Total
NHS	1,453	326	55	117	1,951
NON NHS	27	192	1	211	431
% of Total	62%	22%	2%	14%	

BETTER PAYMENT PRACTICE CODE

	Count Total	Count Pass	% Pass	£'000s Total	£'000s Pass	% Pass
NHS	747	221	30%	5,264	3,557	68%
NON NHS	8,971	6,233	69%	22,985	19,350	84%
TOTAL	9,718	6,454	66%	28,249	22,907	81%

Accounts Payable & Accounts Receivable – Key Highlights

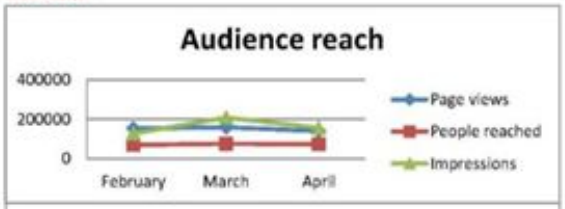
- Debt has increased in month 1 from £12.6m to £15m. Most of this is reflected in NHS debtors. £0.9m connected to Health Education England. In addition a number of invoices have been raised in April relating to 2018-19 which would have been accrued at the end of the Financial Year
- NHS invoices payables have reduced significantly as non disputed items have been cleared and paid following the Agreement of Balances exercise. In contrast the non NHS has increased which is reflective of the efforts undertaken to bring the supplier accounts up to date. The amounts on the system are mostly in "current" which are not yet due for payment
- BPPC performance is affected by the clearance of old invoices from the invoice register as part of the Agreement of Balances clear down. The Trust continues to pay below the 95% expected which is indicative of process compliance issues delaying processing of invoices for payment

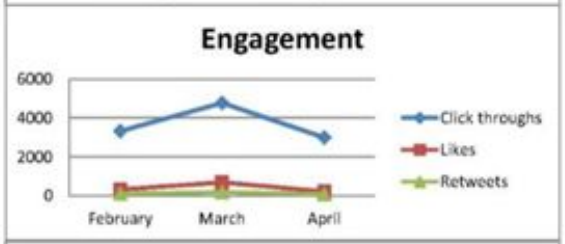
Communications and engagement

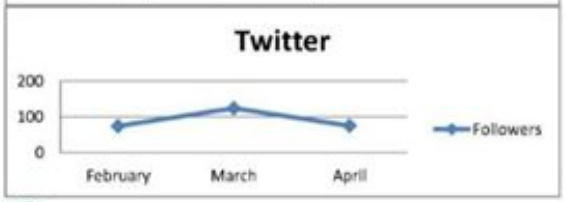
INTERNAL

	This month	Last month
CEO brief video clicks	0	39

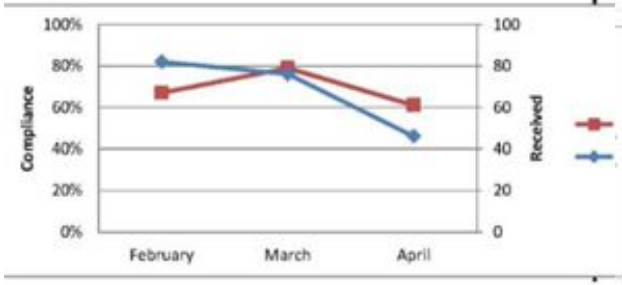
DIGITAL







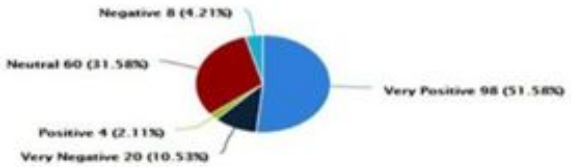
FOI



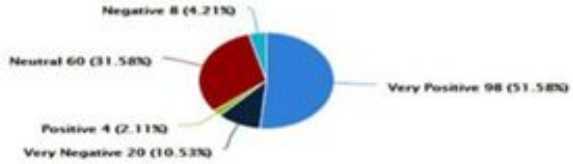
MEDIA

Sentiment

This month



Last month



Key stories

Bucks Free Press:

- Increase in 'seriously ill' children admitted to Bucks hospitals over winter
- Reduction in hospital 'bed blocking' across Bucks hospitals despite increased demand over winter
- Bucks Healthcare apologises after drivers shortchanged when clocks on ticket machines at Amersham Hospital did not go forward

Mix 96:

- Bucks Healthcare celebrates patient reporting milestone
- One in seven new hires at Buckinghamshire Healthcare Trust are from the EU, figures reveal, higher than the national average.

Leighton Buzzard Observer:

- Buzzard Scooter Club deliver hundreds of Easter eggs to children at Stoke Mandeville Hospital

PUBLIC ENGAGEMENT

Key activity

Public engagement events

- Community hubs stakeholder group meetings
- EDS2 patient grading meetings

Internal

- The BHT Way
- Small Change Big Difference discussed as part of Corporate Objectives
- Continued support of eObs rollout
- Support for QI indent development
- Supported the launch of Fabulous Fortnight in community hospitals

External

- ICS Roadshows
- Maternal Mental Health Awareness Week member of speciallist perinatal mental health team interviewed by Mix 96
- Social media cmpgn for Admin Professionals Day
- Inter Spinal Unit Games comms support
- Mother's Day - Midwives campaign

PERFORMANCE AGAINST KPIs - Quarterly

	Baseline	Target	QTD
20% increase in digital engagement*	6,249	7,499	4,166

*no. of times user interacted with our tweets, Facebook or blog posts or BHT Connect articles


NHS
Buckinghamshire Healthcare
NHS Trust

<table>
<tr><td colspan="3">Performance Exception Report</td></tr>
<tr><td rowspan="2">Month: April 2019</td><td>Executive Director:</td><td>Natalie Fox</td></tr>
<tr><td>Completed by:</td><td>Lorraine Pitblado</td></tr>
<tr><td>Indicator/Performance standard</td><td colspan="2">Trusts Accident & Emergency 4hr Standard - 95% of patients to be seen, admitted or discharged within four hours.</td></tr>
<tr><td>Variation from plan</td><td colspan="2">
<table>
<tr><td>April Plan</td><td>90.1% Total patients expected 12,793</td></tr>
<tr><td>April Actual</td><td>89.73%% Total patients attended 13,474</td></tr>
</table>
Attendances were 681 more than planned the 4 hour standard was 0.37% less than trajectory.
• The daily average of patients for the month was 449 which was a decrease from 457 in March
• The best days performance 19/04/2019 was of 98.78% which was the 2nd highest in the country and there were 2 further occasions when performance was >95%
• The Trust ranked 27th for the 4 hour performance across the country
• The daily average seen through GP steaming was 43 patients which was a decrease from 45 in March
</td></tr>
<tr><td>Reason for variation</td><td colspan="2">Highlights for the month of April 2019:
• Attendances across Urgent & Emergency Care at BHT were higher this year 13,474 compared to April last year 11,289
• Conversion rate (rate of attendance to admission) continues to be high due to the acuity of patients - 29.9%
• Performance has continued to be between 88-91%</td></tr>
<tr><td>Impact</td><td colspan="2">Performance of the Emergency Department (ED) constitutional standard of patients seen or discharged within 4 hours has seen less variation throughout April compared to the recent month. In April the ED attendances were in excess of 500 on five days with the average around 449 per day, the highest recorded day was 543 patients on 29th April 2019.

Type 1 A&E performance continues to be a challenge although there was an improvement in April.

Minors breaches continue to pose a significant problem especially out of</td></tr>
</table>

<table>
<tr><td></td><td colspan="2">hours when all patients are managed through 1 single queue.

The Trust implemented its ‘Full Capacity Protocol’ predominately due to lower discharges than admissions which correlated to acuity of those being admitted on a few occasions in April and worked across the organisation to black actions.

Escalation beds on St Joseph’s continue to be utilised which impact the effectiveness of delivering a medical day unit as well as a discharge lounge.

Throughout the previous months work was undertaken by BHT and led by the Infection Control Team to manage, Noro-virus, however Amersham hospital had 2 wards closed during the month with noro-virus.

The length of stay (LoS) has remained stable although still above trajectory however ongoing work through the month through the ‘SAFER’ initiatives continue to support reducing the LoS of patients particularly those greater than 21 days.</td></tr>
<tr><td rowspan="3">Key Actions to be taken to address variation</td><td>Area</td><td></td></tr>
<tr><td>Minors Breaches</td><td>Minors breaches have improved following the completion of phase 1 of the work.
The second phase will focus on the culture of triaging and management of minors throughout the day including escalation.
There is also a piece of work exploring the staffing levels during busy times at the UTC and how we manage some of our staff more effectively across the Trust.
Communication with high performing Trusts that report 100% compliance with minors to understand our gaps.</td></tr>
<tr><td>Type 1 performance</td><td>In line with the expected changes to the A&E target of type 1 being seen within 1 hr. At present our type 1 performance is sub-optimal, mainly due to timeliness of triaging, visibility of type 1 patients and responsiveness of specialities.
A working group will be set up to monitor</td></tr>
</table>

		performance of type 1 and minors that will report into the Urgent Care Group.
	Understanding the increase in demand	We are involved in the collaborative work with NHSI to understand the growth in Emergency department attendance rates. This is national piece of work across organisations of differing configuration. A site visit by NHSI is planned 21st – 23rd May to meet clinical and managerial teams. Data has been submitted prior to the meeting to support. A report will be available in June 2019.
Forecast date to return to plan / trajectory for recovery	Ongoing yearly plan approved to manage demand and improve on constitutional targets. Increase in A&E performance in months 1-3 expected.	

Accident and Emergency			**Y1 M02 Plan 31/05/19 Month 2**	**Y1 M03 Plan 30/06/19 Month 3**	**Y1 M04 Plan 30/06/19 Month 4**
Accident and Emergency - >4 hour wait	*i*		1,200	1,070	1,150
Accident and Emergency - Total Patients	*i*		13,873	13,411	14,219
Accident and Emergency - Performance % (95% standard)			**91.4%**	**92.0%**	**91.9%**

Monitoring	A&E Delivery Board – ED Team meetings and Governance, 2 hour safety huddles and Site & Capacity meeting. A&E Department meeting and daily safety huddles.

Performance Exception Report		
Month: March 2019	**Executive Director:**	Natalie Fox
	Completed by:	Catherine Richards
Indicator / Performance standard	**Cancer Target – 62 day for March 2019** **85% or more of patients to be treated within 62 days of 2WW referral**	
Variation from plan		

Cancer 62 day recovery	Jan 19 M10	Feb 19 M11	Mar 19 M12
Breaches > 62 days - predicted	12.0	11.0	13.0
Total treated - predicted	84.0	76.0	90.0
Predicted Performance	85.7%	85.5%	85.6%
Breaches > 62 days - actual	13.5	18	13.5
Total treated – actual	91.5	87.5	97.5
Monthly Performance - actual	85.2%	79.4%	86.2
104 day breaches	1	2.5	3

Reason for variation

March has seen a significantly improved position compared to performance in February and all cancer targets were met by the Trust for the first time since 2017.

The number of tumour sites not meeting the target has decreased since February. (Note some of the numbers of patients treated are very small which has a significant influence on individual targets.)

Tumour sites not meeting the 62 day target of 85%:

Gynae	75%	2 patients treated – one tertiary referral breached which accounts for 25%
Head & Neck	50%	5 patients treated – 3 breaches all shared with tertiary
Lower GI	60%	5 patients treated – 2 BHT breaches
Lung	37.5%	8 patients treated – 5 breaches (2 x shared with tertiary and 3 x BHT)

The reasons for the breaches included change in treatment plan, diagnostics by external provider, procedure required before cancer treatment could start, patient choice for diagnostics or OP, capacity in OUH, patient unwell whilst on pathway, patient investigated on two pathways, long wait for PET scans in Oxford and difficult diagnosis requiring multiple diagnostics.

	The target for 104 day breaches is zero but there will continue to be breaches where patients are not fit or add a significant delay into their own pathway. There is also the unpredictable nature of tertiary referrals and the date at which the patient is finally treated The number of 104 day breaches has increased since February – there were 5 patients (1 at BHT and 4 shared with tertiary) equating to 3.0 breaches. The breaches were due to patient choice for diagnostics, capacity in OUH, patient requiring procedure before treatment and patient requiring multiple diagnostics for difficult diagnosis	
Impact (People/Safety/Money)	Patients continue to be treated beyond 62 days for reasons other than patient choice. A clinical harm review is carried out for all patients who are treated beyond 104 days in line with national guidance.	
Key Actions to be taken to address variation	**Date:**	**Description:**
	Apr 19	Work with OUH to address capacity problems with PET scanning as this adds delays to our patient pathways Update – contact has been made with Mount Vernon who have capacity to offer PET scans for our lung patients. A national shortage of Choline is causing delays for PET scanning for Urology patients across all providers *Update: New lung patients are now being offered Mount Vernon and are being scanned in less than 7 days with a 2 day turn around for reporting. Problems with urology scans continue and are being discussed at a national level.*
	Apr 19	A new data link between Medway and Infoflex (the cancer information system) is being implemented to ensure 2ww referrals are uploaded immediately rather than being manually entered onto the system. Reporting of 2ww activity will be in real time and tracking can start as soon as the referral is received. Update: All Data issues are now resolved.
	Apr 19	Review of specific patient pathways with lengthy diagnostics to be carried out by TVCA Cancer Pathway Improvement Manager *Update: Learning from patient pathways is being collated and changes being implemented.*

<table>
<tr><td>Forecast date to return to plan/trajectory for recovery</td><td>The plan is to achieve the 62 day target for April 2019 with a predicted performance of 85.5%

Cancer Waiting Times - 62 Day GP Referral
<table>
<tr><th>Trajectory</th><th>M1</th><th>M2</th><th>M3</th><th>M4</th><th>M5</th><th>M6</th></tr>
<tr><td>No. Treated < 62 Days</td><td>77</td><td>65</td><td>63</td><td>70</td><td>71</td><td>72</td></tr>
<tr><td>Total No. Seen</td><td>90</td><td>76</td><td>76</td><td>84</td><td>84</td><td>84</td></tr>
<tr><td>Performance % (85% standard)</td><td>85.6</td><td>85.5</td><td>82.9</td><td>83.3</td><td>84.5</td><td>85.7</td></tr>
</table>
This dip in performance is due to the lack of diagnostic capacity which will impact on our cancer pathways. Extra capacity has been sourced but this will take some time for us to resolve performance.</td></tr>
<tr><td>Monitoring</td><td>Trust Cancer PTL meetings (weekly), Red action list (weekly), APMG (weekly), Cancer Steering Group (monthly), Cancer & Haematology SDU meeting (monthly)</td></tr>
</table>

Performance Exception Report			
Month: April 2019	**Executive Director:**	Bridget O'Kelly	
	Completed by:	David Howe	
Indicator/Performance standard	Nurse vacancy rate of 12%. The nurse vacancy rate is the percentage of vacant nurse posts against the agreed nurse establishment.		
Variation from plan	Nurse Vacancy Rate of 16.8% at 30 April 2019		
Reason for variation	The vacancy rate reduced by 1.2% from March's level of 18.0%. This reduction was due to three key factors: • Number of nurses recruited with NMC Pin was 19.7fte. • 17 staff obtained NMC registration during the month (9 newly qualified, 6 EU nurses, 1 Non-EU, & 1 Return to Practice). • The Trust recorded the lowest number of nurse leavers in a single month for the last five years with 9.3fte leavers in April. It's the first time since January 2015 that the number has been lower than 10fte (9.6fte leavers) in a month. We do normally see a seasonal (positive) variation in April but this month in particular has been better than plan, influenced in particular, by factors 2 and 3 above.		
Impact (People/Safety/Money)	People - There is a risk to us delivering all corporate objectives if we don't attract and retain high calibre and engaged people. In many areas, particularly clinical, vacancies will be filled by temporary staff including high cost agency staff.		
Key Actions to be taken to address variation	**Date:**	**Description:**	
	Domestic		
	May activities	Increasing publicity through social media, using existing staff, alongside regular face to face events. Activity plan in place and includes: "You…and your BHT career" – Itchy Feet events to be held at both Stoke Mandeville on the 16th and Wycombe on the 23rd signposting staff to internal career, development and wellbeing opportunities.	
	Activities live and underway	Development of pipeline of existing staff into all nursing roles both unregistered and registered including: • Spring University of Bedfordshire qualifiers. 19 offers from cohort of 36 (53% of group). Due to commence March – May 2019. • Cohort of 32 staff started 2- year nursing associate programmes in Autumn 2018 • English language training programme in place to support up to 60 EU trained nurses meet the NMC English language requirements during calendar year 2019. • Recruitment is a primary work stream of the NHSI cohort 4 Retention Direct Support Programme	

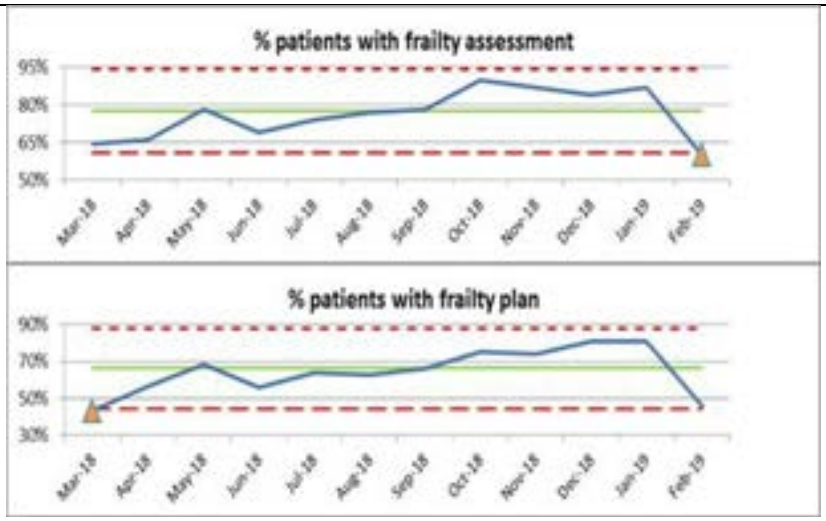
<table>
<tr><td rowspan="3"></td><td colspan="2">International</td></tr>
<tr><td>W/C 6 May 2019</td><td>5 Portuguese and 2 non EU recruits arrive & ready to commence employment at BHT</td></tr>
<tr><td>W/C 22 July 2019</td><td>Porto and Coimbra recruitment events targeting newly qualified nurses and chance to meet next Erasmus placements</td></tr>
<tr><td>Forecast date to return to plan/trajectory for recovery</td><td colspan="2">Formal review of nursing establishment and opportunities for skills mix is currently underway. When this work is complete we will review our nurse vacancy rate. The current trajectory is set out below.
<table>
<tr><th>Qualified Nursing : 19-20</th><th>Apr-19</th><th>May-19</th><th>Jun-19</th><th>Jul-19</th><th>Aug-19</th><th>Sep-19</th><th>Oct-19</th><th>Nov-19</th><th>Dec-19</th><th>Jan-20</th><th>Feb-20</th><th>Mar-20</th></tr>
<tr><td>Vacancy rate</td><td>17.9%</td><td>17.8%</td><td>17.2%</td><td>17.0%</td><td>17.1%</td><td>16.9%</td><td>16.7%</td><td>16.6%</td><td>16.1%</td><td>16.0%</td><td>16.1%</td><td>16.0%</td></tr>
</table></td></tr>
<tr><td>Monitoring</td><td colspan="2">Strategic Workforce Committee</td></tr>
</table>

<table>
<tr><th colspan="4">Performance Exception Report</th></tr>
<tr><td rowspan="2">Month: April 2019</td><td colspan="2">Executive Director:</td><td>Bridget O'Kelly</td></tr>
<tr><td colspan="2">Completed by:</td><td>David Howe</td></tr>
<tr><td>Indicator/Performance standard</td><td colspan="3">Trust wide turnover rate to be 12.0%</td></tr>
<tr><td>Variation from plan</td><td colspan="3">April 2019: 13.5%</td></tr>
<tr><td>Reason for variation</td><td colspan="3">The Trust continues to see a statistical improvement in overall Trust turnover rate. From May 2018 to April 2019 the rate has improved by 2.2%, falling from 15.7 to 13.5%. We remain an outlier on model hospital retention metric. As this data is updated, we would expect to see an improvement, reflecting our improved turnover rates.

There is significant variation in turnover rates for different staff groups. As the table below shows, we have seen a downward trend throughout the last twelve months across most clinical staff groups, reflecting the work in place. The average turnover rate across all staffing categories in April was 14.1% which is the first time this average has fallen below 15% since May 2017 (14.9%).

The Trust has enrolled into cohort 4 of the NHSI nurse retention programme; the team from NHSI has approved and agreed our plan. Actions are in place for Trust wide retention and progressing through the workforce recruitment and retention work stream.</td></tr>
<tr><td>Impact
(People/Safety/Money)</td><td colspan="3">High turnover indicates instability in teams and can result in high vacancy rates; both of these can, in turn, impact on the quality of care and on the Trust financial position as temporary staff are brought in as mitigation. High turnover rates can also be an indication of low staff engagement.</td></tr>
<tr><td rowspan="4">Key Actions to be taken to address variation</td><td>Date:</td><td colspan="2">Description:</td></tr>
<tr><td>Monthly in 2019</td><td colspan="2">50+ workability and pre-retirement planning sessions focusing on retire and return.</td></tr>
<tr><td>May 2019</td><td colspan="2">Third recruitment training session for hiring managers to ensure BHT are appointing the right people for the right post with the right skill set.</td></tr>
<tr><td>May 2019</td><td colspan="2">Itchy Feet event coinciding with International Nursing Day and supporting the mobility of those members of staff who are seeking their next career move.</td></tr>
<tr><td>Forecast date to return to plan/trajectory for recovery</td><td colspan="3">Following this significant drop in April, we have revised our forecast expect to achieve a turnover rate of just over 12% by March 2020.

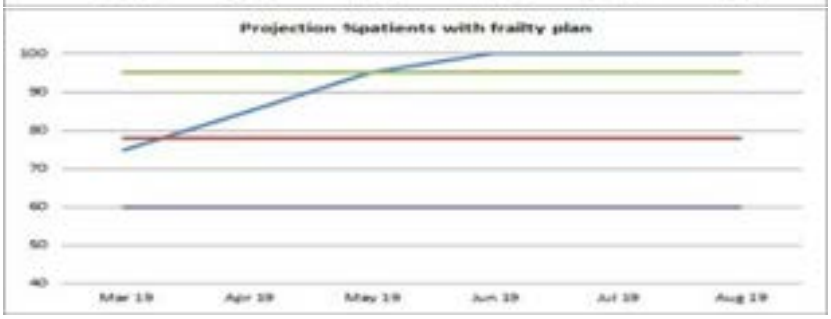
<table>
<tr><th>12 Month Rolling Turnover</th><th>May-19</th><th>Jun-19</th><th>Jul-19</th><th>Aug-19</th><th>Sep-19</th><th>Oct-19</th><th>Nov-19</th><th>Dec-19</th><th>Jan-20</th><th>Feb-20</th><th>Mar-20</th></tr>
<tr><td>Forecast for 19-20 (as at May)</td><td>13.2%</td><td>13.0%</td><td>13.2%</td><td>13.2%</td><td>13.0%</td><td>12.6%</td><td>12.6%</td><td>12.5%</td><td>12.3%</td><td>12.2%</td><td>12.0%</td></tr>
</table>
</td></tr>
<tr><td>Monitoring</td><td colspan="3">Monthly monitoring at SWC</td></tr>
</table>

<table>
<tr><td colspan="3">Performance Exception Report: <u>Frailty Screening Exception Report</u></td></tr>
<tr><td rowspan="2">Month: February 2019</td><td>Executive Director:</td><td>Natalie Fox, Interim Chief Operating Officer</td></tr>
<tr><td>Completed by:</td><td>Riyadh Seebooa, Divisional Director
Jo Birrell, Nurse Consultant – Older People</td></tr>
<tr><td>Indicator/Performance standard</td><td colspan="2">100% compliance of discharge summary including a Frailty Score and a care plan to guide primary care thereafter. This target was on the 15/16 QIP and carried over to present</td></tr>
<tr><td>Variation from plan</td><td colspan="2"> 

There was a decline in compliance in February 2019. This went from 87% in January for Assessment to 60% which triggered the lower control of the SPC. We can reassure there is a predicted improvement in March 2019 figures of 75%.</td></tr>
<tr><td>Top 3 Reason for variation</td><td colspan="2">1) There has been poor ownership of the target by the Clinical teams and the changeover of medics and increase in clinical activity was not managed to maintain a previous level of compliance.

2) The impact of the therapy led unit (ward 8) means that discharge letters are not always completed by the MFOP Junior doctors/consultant There is not a robust process for checking completion or contents of a discharge summary

3) There is poor understanding of the relevance of completing a frailty score</td></tr>
<tr><td>Impact
(People/Safety/Money)</td><td colspan="2">Although a frailty score on discharge does not impact on the patient experience it can support advance planning and ongoing management of Geriatric syndromes in Primary Care. It potentially can impact on acute admission avoidance and person centred care decisions.</td></tr>
</table>

Key Actions to be taken to address variation		**Top 3 High Impact Actions**
	1)	Communication about how to complete the discharge summary and the recommendations per frailty score have been redesigned and re distributed - Jo Birrell and Dr Ana Phelps are leading on this to complete by end of May 2019
	2)	Email to IECC consultants reminding them of their responsibilities in clinical leadership and discussion at the SDU Clinical Governance - Jo Birrell and Dr Ana Phelps are leading on this to complete by end of May 2019
	3)	IECC is leading on a 90 day collaborative regarding Frailty - Dr Syed Hasan, Jo Birrell and Charlotte Moss are leading on this commencing May 15th and completing September 30th 2019
Forecast date to return to plan/trajectory for recovery	 	
Monitoring	The data has been collected for a year with no known comparative data from other areas in the Trust making it impossible to predict if this pattern would be repeated in other parts of the Trust. The audit is labour intensive and has to be completed via a manual search on Evolve due to the known limitations of the Trust IT system The Division will monitor the data at Divisional Level as well as SDU and will also review the outcomes of the 90 day collaborative. The clinical team maintain the aspiration to have robust frailty pathways which manage frailty.	

Buckinghamshire Healthcare NHS
NHS Trust

<table>
<tr><th colspan="3">Performance exception report</th></tr>
<tr><td rowspan="2">Month: March 2019</td><td>Executive Director:</td><td>Natalie Fox</td></tr>
<tr><td>Completed by:</td><td>Jenny Ricketts</td></tr>
<tr><td>Indicator/Performance standard</td><td colspan="2">Referral to Treatment Time (18 weeks). Greater than 92% of the total elective waiting list to be waiting less than 18 weeks for treatment.</td></tr>
<tr><td>Variation from plan</td><td colspan="2">
<table>
<tr><th>2019</th><th>Feb</th><th>March</th></tr>
<tr><td>Monthly waiting list plan</td><td>28,907</td><td>29,296</td></tr>
<tr><td>Monthly waiting list actual</td><td>29,466</td><td>29,225</td></tr>
<tr><td>Waiting list growth/shortfall actual YTD</td><td>- 28</td><td>- 269</td></tr>
<tr><td>Incompletes >18 weeks</td><td>3,477</td><td>3,283</td></tr>
<tr><td>Monthly RTT plan</td><td>88.06%</td><td>89.88%</td></tr>
<tr><td>Monthly RTT actual</td><td>88.2%</td><td>88.8%</td></tr>
<tr><td>52 week breaches</td><td>0</td><td>0</td></tr>
</table>
</td></tr>
<tr><td>Reason for variation</td><td colspan="2">March 2019 successfully delivered a 0.9% reduction in the total waiting list size – meeting the NHS 18/19 operational standard.

The waiting list size continues to be managed by treating more patients over 18 weeks and improvements in data quality.

There is a noticeable increase in 2ww cancer referrals – particularly in Dermatology - seeing an earlier than expected seasonal increase in demand. This continues to be challenging to manage.

• There have been no 52 week breaches throughout 2018/19
• March diagnostic DM01 submission was compliant and has been throughout the whole of 18/19. However, it is confirmed that the DM01 will not be compliant in April due to insufficient endoscopy capacity. This dip is reflected in the performance in diagnostic waits - patients seen within 6 weeks. This was due to a lack of capacity. The service has mobilised extra weekend capacity which commenced mid-May. With this extra capacity, it is anticipated that DM01 will recover below 1% by month 5.
• Operation cataract – Phase one was completed. 946 cataracts operated on in three months. This has successfully contributed to managing the total waiting list size</td></tr>
<tr><td>Impact (People/Safety/Money)</td><td colspan="2">Patients continue to wait in excess of 18 weeks for treatment</td></tr>
<tr><td rowspan="5">Key actions to be taken to address variation</td><td>Date:</td><td>Description:</td></tr>
<tr><td>April 2019</td><td>Outsourcing cardiac CTs to manage diagnostic waiting times</td></tr>
<tr><td>April 2019</td><td>Discussions across the system regarding insourcing endoscopy capacity</td></tr>
<tr><td>May 2019</td><td>Trust wide demand and capacity exercise as part of the Effective Outpatient project</td></tr>
<tr><td>May 2019</td><td>Operation cataract phase two and phase three plans being worked up to sustainably manage waiting times</td></tr>
</table>

7

<table>
<tr><td></td><td></td><td>for patients</td></tr>
<tr><td></td><td>May 2019</td><td>Ongoing 19/20 contract negotiations for over block activity required for Ophthalmology, T and O and Gastro</td></tr>
<tr><td>Forecast date to return to plan/trajectory for recovery</td><td colspan="2">
<table>
<tr><th>Month</th><th colspan="2">TWL</th><th colspan="2">Backlog</th><th colspan="2">%</th></tr>
<tr><th>Projected</th><th>Operating Plan</th><th>Nov. 2018 re-forecast</th><th>Operating Plan</th><th>Nov. 2018 re-forecast</th><th>Operating Plan</th><th>Nov. 2018 re-forecast</th></tr>
<tr><td>Nov-18</td><td>28077</td><td>28542</td><td>2448</td><td>3231</td><td>91.3</td><td>87.95</td></tr>
<tr><td>Dec-18</td><td>29093</td><td>28676</td><td>2648</td><td>3560</td><td>90.9</td><td>87.58</td></tr>
<tr><td>Jan-19</td><td>29393</td><td>28954</td><td>2798</td><td>3685</td><td>90.5</td><td>87.27</td></tr>
<tr><td>Feb-19</td><td>29593</td><td>28907</td><td>2898</td><td>3450</td><td>90.2</td><td>88.06</td></tr>
<tr><td>Mar-19</td><td>29243</td><td>29296</td><td>2748</td><td>2953</td><td>90.6</td><td>89.88</td></tr>
</table>
RTT trajectories updated to reflect revised plans to March 2019. The 19/20 RTT trajectory is under discussion pending agreement on the additional activity agreement. (15 May 2019)
</td></tr>
<tr><td>Monitoring</td><td colspan="2">Trust PTL meetings (weekly), APMG (weekly), SDU Business Meetings (monthly) Surgery Divisional Board</td></tr>
</table>

Performance Exception Report		
Month: May 2019	**Executive Director:**	Dr Tina Kenny
	Completed by:	Dr Renu Riat
Indicator/Performance standard	Quarter 4 (January-March 2019) 95% of patients admitted to hospital have a VTE risk assessment.	
Variation from plan	Quarter 4 January – 91.32% February – 90.67% March – 91.30%	
Reason for variation	There has also been a change in pre-operative practice for elective surgical patients. This has led to a change in the way VTE risk assessment data is being captured. The Trust is seeking guidance from NHSI regarding 'low risk cohorts' as well as liaising with other Trusts to look at how they are recording VTE and what methodology they use to capture this data. The national APPTG annual review benchmark data demonstrates that the trust is good at reporting hospital associated thrombosis (HAT). The trust reported 6% of cases of HAT were in patients not receiving any thromboprohylaxis. The national benchmark figure is much higher at 17%. This suggests that the current issue relates to data capture rather than patient care	
Impact (People/Safety/Money)	**Safety** Patients are at risk of hospital acquired thrombolysis if not risk assessed after admission.	
Key Actions to be taken to address variation	**Date:**	**Description:**
	Domestic	
	June	Regular ward level reporting will now be provided by the information team in order to identify those areas that have the lowest percentage compliance.
	June	A new quarterly ward audit has been launched.
	June	Once clarify has been received from NHSI regarding 'low risk cohorts', the reporting methodology will be updated to reflect this.
	June	Validation of data to continue working closely with coding and informatics.

	Long term	Mandatory VTE assessments recorded via E-Obs/E-Prescibing.
Forecast date to return to plan/trajectory for recovery	Increase the current position by 1% each month for 5 months to reach 95% compliance.	
Monitoring	Analyse and validate data to focus on areas with the lowest compliance. Monitoring will continue via VTE Committee Meeting. Report monthly to the Quality & Patient Safety Group.	

Agenda item:
Enclosure no: TB2019/

Safe & compassionate care, every time

Buckinghamshire Healthcare NHS Trust

Public Trust Board
29 May 2019

Title	Infection Prevention & Control report – March 2019
Responsible Director	Dr Tina Kenny
Purpose of the paper	To provide the Board with Infection Prevention data for March 2019 BHT Totals – Review & Reassignment of *Clostridium difficile* cases 2017-18 and 2018-19 to new 2019/20 Criteria for Comparison Purposes
Action / decision required (e.g., approve, support, endorse)	For information

IMPLICATIONS AND ISSUES TO WHICH THE PAPER RELATES (PLEASE MARK IN BOLD)					
Patient Quality	*Financial Performance*	*Operational Performance*	*Strategy*	*Workforce performance*	*New or elevated risk*
Legal	*Regulatory/ Compliance*	*Public Engagement /Reputation*	*Equality & Diversity*	*Partnership Working*	*Information Technology / Property Services*

ANNUAL OBJECTIVE	
Which Strategic Objective/s does this paper link to? *Annual HCAI objectives* *MRSA bacteraemia: Zero cases 2018/19* *Clostridium Difficile: 31cases 2018/19*	
Please summarise the potential benefit or value arising from this paper: The report outlines Healthcare Associated Infection data March 2019	
RISK	
Are there any specific risks associated with this paper? If so, please summarise here.	*Non-Financial Risk*:
	Financial Risk:
LINK TO CARE QUALITY COMMISSION ESSENTIAL STANDARDS OF SAFETY AND QUALITY	
Which CQC standard/s does this paper relate to?	15 (2) *(if you need advice on completing this box please contact the Director for Governance)*

Author of paper: Amanda Adkins
Presenter of Paper: Dr Tina Kenny
Other committees / groups where this paper / item has been considered: **Quality Committee and IPC committee**
Date of Paper: 14/05/2019

8

Infection Prevention & Control Report – March 2019

March 2019	Limits set by PHE	Trust Total from April 2018	Integrated Medicine	Integrated Elderly & Community Care	Surgery & Critical Care	Women, Children & Sexual Health	Specialist Services
Clostridium difficile	31	45	1	0	1	0	0
MRSA Bacteraemia	0	1	0	0	0	0	0
MSSA Bacteraemia (BHT associated (post 48 hours)	n/a	16	0	0	0	0	0
Line Infections	n/a	30	1	0	0	0	0
Hand Hygiene Observational Audit Compliance %	n/a	n/a	99%	97%	97%	100%	98%
GNBSI - (E.Coli , Klebsiella & Pseudomonas aeruginosa) (BHT catheter associated) (Case that meet the criteria) (BHT associated (post 48 hours)	n/a	68	0	2	5	0	2

For 2018/2019 the Trust objectives are

Clostridium difficile 31 cases
MRSA bacteraemia 0 cases

Meticillin Resistant Staphylococcus aureus (MRSA) Bacteraemia – 0 cases in March 2019.

Clostridium difficile - *2* cases identified in March.
2 Post infection reviews have been undertaken both cases were identified as **Unavoidable.**

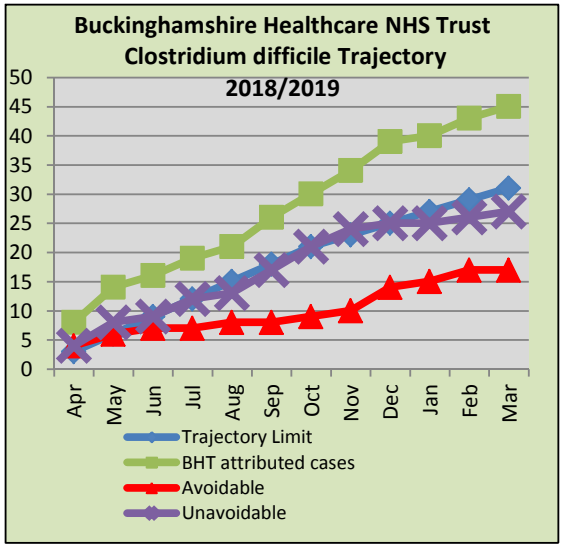
(Total for 2018/19 = 17 Avoidable , 28 Unavoidable)

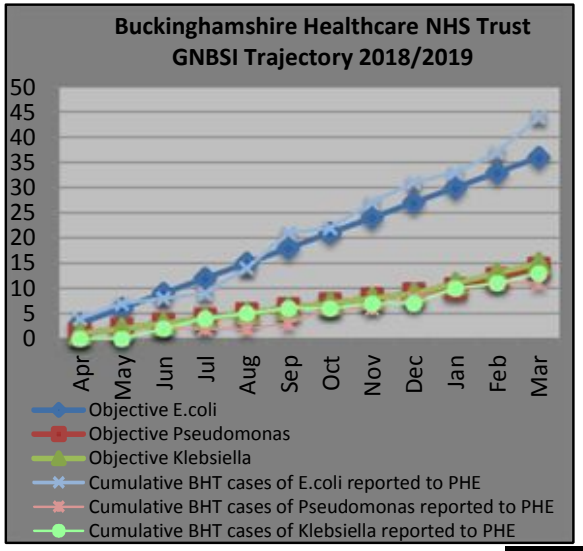
Outstanding case from February 2019. A Post infection review has been undertaken and the case was deemed as **Unavoidable.**

Clostridium difficile objectives for 2018/2019 have been published. See second page for explanation.

Meticillin Sensitive Staphylococcus aureus (MSSA) Bacteraemia –
No cases identified in March. Those that are BHT associated with devices will have a Root Cause Analysis (RCA) carried out.

Line Infections - 1 case in March. Following PIR meeting this case was deemed Unavoidable.





4 Outstanding cases from February. Following PIR meetings 2 cases were deemed Unavoidable and 2 cases Avoidable.

- Case 1 – Cannula -**Avoidable** - Lessons Learnt - reported as an Serious Incident, still under investigation, initial RCA shows multiple lapses in care.
- Case 2 – PICC - **Avoidable** - Lapses in care/Lessons Learnt - Doctors induction training for lines to be increased, Pharmacy lack of Hepscel, restricted OPAT services, review of contract of Registered Medical Officer at Wycombe Hospital. For this case international shortage of Urokinase, paperwork to be assessed.

Central lines: Benchmark - Zero tolerance to avoidable line infections
(Total for 2018/19 = 7 Avoidable , 23 Unavoidable,)

Gram-negative Blood Stream Infection (GNBSI) (E.coli, Klebsiella & Pseudomonas aeruginosa)
The focus on GNBSI has been developing nationally. As part of that, this year we introduced an RCA for every GNBSI. There has been national and regional discussion about the value of RCA and our local findings have demonstrated that of 30 assessed, one was avoidable. As a result, going forward we are moving to a sampling approach with monitoring of post 48 hour cases.

Clostridium difficile Objectives 2019/2020

The organisation classifications are taken from the Estates Return Information Collection (ERIC) for 2017/18 published by NHS Digital.

Objectives for 2019/20 are set to the same as each trusts' number of cases estimated for 2018/19 based on rate for 2018/19 Q1-3 then extrapolated to the full year to give an estimated count. The objective is then calculated from that count. If a trust has less than or equal to ten cases the objective will be equal to that count. If a trust has more than ten cases the objective will be one less than the count.

NHS Improvement : *Clostridium difficile* infection objectives for NHS organisations in 2019/20 and guidance for the intention to review financial sanctions and sampling rates from 2020/21. February 2019

Clostridium difficile Objectives 2019/2020

The *Clostridium difficile* objectives for 2019 / 2020 have been published by NHS Improvement.
The BHT 2019/2020 objective for cases of healthcare acquired/associated *Clostridium difficile* is **65**.
(2018/2019 objective was 31).

The reason for the increase in objective is that the categorising criteria has changed as below:

- **Hospital onset healthcare associated:** cases that are detected in the hospital **three** or more days after admission.
- **Community onset healthcare associated:** cases that occur in the community (or within **two** days of admission) when the patient has been an inpatient in the trust reporting the case in the previous **four** weeks.
- **Community onset indeterminate association:** cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 12 weeks but not the most recent four weeks.
- **Community onset community associated:** cases that occur in the community (or within two days of admission) when the patient has not been an inpatient in the trust reporting the case in the previous 12 weeks.

This is a reason for the increase of objective (31 cases in 2018/2019) the length of stay before acquisition has been reduced.

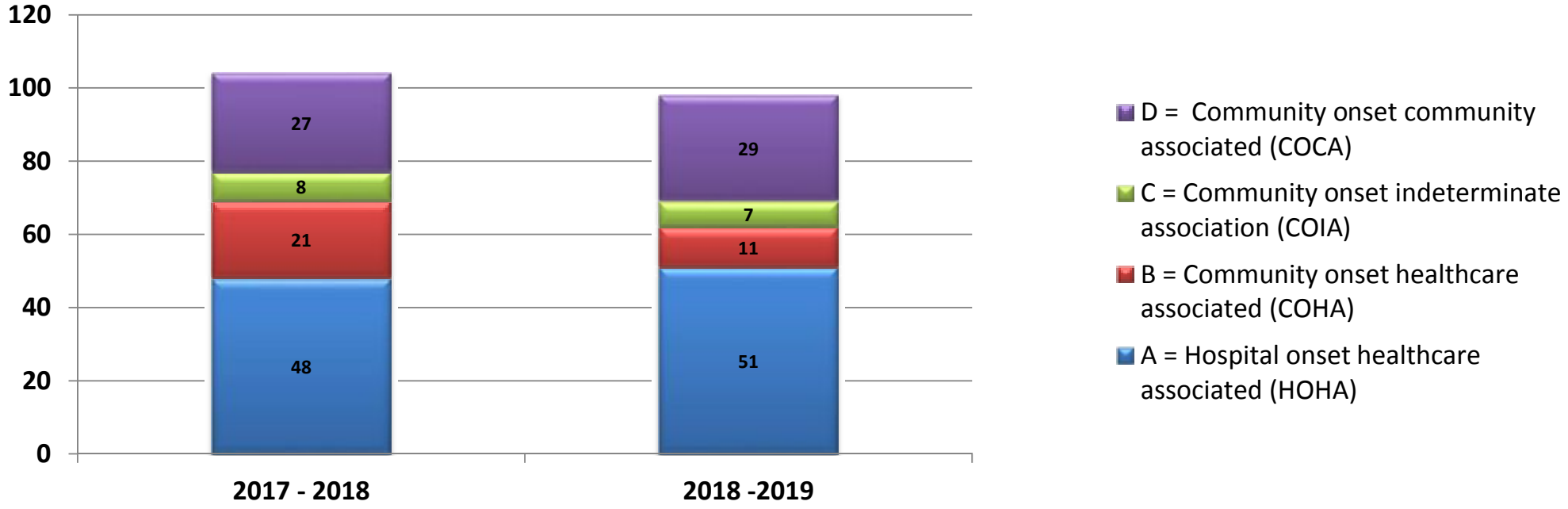
This is a change previous y these were not part of the objective another reason for the increase .

As from April 2019 for Healthcare associated cases a CCG *Clostridium difficile* Investigation Meeting will be undertaken in a formal manner. A completed RCA is to be presented by the Clinical Team at this meeting. A Datix must also be completed and updated with lessons learned and actions taken. See attached BHT Clostridium difficile Toxin Positive Cases -RCA Process Time Table for further information.

BHT Totals – Review & Reassignment

of *Clostridium difficile* cases 2017-18 and 2018-19

To New 2019/20 Criteria for Comparison Purposes



The figures within the graph are the results following recalculation of the 2017-18 and 2018-19 following the new criteria.

- 2017/18 there were 69 cases, following the new criteria this would have been **above target**
- 2018/19 there were 61 cases, following the new criteria this would have **met the target**
- 2019/20 BHT have been given an objective of 65 cases – **the aim is to be on or below the target.**

Agenda item: 9
Enclosure no: TB2019/51

Safe & compassionate care, every time

Buckinghamshire Healthcare NHS Trust

PUBLIC BOARD MEETING
Wednesday 29 May 2019

Details of the Paper

Title	Corporate Objectives 2019-2021: Implementation Plan
Responsible Director	David Williams, Director of Strategy
Purpose of the paper	To approve the approach to delivering the BHT corporate objectives.
Action / decision required (e.g., approve, support, endorse)	Approve

IMPLICATIONS AND ISSUES TO WHICH THE PAPER RELATES (PLEASE MARK IN BOLD)					
Patient Quality	***Financial Performance***	***Operational Performance***	***Strategy***	***Workforce performance***	*New or elevated risk*
Legal	*Regulatory/ Compliance*	*Public Engagement /Reputation*	***Equality & Diversity***	***Partnership Working***	***Information Technology / Property Services***

ANNUAL OBJECTIVE	
Which Strategic Objective/s does this paper link to? All	
Please summarise the potential benefit or value arising from this paper: Increased focus on delivering a streamlined set of corporate objectives that will transform our culture, workforce and clinical services. EMC and Board Committee agendas will be structured to align with the agreed objectives.	
RISK	
Are there any specific risks associated with this paper? If so, please summarise here.	*Non-Financial Risk*: None
	Financial Risk: None
LINK TO CARE QUALITY COMMISSION ESSENTIAL STANDARDS OF SAFETY AND QUALITY	
Which CQC standard/s does this paper relate to?	Well-led *(if you need advice on completing this box please contact the Director for Governance)*

Author of paper: Daniel Leveson, Deputy Director of Strategy
Presenter of Paper: David Williams, Director of Strategy
Other committees / groups where this paper / item has been considered: **Executive Management Committee**
Date of Paper: 29 May 2019

Agenda item: 9
Enclosure no: TB2019/51

Corporate Objectives 2019–2021: Implementation Plan

1. Introduction

Each year the Trust Board agree its corporate objectives. These are the goals set by the Board related to the organisation as a whole that have the most influence on delivering our strategy.

For 2019/20, following input from the Board, engagement events and work with the Senior Leadership Team it has been agreed to focus our objectives on three key areas that will transform our culture, workforce and clinical services. The following three corporate objectives and related programmes have been agreed:

Corporate objective	Programmes	Executive lead	Committee
Continue to improve our culture	BHT Way – always improving: - Listening to the patient voice - An organisation that learns - Culture of quality improvement - Making it easier to get things done	Chief Nurse Chief Nurse Director of Strategy Chief Operating Officer	Quality Quality Quality Finance
	Small Change, Big Difference	Medical Director	Quality
Implement new workforce models	Innovate with new models of care and/or staffing to tackle gaps in workforce	Chief Nurse	Workforce
	Make BHT a great place to work	Director of Workforce & OD	Workforce
	Develop teams, talent and an inclusive workforce	Director of Workforce & OD	Workforce
Tackle inequalities and variation	Build new community partnerships	Director of Strategy	Finance
	Get It Right First Time and reduce clinical variation	Medical Director	Finance
	Modernise outpatient services	Chief Operating Officer / Medical Director	Quality
	Embed use of accurate data across the Trust	Director of Strategy	Finance
Enablers To deliver: • Digital strategy • Estates strategy • Clinical strategy • Commercial transformation • Corporate service transformation		Director of Strategy Commercial Director Director of Strategy Commercial Director Director of Finance	Finance Finance Quality Finance Finance

The following changes to the reporting of the corporate objectives are proposed:

- Culture of Quality Improvement reporting has changed from Board to Quality Committee.
- Small change, Big Difference reporting into Quality Committee has changed from Clinically-led financial plan reporting into Finance Committee.
- Build new community partnerships reporting has changed from Board to Finance Committee.

Agenda item: 9
Enclosure no: TB2019/51

This paper outlines and summarises the approach to managing, reporting and monitoring the Corporate Objectives programme during 2019/20 and 2020/21.

2. Managing Corporate Objectives

Corporate objectives and plans traverse our three strategic priorities – Quality, People and Money and will be in place for two years. Our digital, estates, clinical and commercial strategies are designed to support the delivery of our objectives. All Board committees, together with EMC, are being structured to oversee the delivery of this plan and associated projects.

At a high level, each of the lead executives, has worked with their teams to develop project initiation documents (PIDs) that outline key tasks over the two years as well as identify key performance indicators. Each lead executive is accountable for the delivery of these plans.

The Board Assurance Framework is being updated to reflect the changes to BHT's corporate objectives. In addition, reporting and templates (e.g. coversheets) are being changed to ensure that as services or divisions develop plans they are aligned with the strategic direction of the Trust. These structures will ensure that plans link to the corporate objectives and their impacts are measured in terms of the delivery of our strategic priorities of Quality, People and Money.

3. Reporting and Monitoring Corporate Objectives

The delivery of these plans will be reported at the relevant sub-committee of the Board and will be used to drive the work programmes for these sub-committees during that period. The sub-committees provide assurance to the Trust Board about the governance as well as progress or risks to delivery.

In summary it is proposed that progress of plans is reported to EMC and related sub-committee of the Board quarterly and the Trust Board will receive a bi-annual report (in November and May). The detailed schedule is included in *Appendix 1*.

It is proposed to adopt a short and simple approach to reporting the progress status of projects, known as **ABCD** reporting. **ABCD** reports have four aspects presented in a quadrant (see example below) as follows:

- **A** stands for **Achieved** and should be milestones or deliverables accomplished and quantified. It should not be ongoing / work in progress tasks or processes.
- **B** stands for **Benefits** and is linked to the achievements and should demonstrate the benefit of the change delivered. These can be related to quality, people and money strategic priorities.
- **C** stands for **Concerns** and should provide facts and figures of things that if not treated could cause a negative impact to the project. This quadrant should lead to early detection and mitigations.
- **D** stands for **Do Next** and should clearly show the key deliverables planned for the next quarter.

Agenda item: 9
Enclosure no: TB2019/51

Corporate Objective	**Insert name of corporate objective**
Project	**Insert title of project**
Executive Lead	**Insert name of Executive lead**
Reporting Period	**Insert reporting period (quarter)**

Achieved • Insert milestones or deliverables accomplished and quantified. It should not be ongoing / work in progress tasks or processes.	**Benefits** • Linked to the achievements and should demonstrate the benefit of the change delivered. These can be related to quality, people and money strategic priorities.
Concerns • Provide facts and figures of things that if not treated could cause a negative impact to the project. This quadrant should lead to early detection and mitigations.	**Do Next** • Should clearly show the key deliverables planned for the next quarter

9

4. Measuring the Impact of Corporate Objectives

Each PID has identified key performance indicators (KPIs) to measure their impact at a granular level. During quarter 1 the Executive leads and their teams have identified their 'priority' KPIs to monitor and report on at the Trust Board. The following table summarises the 'priority' KPIs that have been identified through this process:

Corporate Objective	Project Description	Measure	Baseline	Target
Continue to improve our culture	Listening to the patient voice	National inpatient survey	Top 50%	Top 25%
	An organisation that learns	National reporting and learning system (incidents/excellence)	877	925
	Culture of quality improvement	Staff Survey: Q '…able to make improvements in my area of work'	57%	61%
	Making it easier to get things done	Staff Survey: KF2 'quality of work able to deliver'	3.91	Top 25%
	Small Change, Big difference	Reduction in late orders (30%)	4,191	2,934
Implement new workforce models	Innovate with new models of care and/or staffing to tackle gaps in workforce	Nurse Turnover Rate	14.3%	13.3%

Agenda item: 9
Enclosure no: TB2019/51

	Make BHT a great place to work	Staff Survey: Engagement Score	7.0	7.1
	Develop teams, talent and an inclusive workforce	Staff Survey: KF21 '% staff believing the organisation provides equal opportunities'	White staff 90% BME staff 81%	90%
Tackle inequalities and variation	Build new community partnerships	Slow the growth in NEL admissions	40,011	41,504
	Get it Right First time and reduce clinical variation	Top 2 recommendations in GIRFT specialties	Benchmark per specialty	Benchmark per specialty
	Modernise outpatient services	Improve clinic slot utilisation	80%	90%
	Embed use of accurate data across the Trust	Clinical Coding: Average number of co-morbidities per episode of care	4.4	5.5

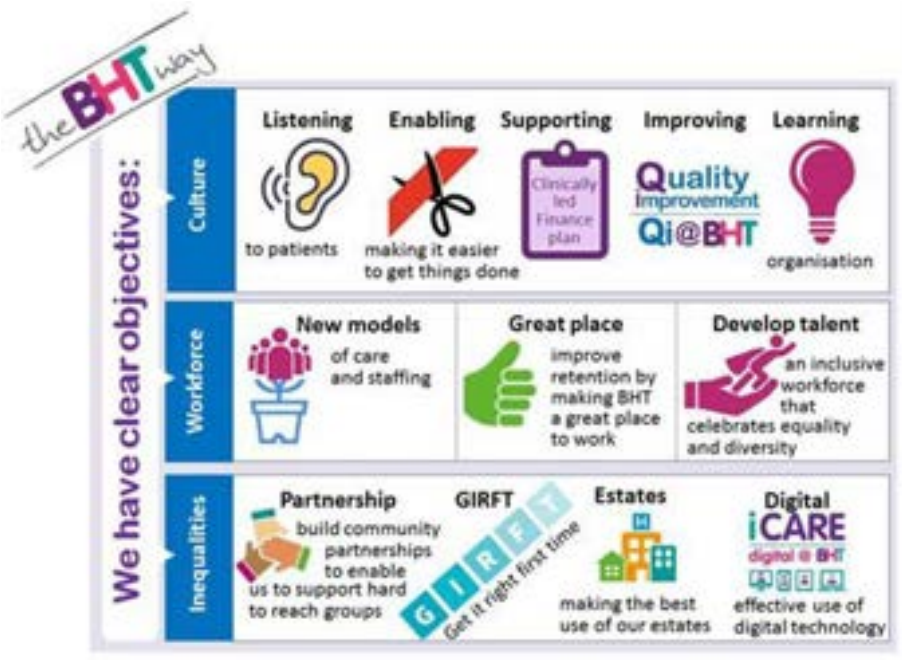
4. Embedding Corporate Objectives

As in many organisations, making the BHT strategy and its corporate objectives a reality at every level of the organisation from 'ward to board' is a challenge. The Executive will continue to engage staff in the delivery of the corporate objectives and strategic priorities via 'The BHT Way'. Engaging with our colleagues across the Trust on creating joint solutions to the challenges we face is an integral part of transforming our culture. The programme for the next twelve months is:

Month	Focus of event
July	Tackling inequalities
October	Continue to improve our culture
January	Implementing new workforce models
April	Learning from 19/20 and Looking Ahead for 20/21!

9

The below infographic has been developed and was launched during April's BHT Way and will be widely disseminated:



Agenda item: 9
Enclosure no: TB2019/51

The strategy team is working closely with the communications, library services and organisational development teams to deliver the BHT Way as well as engage teams and services in the corporate objectives and strategic direction of the organisation. At this stage the team is considering how to ensure that consideration of what corporate objectives and strategic priorities mean for individuals and teams are incorporated into inductions and leadership/management training.

Finally, a proposal is under development for teams to create boards/posters and notices that routinely ask and answer questions related to the delivery of the corporate objectives such as:

- How have you responded to the patient voice?
- How have you helped create a learning organisation?
- What have you done to make it easier to get things done?

There is potential to incorporate themes and approaches from this into Feedback Friday and encourage us to share, celebrate and learn about what we are all doing to deliver our strategy. This is an evolving programme that will develop during the course of the 2 years and will create a strategic culture and enable teams to make changes linked to the Trust's aspirations.

5. Next steps

- Note the approach to managing and engaging on the Trust's corporate objectives, and approve proposed changes to reporting.
- Note the proposed reporting schedule and outline reporting templates for corporate objectives.
- Support sub-committees to oversee the delivery of corporate objectives.

Daniel Leveson (Deputy Director of Strategy) and Chloe Powell (Business Manager Chief Executive Office) on behalf of David Williams (Director of Strategy and Business Development)

Agenda item: 9
Enclosure no: TB2019/51

Appendix 1

Objective	Programme	Executive lead	Reporting against plan				
				EMC (quarterly)	Board committee (quarterly)		Trust Board (biannualy)
Continue to improve our culture	Listening to the patient voice	CN	Q1	02-Aug-19	Quality & Clinical Governance Committee	03-Sep-19	
			Q2	01-Nov-19		03-Dec-19	27-Nov-19
			Q3	01-Feb-19		03-Mar-20	
			Q4	01-Apr-20		07-May-20	27-May-20
	An organisation that learns	CN	Q1	04-Jun-19	Quality & Clinical Governance Committee	02-Jul-19	
			Q2	06-Sep-19		01-Oct-19	27-Nov-19
			Q3	06-Dec-19		07-Jan-20	
			Q4	06-Mar-20		07-Apr-20	27-May-20
	Culture of quality improvement	Dir of Strat	Q1	19-Jul-19	Quality & Clinical Governance Committee	06-Aug-19	
			Q2	18-Oct-19		05-Nov-19	27-Nov-19
			Q3	17-Jan-20		04-Feb-20	
			Q4	15-Apr-20		05-May-20	27-May-20
	Making it easier to get things done	COO	Q1	28-Jun-19	Finance & Business Performance Committee	30-Jul-19	
			Q2	27-Sep-19		22-Oct-19	27-Nov-19
			Q3	27-Dec-19		28-Jan-20	
			Q4	27-Mar-20		28-Apr-20	27-May-20
	Clinically-led financial plan; Small Change Big Difference	MD/DoF	Q1	21-Jun-19	Quality & Clinical Governance Committee	06-Aug-19	
			Q2	20-Sep-19		05-Nov-19	27-Nov-19
			Q3	20-Dec-19		04-Feb-20	
			Q4	20-Mar-20		05-May-20	27-May-20
Implement new workforce models	Innovate with new models of care	CN	Q1	14-Jun-19	Strategic Workforce Committee	06-Aug-19	
			Q2	13-Sep-19		01-Oct-19	27-Nov-19
			Q3	13-Dec-19		04-Feb-20	
			Q4	13-Mar-20		07-Apr-20	27-May-20
	Make BHT a great place to work	Dir of W&OD	Q1	24-May-19	Strategic Workforce Committee	04-Jun-19	
			Q2	09-Aug-19		01-Oct-19	27-Nov-19
			Q3	08-Nov-19		03-Dec-19	
			Q4	14-Feb-19		07-Apr-20	27-May-20
	Develop teams, talent and an inclusive workforce	Dir of W&OD	Q1	12-Jul-19	Strategic Workforce Committee	06-Aug-19	
			Q2	11-Oct-19		01-Oct-19	27-Nov-19
			Q3	10-Jan-20		04-Feb-20	
			Q4	08-Apr-20		07-Apr-20	27-May-20
Tackle inequalities and variation	Build new community partnerships	COO/Dir of Strat	Q1	26-Jul-19	Finance & Business Performance Committee	27-Aug-19	
			Q2	25-Oct-19		26-Nov-19	27-Nov-19
			Q3	24-Jan-20		25-Feb-20	
			Q4	22-Apr-20		26-May-20	27-May-20
	GiRFT and reduce clinical	MD	Q1	05-Jul-19	Finance & Business	30-Jul-19	
			Q2	04-Oct-19		22-Oct-19	27-Nov-19

Agenda item: 9
Enclosure no: TB2019/51

	variation		Q3	03-Jan-20	Performance Committee	28-Jan-20	
			Q4	01-Apr-20		28-Apr-20	27-May-20
	Modernise outpatient services	COO/MD	Q1	19-Jul-19	Quality & Clinical Governance Committee	06-Aug-19	
			Q2	18-Oct-19		05-Nov-19	27-Nov-19
			Q3	17-Jan-20		04-Feb-20	
			Q4	15-Apr-20		05-May-20	27-May-20
	Embed use of accurate data across the Trust	Dir of Strat	Q1	21-Jun-19	Finance & Business Performance Committee	30-Jul-19	
			Q2	20-Sep-19		22-Oct-19	27-Nov-19
			Q3	20-Dec-19		28-Jan-20	
			Q4	20-Mar-20		28-Apr-20	27-May-20
Enablers	Digital strategy	Dir of Strat	Q1	26-Jul-19	Finance & Business Performance Committee	27-Aug-19	
			Q2	25-Oct-19		26-Nov-19	27-Nov-19
			Q3	24-Jan-20		25-Feb-20	
			Q4	24-Apr-20		26-May-20	27-May-20
	Estates strategy	Commercial Dir	Q1	03-May-19	Finance & Business Performance Committee	25-Jun-20	
			Q2	23-Aug-19		24-Sep-20	27-Nov-19
			Q3	22-Nov-19		28-Jan-20	
			Q4	28-Feb-20		24-Mar-20	27-May-20
	Clinical strategy	Dir of Strat	Q1	28-Jun-19	Quality & Clinical Governance Committee	06-Aug-19	
			Q2	27-Sep-19		05-Nov-19	27-Nov-19
			Q3	27-Dec-19		04-Feb-20	
			Q4	27-Mar-20		05-May-20	27-May-20
	Commercial transformation and corporate services transformation	Commercial Dir/DoF	Q1	26-Jul-19	Finance & Business Performance Committee	27-Aug-19	
			Q2	25-Oct-19		26-Nov-19	27-Nov-19
			Q3	24-Jan-20		25-Feb-20	
			Q4	22-Apr-20		26-May-20	27-May-20

Agenda item: 10
Enclosure no: TB2019/53

Safe & compassionate care, every time

Buckinghamshire Healthcare NHS
NHS Trust

Public Trust Board
Wednesday 29th May 2019

Title	2018/19 Out-turn Financial Performance
Responsible Director	Wayne Preston, Director of Finance (Interim)
Purpose of the paper	To brief Trust Board of the financial out-turn for 2018/19
Action / decision required (e.g., approve, support, endorse)	To Note

IMPLICATIONS AND ISSUES TO WHICH THE PAPER RELATES (PLEASE MARK IN BOLD)					
Patient Quality	***Financial Performance***	***Operational Performance***	*Strategy*	*Workforce performance*	*New or elevated risk*
Legal	***Regulatory/ Compliance***	*Public Engagement /Reputation*	*Equality & Diversity*	*Partnership Working*	*Information Technology / Property Services*

ANNUAL OBJECTIVE	
Which Strategic Objective/s does this paper link to? Financial Sustainabiity	
Please summarise the potential benefit or value arising from this paper: This paper informs Trust Board of the final 2018/19 financial performance	
RISK	
Are there any specific risks associated with this paper? If so, please summarise here.	*Non-Financial Risk*: Not being financially sustainable could impact delivery of safe, high quality services
	Financial Risk: Reporting of financial performance is a regulatory, and auditable requirement
LINK TO CARE QUALITY COMMISSION ESSENTIAL STANDARDS OF SAFETY AND QUALITY	
Which CQC standard/s does this paper relate to?	Use of Resources *(if you need advice on completing this box please contact the Director for Governance)*

Author of paper: Wayne Preston
Presenter of Paper: Wayne Preston, Director of Finance (Interim)
Other committees / groups where this paper / item has been considered: This subject has been considered at Executive Management Committee, Finance and Business Performance
Date of Paper: 20th May 2019

10

Agenda item: 10
Enclosure no: TB2019/53

1. Introduction

The Trust submitted its draft accounts to timetable and they are currently being audited by the External Auditors. The draft accounts were set before the Audit Committee for review and approval prior to their submission to NHSI. The Audit Committee on behalf of Trust Board reviews the annual accounts, audit reports and annual statements, but a summary of the key performance metrics are included here to ensure the full board membership is aware.

2. Key Metrics

Key metrics related to the Trust's reported performance are set out below:

Target	Draft Value
Financial Performance	£31.6m overspend
EFL	£0.3m undershoot
PSPP	83.7% by value
Dividends	3.5%
CRL	£0.01m undershoot

The Trust delivered a £31.6m deficit compare to a £10m surplus plan, a variance of £41.6m. The final delivery was in line with discussions with NHSI during Q4, but was disappointing compared to initial planning. The reasons for deterioration from plan have been discussed in previous Board meetings and include: non-receipt of PSF £8.6m, under delivery of efficiencies £12m, lower than planned income levels £10m, £5m balance sheet items, and £6m in year budgetary pressures.

The External Financing Limit and Capital Resource Limit were both slightly under shoots which is acceptable and well within tolerance levels.

The Public Sector Payment Policy requires 95% of invoices to be paid within 30 days, the trust delivered 83.7% by value, which is disappointing, but indicative of the pressure faced throughout the year.

3. Recommendation

Board are requested to note the report.

Agenda item: 11
Enclosure no: TB2019/54

Safe & compassionate care, every time

Buckinghamshire Healthcare NHS Trust

PUBLIC BOARD MEETING
29 MAY 2019

Details of the Paper

Title	Seven day services – Ten clinical standards and results and analysis from the survey undertaken in April 2019
Responsible Director	Tina Kenny, Medical Director
Purpose of the paper	To update the Trust Board on the ten seven day clinical standards that were assessed during the NHS Improvement Seven day services survey in April 2019
Action / decision required (e.g., approve, support, endorse)	The Trust Board is asked to: • Note the findings of the April 2019 survey • Support the recommendations included in the report

IMPLICATIONS AND ISSUES TO WHICH THE PAPER RELATES (PLEASE MARK IN BOLD)					
Patient Quality	*Financial Performance*	***Operational Performance***	*Strategy*	*Workforce performance*	*New or elevated risk*
Legal	***Regulatory/ Compliance***	*Public Engagement /Reputation*	*Equality & Diversity*	*Partnership Working*	*Information Technology / Property Services*

ANNUAL OBJECTIVE

Which Strategic Objective/s does this paper link to?
• Tackle Health Inequalities

Please summarise the potential benefit or value arising from this paper:
• The paper identifies the outcome of the seven day survey reported by the Trust against national 7DS benchmarks for the ten clinical standards. Submission date 30th June 2019

RISK

Are there any specific risks associated with this paper? If so, please summarise here.	*Non-Financial Risk*: Quality – if seven day services are not provided consistently then there is a risk of increasing harm and/or poor service delivery.
	Financial Risk: Cost of providing additional clinical resources to ensure compliance with 7DS clinical standards

LINK TO CARE QUALITY COMMISSION ESSENTIAL STANDARDS OF SAFETY AND QUALITY

Which CQC standard/s does this paper relate to?	*(if you need advice on completing this box please contact the Director for Governance)*

Author of paper:	Mandy Chetland, Head of Medical Quality
Presenter of Paper:	Mandy Chetland, Head of Medical Quality
Other committees / groups where this paper / item has been considered:	

11

Agenda item: 11
Enclosure no: TB2019/54

Date of Paper:	29th April 2019

Safe & compassionate care, every time

Buckinghamshire Healthcare NHS
NHS Trust

Board assurance framework for Seven Day Hospital Services

Results and analysis from self-assessment undertaken in April 2019

1. INTRODUCTION

1.1 The Seven Day Hospital Services (7DS) Programme was developed to support providers of acute trusts to deliver high quality care and improve outcomes on a seven day basis for patients admitted to hospital in an emergency.

1.2 Measurement of improvement outcomes were focused around ten clinical standards, four of which were priority standards. A self-assessment tool has been in place since 2016 to measure delivery against the four priority standards.

1.3 In 2019, the assessment increased the focus on the remaining six clinical standards for continuous improvement.

2. 7DS CLINICAL STANDARDS

(Please see Appendix 2 for full definition of standards)

2.1 Priority standards:

- Standard 2 : Time to initial consultant review
- Standard 5 : Access to diagnostics
- Standard 6 : Access to consultant led interventions
- Standard 8 : Ongoing daily consultant-directed review.

2.2 Standards for continuous improvement:

- Standard 1 : Patient experience
- Standard 3 : Multidisciplinary team review
- Standard 4 : Shift handovers
- Standard 7 : Mental health
- Standard 9 : Transfer to community, primary and social care
- Standard 10 : Quality Improvement

3. SELF ASSESSMENT RESULTS

3.1 Priority Clinical Standard 2 – Time to first consultant review

There was no requirement this year to do an audit. Additional information could be used to support compliance, eg., job planning and other wider sources of information with links to delivering the standard.

Based on the guidance, a smaller audit was undertaken with supporting evidence provided with mortality data, cardiac arrest data and A&E breach data. All of which show there is no weekday/weekend activity that resulted in quality of care being reduced at the weekend.

Our current job planning system does not provide data to evidence 7 day consultant,

Recommendation 1: Until the job planning system can provide sufficient information to provide satisfactory evidence, larger audits should be carried out as in previous years.

A total of 90 patients were audited of which 93% of them were seen and assessed by a suitable consultant within 14 hours.

It should be noted that the audit did not include any patients admitted on a Monday, this was purely random as the methodology was as suggested by the audit guidance.

Of the six patients who did not meet the standard, one was confirmed as having a review after 14 hours of admission, the remaining five did not meet the standard due to no time of review being entered on to the notes.

	Day of admission								
	Tue	Wed	Thu	Fri	Sat	Sun	Week day	Week end	Total
Number of patients reviewed by a consultant within 14 hours	13	19	10	18	16	9	60	24	84
Number of patients reviewed by a consultant outside 14 hours	0	1	0	4	0	1	5	1	6
Total	13	20	10	22	16	9	65	25	90
Proportion of patients reviewed by a consultant within 14 hours of admission at hospital	100%	95%	100%	81%	100%	80%	92%	96%	93%

Compliance is 90% and therefore the Trust has met the standard for Clinical Standard 2.

3.2 Priority Clinical Standard 5 - Access to diagnostics

'Are the following diagnostic tests and reporting always or usually available on site or off site by formal network arrangements for patients admitted as an emergency with critical and urgent clinical needs, in the appropriate timescales?'

The response was as follows:

	Weekday	Weekend
Service	April 2019	April 19
CT	Yes	Yes
Echocardiograph	Yes	Yes
Microbiology	Yes	Yes
MRI	Yes	Yes

Ultrasound	Yes	Yes
Upper GI Endoscopy	Yes	Yes

3.3 Priority Clinical Standard 6 - Access to consultant led interventions

'Do inpatients have 24 hour access to consultant directed interventions 7 days a week, either on site or via formal network arrangements?'

The response was as follows:

	Weekday	Weekend
Critical care	Mix of on and off site (all by formal arrangement)	Mix of on and off site (all by formal arrangement)
Primary Percutaneous Coronary Intervention	Mix of on and off site (all by formal arrangement)	Yes – off site (via formal arrangement)
Cardiac Pacing	Mix of on and off site (all by formal arrangement)	Yes – off site (via formal arrangement)
Thrombolysis for Stroke	Yes – on site	Yes – on site
Emergency General Surgery	Yes – on site	Yes – on site
Interventional Endoscopy	Yes – on site	Yes – on site
Interventional Radiology	Mix of on and off site (all by formal arrangement)	Mix of on and off site (all by formal arrangement)
Renal Replacement	Yes – on site	Yes – on site
Urgent Radiotherapy	Yes – off site (via formal arrangement)	Yes – off site (via formal arrangement)

3.4 Priority Clinical Standard 8 - Ongoing daily consultant-directed review

The overall proportion of patients who required twice daily consultant reviews and were reviewed twice by a consultant was **100 %.**

The overall proportion of patients who required a daily consultant review and were reviewed by a consultant was **89 %.**

Patient required twice daily review	Total for Review	pass	fail	%
Day 2	1	1	0	100%
Day 3	0			
Day 4	0			

Day 5	0			
Day 6	0			

Patient required once daily review	Total for Review	pass	fail	%
Day 2	83	82	1	99%
Day 3	62	52	10	84%
Day 4	48	41	7	85%
Day 5	37	29	8	78%
Day 6	32	28	4	88%

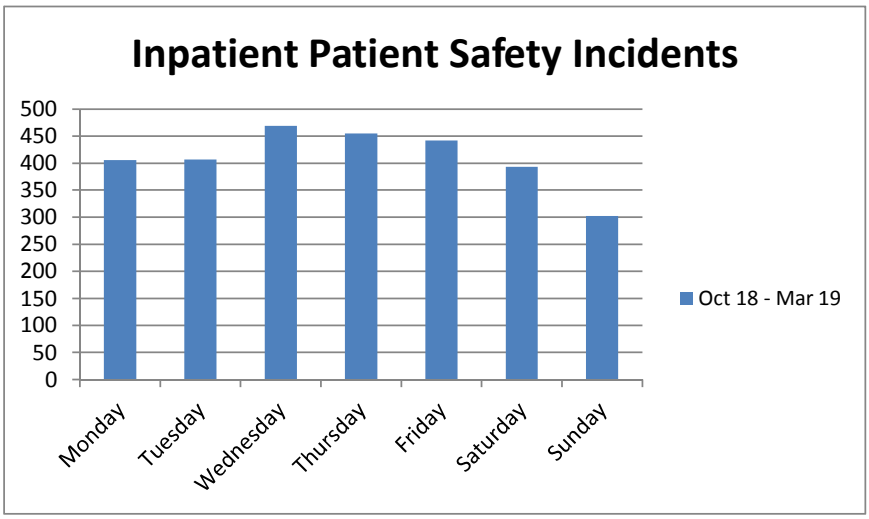
3.5 Clinical Standard 1- Patient experience

Descriptor: Patients, and where appropriate families and carers, must be actively involved in shared decision making and supported by clear information from health and social care professionals to make fully informed choices about investigations, treatment and on-going care that reflect what is important to them. This should happen consistently, seven days a week. Patients must be treated with dignity, kindness, compassion, courtesy, respect, understanding and honesty at all times.

Incident date is not recorded for complaints/PALs so reporting on weekday/weekend variances is not possible at this time.

Recommendation 2 : manual audit to be undertaken to provide board assurance of patient experience for the next seven day service submission.

Safety incidents are recorded by incident date and can be reported on. The following chart illustrates the number of incidents by days of the week over a six month period.



The following shows the average number of incidents per month on each day of the week.

	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Monthly averages	68	68	78	76	74	66	50

Both charts show there is no increase in safety incidents over the weekend.

3.6 Clinical Standard 3 - Multidisciplinary team review

Descriptor: All emergency inpatients must be assessed for complex or on-going needs within 14 hours by a multi-professional team, overseen by a competent decision-maker, unless deemed unnecessary by the responsible consultant. An integrated management plan with estimated discharge date and physiological and functional criteria for discharge must be in place along with completed medicines reconciliation within 24 hours.

Nursing and medical staff undertake daily board reviews of patients on all wards but the involvement of therapy services is reduced out of normal working hours.

Recommendation 3 – Audit to be undertaken on involvement of therapy services across 7 days.

Daily Facilitated Meetings to enable safe, effective and timely discharge through a **daily multidisciplinary team review** highlighting and documenting issues/and or actions that need to be taken to facilitate the discharge.

Safety Huddles are undertaken in A&E and other wards to give healthcare staff (clinical and non-clinical) an opportunity to understand what is doing on with each patient and anticipate future risks to improve patient safety and care.

3.7 Clinical Standard 4 - Shift handovers

Descriptor: Handovers must be led by a competent senior decision maker and take place at a designated time and place, with multi-professional participation from the relevant in-coming and out-going shifts. Handover processes, including communication and documentation, must be reflected in hospital policy and standardised across seven days of the week.

The Trust's handover guidance states responsibilities for handover, good practice, communication standards using SBAR *situation, background, assessment, recommendations).

In addition to the audits, handover was the topic for the Serious Incident Learning Group in December 2018. The learning shared from this group was:

- Face to face communication
- Structured documentation
- Patient involvement
- Use of IT to support

- Adoption of a reliable, tested approach such as Safety Huddles

E-Obs which has now gone live across the Trust supports handovers by enabling clinical staff to:

- View the Ward bed board and access the patients' observations and data on a hand held device.
- Access patients' observations and other clinical information on patients being treated on wards.
- View the overall status of patients and deteriorating patients can be detected early and care prioritized accordingly.
- View detailed charts, historical and current data in real time on any BHT PC without being on the ward.
- Doctors can respond more effectively using the real-time clinical and location information immediately available.

3.8 Clinical Standard 7 - Mental health

Descriptor: Liaison mental health services should be available to respond to referrals and provide urgent and emergency mental health care in acute hospitals with 24/7 Emergency Departments 24 hours a day, 7 days a week.

Buckinghamshire Healthcare Trust in collaboration with Oxford Health provides a psychiatric in-reach liaison service (PIRLS). PIRLS provides assessment and support to people who present with mental health needs in the acute hospital setting and operates 24 hours a day, 7 days a week.

Once a patient has been referred the response times are:

A&E	1 hour
Ward 10, ITU and AMU	4 hours
Wards	24 hours

Mental health services are also available from CAMHS for children presenting at A&E with specific pathways for self-harm and eating disorders.

3.9 Clinical Standard 9 - Transfer to community, primary and social care

Descriptor: Support services, both in the hospital and in primary, community and mental health settings must be available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken.

The services provided are:

- Discharge co-ordinators currently work Monday to Friday. The team have been trialling 7 day services. Bank Holidays are routinely covered
- In patient pharmacy services are open 7 days a week and on call out of hours.
- Therapy services cover 7 days a week , weekends are a reduced service to SMH and WGH sites but cover from 08.30-16.30. There is also an on call service for out of hours emergency

- Social care are on SMH site 7 days a week. They are able to access Step Down beds however access to packages of care are limited due to provider availability. Health community Services cover 7 days a week
- Transport is available 7 days a week via our Patient Transport Provider, we also supplement this with a private crew
-

3.10 Clinical Standard 10 - Quality Improvement

Descriptor: All those involved in the delivery of acute care must participate in the review of patient outcomes to drive care quality improvement. The duties, working hours and supervision of trainees in all healthcare professions must be consistent with the delivery of high-quality, safe patient care, seven days a week.

Quality outcomes and improvements are monitored using the following metrics:

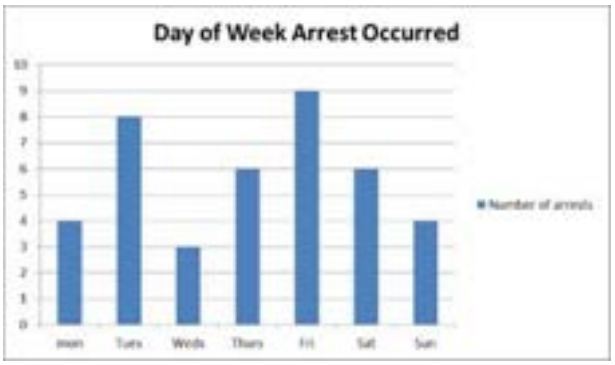
- Weekday and weekend mortality
- Cardiac arrests
- A&E Performance

3.10.1 Weekday and weekend mortality

Dr Foster data shows weekday HSMR is considered 'lower than expected' while weekend rates are considered statistically as 'as expected' compared to other non-specialist acute trusts in England. No individual day is considered higher than expected.

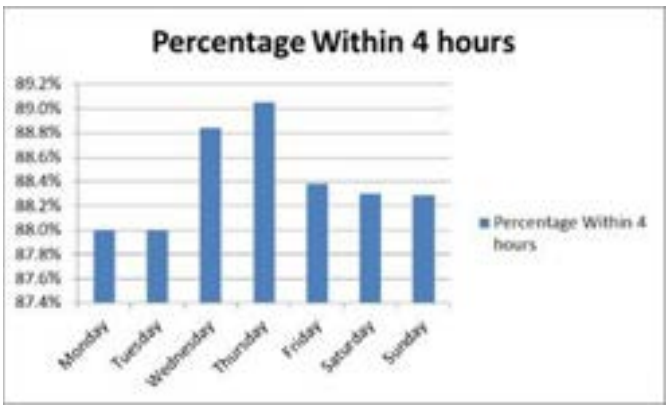
3.10.2 Cardiac Arrests

The Trust currently meets or exceeds national guidelines for ROSC from cardiac arrest and incidence per 1000 admissions. Analysis has identified there does not seem to be any significance as to which day of the week the arrest occurs on.



3.10.3 A&E Breaches

Analysis of the number of breaches on particular weekdays shows no significant increase at weekends.



4. RECOMMENDATION

4.1 Recommendation 1 : Until the job planning system can provide sufficient information to provide satisfactory evidence, larger audits should be carried out as in previous years.

4.2 Recommendation 2 : manual audit of complaints and PALs to be undertaken within the next three months to provide board assurance of patient experience for the next 7DS submission.

4.3 Recommendation 3 : Audit to be undertaken on involvement of therapy services across 7 days.

5. AUTHOR

Mandy Chetland 16th April 2019

Safe & compassionate care, every time

Buckinghamshire Healthcare NHS
NHS Trust

Appendix 1

References and Evidence Sources

Clinical Standard	Evidence	Document
3	Policy for discharge of inpatients from hospital	bht_pol_107_v5.0_rvw_11_2018_ext_to_
4	E-Obs Standard Operating Procedure (draft)	DRAFT eObs Clinical SOP v5 0.docx
4	NEWS escalation policy	NEWS escalation policy.pdf
4	Hospital at Night Handover framework	HAN Handover Framework.docx
4	SBAR	sbar_poster.pdf
4	Handover Guideline	Handover guideline_43.pdf
4	Agenda from SI Learning Group	Agenda SI Learning Group 18 Dec 2018.p
7	Mental Health protocol for 16-17 years	Mental health 16 - 17 years old protocal.pd
7	PIRLS poster	PIRLS poster.pdf
7	Mental health booklet	MH Booklet word v3.pdf
7	Mental health emergency care map	Mental Health Emergency Care Map
7	Self-Harm Pathway for under 18s	DSH pathway for under 18 Bucks (2).dc

Safe & compassionate care, every time

Buckinghamshire Healthcare NHS
NHS Trust

7	CAMHS referral criteria	referral_criteria_buc ks_camhs_cmht.pdf
7	Out of hours pathway for children	Out of Hours Pathways for a Youn
10	Cardiac Arrest Report	Cardiac Arrest Report Jan 1st 2018
10	Dr Foster Mortality Insight Report	BH Mortality Insight Report_Apr_19_v0 1

Safe & compassionate care, every time

Buckinghamshire Healthcare NHS
NHS Trust

Appendix 2

7DS (Seven Day Services) – Four Priority Standards	
PRIORITY Clinical Standard 2 - All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours	
Target	Assurance of delivery of this standard for 90% of all patients admitted in an emergency.
Evidence	Three sources of evidence that in combination give a complete view of delivery of Clinical Standard.
PRIORITY Clinical Standard 5 - the availability of six consultant-directed diagnostic tests for patients to clinically appropriate timescales, which is within one hour for critical patients, 12 hours for urgent patients and 24 hours for non-urgent patients.	
Target	Overall compliance (ie achievement of the 90% threshold) is based on a combination of these weekday and weekend assessments
Evidence	Q: Are the following diagnostic tests and reporting always or usually available on site or off site by formal network arrangements for patients admitted as an emergency with critical and urgent clinical needs, in the appropriate timescales? • Computerised tomography (CT) • Ultrasound (USS) • Upper GI endoscopy • Magnetic resonance imaging (MRI)
PRIORITY Clinical Standard 6 - 24-hour access seven days a week to nine consultant-directed interventions.	
Target	Overall compliance (ie achievement of the 90% threshold) is based on a combination of these weekday and weekend assessments.
Evidence	Q: Do inpatients have 24-hour access to the following consultant-directed interventions seven days a week, either on site or via formal network arrangements? • Critical care • Interventional radiology • Emergency surgery • Emergency renal replacement therapy • Stroke thrombolysis • Percutaneous coronary intervention
PRIORITY Clinical Standard 8 - ongoing consultant-directed reviews received by patients admitted in an emergency once they have had their initial consultant assessment.	
Target	Assurance of delivery of this standard for 90% of all patients admitted in an emergency
Evidence	Four sources of evidence that in combination give a complete view of delivery of Clinical Standard

7DS (Seven Day Services) – Standards for Continuous Improvement
Clinical Standard 1 - Patient Experience
Patients, and where appropriate families and carers, must be actively involved in shared decision making and supported by clear information from health and social care professionals to make fully informed choices about investigations, treatment and on-going care that reflect what is important to them. This should happen consistently, seven days a week.
Clinical Standard 3 - MDT review
All emergency inpatients must be assessed for complex or on-going needs within 14 hours by a multi-professional team, overseen by a competent decision-maker, unless deemed unnecessary by the responsible consultant. An integrated management plan with estimated discharge date and physiological and functional criteria for discharge must be in place along with completed medicines reconciliation within 24 hours.

Clinical Standard 4 - Shift Handovers
Handovers must be led by a competent senior decision maker and take place at a designated time and place, with multi-professional participation from the relevant in-coming and out-going shifts. Handover processes, including communication and documentation, must be reflected in hospital policy and standardised across seven days of the week.
Clinical Standard 7 - Mental Health
Liaison mental health services should be available to respond to referrals and provide urgent and emergency mental health care in acute hospitals with 24/7 Emergency Departments 24 hours a day, 7 days a week. Where an emergency* mental health need is identified in the Emergency Department or on an acute general hospital ward, a liaison mental health service should respond to the referral within one hour. Emergency referrals should be made at the earliest opportunity after a patient arrives in the ED. An emergency response consists of a review to decide on the type of assessment needed and arranging appropriate resources for the assessment. Within four hours of arriving in an ED or being referred from a ward, the patient should: • have received a full biopsychosocial assessment, and • have an urgent and emergency mental health care plan in place, and • at a minimum, be en-route to their next location if geographically different, or • have been accepted and scheduled for follow-up care by a responding service, or • have been discharged because the crisis has resolved or • have started a Mental Health Act assessment. Where an urgent** mental health need is identified on acute general hospital ward, a liaison mental health service should respond to the referrer within one hour of receiving a referral to ascertain its urgency, the type of assessment needed and resources required for the assessment. The urgent and emergency liaison mental health assessment should start within 24 hours of receiving a referral. Within 24 hours of presenting with a suspected urgent mental health problem on a general hospital ward it is recommended that a person should: • have received a full biopsychosocial assessment, and • have an urgent and emergency mental health care plan in place, and • at a minimum, be en route to their next location if geographically different, or • have been accepted and scheduled for a follow-up appointment by a responding service, or • have been provided with advice or signposted, where appropriate
Clinical Standard 9 - Transfer to community, primary and social care
Support services, both in the hospital and in primary, community and mental health settings must be available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken.
Clinical Standard 10 - Quality Improvement
All those involved in the delivery of acute care must participate in the review of patient outcomes to drive care quality improvement. The duties, working hours and supervision of trainees in all healthcare professions must be consistent with the delivery of high-quality, safe patient care, seven days a week.

Agenda item: 12
Enclosure no: TB2019/55

Safe & compassionate care, every time

NHS Buckinghamshire Healthcare NHS Trust

BOARD COMMITTEE ASSURANCE REPORT FOR PUBLIC BOARD
Wednesday 29th May 2019

Details of the Committee

Name of Committee	Quality and Clinical Governance Committee: Service Review meeting and Formal meeting
Committee Chair	Professor Mary Lovegrove and Professor David Sines respectively
Meeting dates:	2nd April 2019 and 7th May 2019
Was the meeting quorate?	Yes
Any specific conflicts of interest?	None
Any apologies	2nd April 2019: Dr Amin, Mr Macdonald, Mrs Warren, Mrs Chetland, Miss Tasker, Mrs Atkins, Mrs Tebbutt, Miss Birrell, Mrs Ballinger, Ms Fox. 7th May 2019: Dr Amin, Mr Macdonald, Miss Tasker, Mr Shorten, Mrs Ricketts, Mrs Atkins, Ms Kaur.

KEY AREAS OF DISCUSSION:

2nd April 2019
The Committee focused its discussions around the following areas:

- Service Review: Surgery and Critical Care Division
- The Corporate Risk Register
- Infection Prevention and Control report, Clostridium Difficile Toxin Root Cause Analysis
- CIP programme Quality Impact Assessment
- Allocate/Healthroster implementation update
- National Inpatient Survey 2018 findings
- Integrated Performance Report
- Organ and Tissue Donation meeting minutes, October 2019

7th May 2019

- VTE report
- Infection Prevention and Control report and update: BHT line infections, Clostridium Difficile Toxin engagement criteria, CDT avoidable unavoidable cases and Gram negative Blood Stream Infection update
- Flu and Clinical Utilization review
- Corporate Risk Register

12

Agenda item: 12
Enclosure no: TB2019/55

- Integrated theatre utilization, Ophthalmology Serious incident, infrastructure improvements
- Paediatric services update: community paediatric recovery plan
- Patient Experience report Q4
- Integrated Performance Report and exception reports; Sepsis reporting
- Seven Day Service: Board Assurance Framework
- Draft Terms of Reference 2019/20 for approval (attached)
- BHT Safeguarding Committee draft minutes, 9th April 2019

AREAS OF RISK TO BRING TO THE ATTENTION OF THE BOARD:

2nd April 2019

Service Review

- non-clinical staffing risk within the booking team added to the Corporate Risk Register: Professor Sines recognised there is attrition within the risk
- 2018 National Hip Fracture Database: achievement to the national Best Practice Tariff is being taken seriously by the division

Corporate Risk Register

- CRR 27A: the electricity infrastructure project – patients and staff safety. Estates and Surgery division to have a management plan in place

7th May 2019

Corporate Risk Register

- CRR 27A: the electricity infrastructure project – patients and staff safety. Chief Operating Officer to discuss delay mitigation off line

- System wide risks are currently being reviewed

Paediatric services

- Backlog for the completion of Education Health Care Plans; a locum has been employed to clear the backlog

- Integrated Performance report: frailty deep dive agenda item for June 2019 Committee meeting

ANY EXAMPLES OF OUTSTANDING PRACTICE OR INNOVATION:

2nd April 2019

- - Key quality achievements: detailing the extremely complex surgical patient discharge home after 18 months in hospital without a line infection, pressure sore or adverse incident; a letter from the Queen acknowledging the care provided
- -Mr Shorten invited to engage with Ms Kaur within the shared learning engagement piece as a member of the Patient Experience Group
- -the implementation of 'Operation cataract trial': patient feedback of this service has been amazing.
- -CSSD business case approved: Mrs Ricketts formally thanked the Trust Chair and Committee Chair for their support and contributing to the achievement
- -two-week cancer huddles introduced
- -reduction in falls reported
- -introduction of a pressure relieving champion link nurse
- -Medical support worker role on the surgical floor – no serious incidents of Venous Thomboembolism

Agenda item: 12
Enclosure no: TB2019/55

declared in general surgery patients since April 2018 and compliance has improved
- Excellence reporting: high increase in reporting and the positive celebration of successes. Mrs Ricketts to review the next steps and the incorporation of Corporate Objectives
- redesign of cancer pathways to improve compliance with the cancer targets as well as manage increasing demand for services
- innovative working around current staffing levels; successful recruitment to the post of Advanced Nursing Practitioner in Urology
- increase in curative surgery resulting in a slight increase risk to patients with the low number of 11% dealt as an emergency: national figure is 20%; this is driven through the two-week wait programme
- high rate of laparoscopic surgery offered to patients at 85% and the service drive is to achieve the lowest Length of Stay in the country
- low mortality rate reported for three Colorectal Surgeons attributed to attracting a new Colorectal Surgeon to the Trust
- consistency with theatre leadership enhanced by a Band 7 post as part of the transformation process; a new and improved process is visible in theatres reflecting cultural changes

7th May 2019
- the introduction of Medical Support Workers within the VTE prevention team
- high scores delivered around the quality round and engagement with the National Spinal Injuries Centre patient group events as part of the patient experience report
- patient involvement within quality rounds
- sepsis work rolled out to community and care homes to foster professional quality enhancement

AUTHOR OF PAPER:	Carolyn Morrice, Chief Nurse

Safe & compassionate care, every time

NHS Buckinghamshire Healthcare NHS Trust

Quality and Clinical Governance Committee

Terms of Reference

1. Purpose

The main purpose of the Quality and Clinical Governance Committee is to assure the Board directly and through consultation with the Audit Committee that the structures, systems and processes are in place and functioning to support an environment for the provision and delivery of excellent quality and clinical governance in our health services.

It is also to assure the Board that where risks and issues exist that may jeopardise the Trust's ability to deliver excellent quality healthcare and maintain robust clinical governance, they are being managed in a controlled and timely way.

The Quality and Clinical Governance Committee provides the Trust Board with a forum for Trust senior leadership at Trust Board and service level to meet and establish direction in relation to quality; and to review assurance concerning all aspects of quality, safety and clinical governance relating to the provision of care and services in support of getting the best clinical outcomes and experience for our patients.

2. Constitution

The Board hereby resolves to establish a Committee of the Board to be known as the Quality and Clinical Governance Committee ('the Committee'). The Committee has no executive powers, other than those specifically delegated in these terms of reference. The terms of reference can only be amended with the approval of the Trust Board.

These terms of reference shall apply for as long as the Trust is an NHS Trust and can only be amended by the Board of Directors.

3. Frequency of Meetings and Membership

3.1 The Committee shall normally meet on a monthly basis.

3.2 The Committee may also meet at such other times as the Chair of the Committee shall require. Meetings of the Committee shall be summoned by the Secretary of the Committee at the request of the Chair of the Committee.

3.3 A term of membership for a non-executive director shall be for two years and renewable for three further two year terms subject to the approval of the Board of Directors.

3.4 One of the members will be appointed Chair of the Committee by the Board and will not be a Chair of any other standing Committee of the Board.

3.5 Members of the committee shall be appointed by the Board. Members shall include as a minimum:

- Three Non-Executive Directors including the Chair
- Chief Executive Officer
- Medical Director;
- Chief Nurse (representing nursing and allied health professions)
- Chief Operating Officer

3.6 Attendees

The following will be required to attend meetings:

- Director for Governance
- Deputy Chief Nurse
- Head of Midwifery
- Chief Pharmacist
- Head of Allied Health Professionals
- Patient representative

There is an open invitation to a Clinical Commissioning Group (CCG) Representative and a designated patient representative is welcome to attend the Committee.

Other attendees will be invited according to agenda items, include the Head of Safeguarding and deputy representative from the Infection Prevention and Control team.

When a Division presents its Divisional Service Review on quality it is expected that the Divisional Director, Divisional Chair and Divisional Chief Nurse will attend.

The Chair of the Audit Committee shall not be a member of the Committee.

4. Quorum

4.1. The quorum necessary for the transaction of business shall be two NEDs plus one executive. A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee. In the absence of the Committee Chair and/or an appointed Deputy, the remaining non-executive members present shall elect one of themselves to chair the meeting.

4.2. Where a Committee meeting is not quorate under paragraph 4.1 within one half hour from the time appointed for the meeting; or becomes inquorate during the course of the meeting, the Committee members present may determine to adjourn the meeting to such a time, place and date as may be determined by the members present.

5. Meetings

5.1 Meetings of the committee may be called by the secretary of the committee at the request of the committee chair.

5.2 Unless otherwise agreed, notice of each meeting confirming the venue, time and date shall be forwarded to each member of the Committee no later than ten days before the date of the meeting. Supporting papers shall be sent to Committee members and to other attendees, as appropriate five days ahead of the date of the meeting. The Committee shall follow an annual work plan reviewed by the members in advance of each financial year.

6. Authority

6.1 The Board of Directors has delegated to the Committee the authority to deal with the matters set out in paragraphs below.

6.2 The Quality and Clinical Governance Committee is an advisory body with no executive powers; it is not the duty of the Quality and Clinical Governance Committee to carry out any function that properly belongs to the Board of Directors or the Executive Management Committee.

6.3 The Committee is, however, authorised by the Board to investigate any activity within its duties as set out below and to seek any information it requires from any employees, who are directed to co-operate with any request made by the Committee.

6.4 The Committee is authorised by the Board to obtain external legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary. This shall be authorised by the Chair of the Committee and shall be within any budgetary constraints imposed by the Board of Directors.

6.5 The Committee has the authority to require any member of staff to attend its meetings.

7. Duties

The Committee is authorised to seek any information it requires from any member of staff and all members of staff are directed to cooperate with any request made by the Committee.

The Committee will identify its annual objectives, produce an annual work plan in the agreed Trust format, measure performance at the end of the year and produce an annual report. This will also include an assessment of compliance with the Committee's terms of reference and a review of the effectiveness of the committee

The duties of the Committee are set out below under headings of Quality Improvement and Clinical Governance.

Quality Improvement

The Committee will:

- Provide leadership and assurance to the Board on the effectiveness of the structures, policies, systems and processes for Quality Improvement, specifically in the areas of: Patient Safety; Clinical Effectiveness; and Patient Experience

- Review the Quality Improvement Strategy to ensure continuous improvement is delivered in quality and safety.

- Review the need for a Quality Improvement Framework sitting alongside the Quality Improvement Strategy with a particular focus on quality issues and staff impact. Oversee the development of any such Quality Improvement Framework.

- Review assurance of progress with the Quality Improvement Plan and escalate to Board if there is a lack of positive assurance

- Examine in-depth key quality issues and thereby contribute to the development of a quality culture

- Oversee implementation of all elements of the quality improvement strategy. In particular, obtaining assurance that the measures for success are implemented within the appropriate time scales

- Gain assurance over the full range of quality performance via the quality report, quality dashboard, minutes and reports from relevant stakeholder groups and the provision of any other quality related information that the committee may request

Clinical Governance

The Committee will

- Provide leadership and assurance to the Board on the effectiveness of the structures, policies, systems and processes for clinical governance, specifically in the areas of: Patient Safety; Clinical Effectiveness; and Patient Experience

- Review assurance specific clinical governance processes related to clinical audit, clinical negligence claims, complaints management, incident management (including serious incidents), and Trust response to publications from the National Institute for health and Clinical Excellence

- Receive assurance with regard to compliance with CQC regulations and the process for compliance with legislation at least annually

- Receive assurance on the process for review of reports arising from external reviews and review the external reviews register at least twice a year

- Review quality related risks on the Corporate Risk Register at least 4 times a year

- Oversee the development of the Quality Accounts, ensuring they reflect the views of key stakeholders and advise the Audit Committee on publication

- Undertake any other responsibilities as delegated by the Trust Board

8. Reporting

8.1 The minutes of all meetings shall be formally recorded and a report from the Committee shall be presented to the Board of Directors each month summarising the meetings of this Committee.

8.2 The Trust's annual report shall include a section describing the work of the Committee in discharging its responsibilities

8.3 The organograms appended below demonstrate the reporting lines from the Sub Groups to Quality and Clinical Governance Committee through to the Trust Board.

9. Review

9.1 The Terms of Reference of the Committee shall be reviewed by the Board of Directors at least annually.

9.2 The Committee shall carry out an annual review of these terms of reference and the effectiveness of the Committee in meeting its purpose. It is expected that Committee members shall attend each meeting, attendance shall be recorded and form part of the annual review.

9.3 The Board will monitor the effectiveness of the committee through receipt of the committee's minutes and such written or verbal reports that the chair of the committee is required to provide.

10. Support

10.1 The Committee shall be supported administratively by the office of the Chief Nurse. This support shall ensure:

- Papers will be distributed five working days before the meeting in electronic copy. Advice to the committee on pertinent areas is provided.
- That Minutes are taken and a record of matters arising and issues to be carried forward is made.

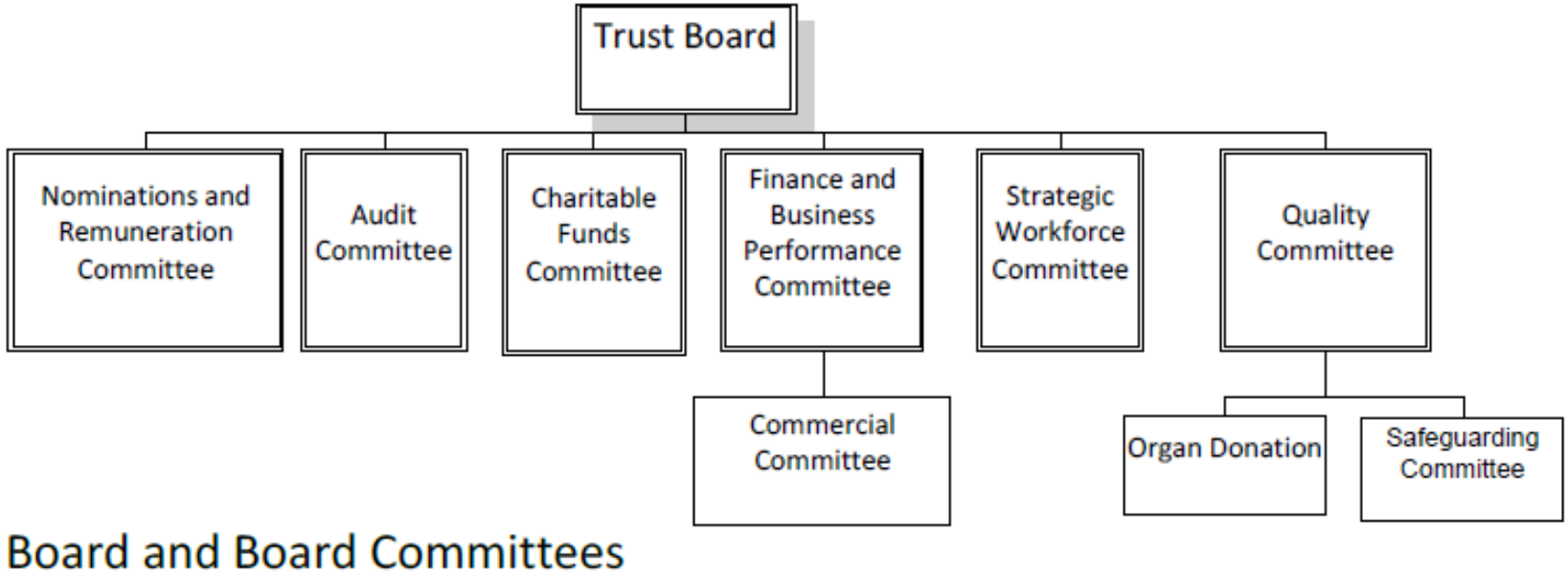
Document Control

Version	Date	Author	Comments
1.0	1 Dec 2013	E Hollman	Draft for Committee Chair
1.1	7 Jan 2014	B H Courtney	Amended draft for Committee Chair and review by Quality and Clinical Governance Committee
1.2	7 Feb 2014	A Walker	Distributed for comment
1.3	4 Mar 2014	A Walker	Final agreed

1.4	12 Mar 2014	A Walker	Forwarded to Board
1.5	Sept 2014	A Walker	Updated • to include ACNs and Head of Allied Health on membership • allow Trust chair as non-exec member of the Committee
1.6	5 Nov 2014		Forwarded to Board
1.7	12 January 2016	E Hollman	Updated to reflect revised membership and increased numbers of meetings.
1.8	22 December 2016	E Hollman	Updated to reflect matters agreed by Committee Chairs, the planning of formal meetings and Service Reviews, and to introduce the review of the Corporate Risk Register overtly.
1.9	4/1/18	E Hollman	Updated to reflect current situation and changes to committee structures.
2.0	28/1/19	E Hollman	Updated to reflect current situation and changes to committee structures.
2.1	7/5/19	S Manthorpe	Draft document to be approved by Committee

Appendix 1

Trust Board and Committees



Agenda item: 13
Enclosure no: TB2019/56

Safe & compassionate care, every time

Buckinghamshire Healthcare NHS
NHS Trust

BOARD COMMITTEE SUMMARY REPORT

Name of Committee	Finance and Business Performance Committee
Committee Chair	Mr Rajiv Jaitly
Meeting date:	23rd April 2019
Was the meeting quorate?	Yes
Any specific conflicts of interest?	None
Any apologies	Mr Gary Heneage

KEY AREAS OF DISCUSSION:

Month 12 finance report and Financial Recovery Plan
The report highlighted the delivery of a £31.6m deficit after receipt of £3.3m PSF non-recurrent allocation, which was in line with previously discussed forecast, although continued trend of under-performance to plan.

2019/20 Control Total / Budget / Operational Plan
The Trust submitted a plan in line with notified control total, but the ICS System submitted a non-compliant financial plan. Due the potential loss of non-recurrent incentive funding into the system and subsequent impact upon the Trust finances Committee was not able to approve the Annual Budget. Trust management however require a budget against which to continue to operate, and thus Committee approve the budget for the first two months of the year.

Cash
The current cash position was discussed with approval sought to recommend to the Board a drawn down in May of £10.7m, to fully reflect the 2018/19 deficit position and compensate for the time lag in receipt of PSF/FRF.

Finance Department Improvement Plan (FDIP)
The FDIP was discussed and the external support work plan explained to committee, and updates and progress will be reported to future committees.

Efficiency Programme
The programme was presented and the latest gap highlighted, with discussion on the widr system planning and the actions being taken to change behaviours to impact this year different to last.

Capital
The summary capital programme was presented and discussion focussed on the constraints of resource versus the requirements. The small discretionary element was to be protected during Q1 for later equipment failures and emergency items.

Performance Floodlight Integrated Performance Report
Discussion focused on A&E performance and 62 day cancer targets.

AREAS OF RISK REVIEWED IN THE MEETING

- Capital and Cash requirements
- I&E Performance
- Efficiency Plans
- Integrated performance – A&E four hour / cancer
- SI in Estates
- Brexit in terms of contingency planning

ANY EXAMPLES OF OUTSTANDING PRACTICE OR INNOVATION:

AUTHOR OF PAPER:	Wayne Preston, Director of Finance (Interim)

13

Agenda item: 13
Enclosure no: TB2019/56

Agenda item: 14
Enclosure no: TB2019/57

Safe & compassionate care, every time

Buckinghamshire Healthcare NHS
NHS Trust

BOARD COMMITTEE SUMMARY REPORT FOR AUDIT COMMITTEE

Name of Committee	Audit Committee
Committee Chair	Mr Graeme Johnston
Meeting date:	9th May 2019
Was the meeting quorate?	Yes
Any specific conflicts of interest?	None
Any apologies	Dr D Amin

KEY AREAS OF DISCUSSION:

The Audit Committee would like to bring the following points to the attention of the Board:

The draft internal chief auditor's opinion has indicated Green/Amber which indicates the organisation has an adequate and effective framework for risk management, governance and internal control.

The Audit Committee reviewed in detail the Trusts Annual Governance Statement as required with before it is submitted as part of the Annual Report to NHS Improvement. The final version of the report and the Annual Report will be reviewed at the Extra Audit Committee on 28th May before the final submission to NHS Improvement on 29th May 2019.

AUTHOR OF PAPER:	Sue Manthorpe, Director for Governance

Reference	Description of risk to achieving objective	Risk score unmitigated by controls	Key controls	Assurance on controls	Assurance RAG	Gaps in controls or assurance	Current Risk Rating (mitigated by controls)	Action to address gap	Lead
Includes Reference to Corporate Risk Register where relevant	*Focused on strategic risk.*	*The score if there were no controls in place*	*IC = internal control EC = external control Controls recorded on separate lines*	*IA = internal assurance EA = external assurance Assurances map to individual controls.*	*No assurance = red No external assurance = amber Internal and external and timely assurance = Green*	*Areas which will require action if risk score or assurance RAG are to improve.*	*This indicates the level of concern i.e. are the assurances giving us negative or positive indications.*	*This will include timescales for tracking and show where timescales have not been met.*	*Executive director lead*
Quality We will offer high quality, safe and compassionate care in patients' homes, the community or one of our hospitals									
1. Continue to improve our culture Key Focus: 1.1 Listening to the patient voice 1.2 An organisation that learns 1 .3Culture of quality improvement 1.4 Making it eaiser to get things done 1.5 Small Change big Difference									
1.1 Listen to our Patient Voice (Chief Nurse) 1. BHT to be in the top 25% of performing trusts in the country for overall patient experience by March 2021 2. Staff provided with the tools and skills required to listen and act on patient voice to improve services and patient experience 3. Perfect Ward patient assessors trained and delivering quality rounds across 50% of inpatient wards by March 2021									

Reference	Description of risk to achieving objective	Risk score unmitigated by controls	Key controls	Assurance on controls	Assurance RAG	Gaps in controls or assurance	Current Risk Rating (mitigated by controls)	Action to address gap	Lead
BAF 1.1	There is a risk that if we do not listen to our patients and take appropriate action that this will negatively impact on patient experience and care outcome. *Board Committee with oversight: Quality and Clinical Governance*	16	Systematic collection of Friends and Family Test (FFT) information. All our services within a hospital setting are asked to provide this feedback.(EC) National surveys for Inpatient, cancer, A&E, Maternity and CYP monitor patient experience (EC) Systematic Quality Rounds on a monthly basis in all clinical areas and in the community. There is real time patient feedback through this mechanism. (EC) Non-Executive director review of a sample of complaints each month. (IC) Chief Executive Officer and Chief Nurse see every complaint that comes to the organisation. (IC) Themes from FFT and compliments fed back at local level. (IC) Patient story at each public board meeting. (IC) Patient representative on the Quality and Clinical Governance Committee. (IC) Patient Experience Strategy and Implementation Plan. (IC) Patient Experience Group chaired by Associate Chief Nurse for Quality standards and Patient experience, provide patient oversight of implementation of PE strategy (IC)	FFT data is reported in the Integrated Performance Report to the Board. Information including the narrative is sent to wards on a monthly basis. (IA) Patient Safety and Quality Group receives progress reports on a bi-monthly basis on the implementation plan. (IA) Summary report from Quality Rounds reported to Patient Safety and Quality Group, Executive Management Committee and Quality and Clinical Governance Committee. (IA) External peer reviews seek patient views as part of the process e.g. CARF, cancer. (EA) Healthwatch oversight of quality including focused reviews. (EA)	**Green**	Listening to the patient voice is not prioritised within the QSIR methodology There is a time lag with current FFT data collection and reporting, which impacts on ability of frontline staff to take action to improve the patient experience	**8 (4x2)**	Work with the Quality Improvement team to incorporate listening to the patient voice into QSIR methodology Seek funding for Envoy FFT platform	Chief Nurse
1.2 Develop as a learning organisation (Chief Nurse) **Key Focus: The key performance indicators that will used to monitor the progress of this project is the following:** **One defined purpose that will result in one KPI with the following objectives** **1. Clinical Accreditation Programme established across all inpatient wards and ten wards accredited by the end of March 2020** **2. Create a learning panel with system wide partners as an ICS that focuses on improvement by the end of September 2020** **3. Develop a system wide quality strategy for learning (including QISR methodology) by December 2020** **4. Support the organisation to move to a predictive state rather than a reactive state to improve quality and patient safety by the end of June 2020 (measure against baseline audit taken 2019)** **5. Ensure all patient facing teams have team level safety huddles on a daily basis by the end of June 2019 (annual audit against SOP)** **6. Incorporate the Safety I safety II principles across the trust with a focus on looking at what goes right and learning from it by the end of March 2021**								
BAF 1.2	There is risk that without a framework in place setting out how we will develop as a learning organisation that the quality of care and staff engagement will be impacted negatively. *Board Committee with oversight: Strategic Workforce Committee*	16	Overarching framework in place setting out a systematic set of interventions (IC)	Minutes from Executive Management Committee. (IA)	**Amber**	There needs to be dedicated time and support to review and re-balance quality control, assurance and improvement There must be dedicated resource to engage with staff at all levels (mass participation) including induction where discussions can take place regarding the culture that we want to create in order to learn and improve and we must make it easy for staff to get involved.	**9 (3x3)**	Work with the Quality Improvement team and other stakeholders to ensure successful delivery of this project.	Chief Nurse
			Go Engage programme introduced across the Trust (IC)	Reporting of results to EMC and Strategic Workforce Committee. (IA)					
			Quality improvement training rolled out across the Trust (IC)	No. of staff enrolled in Quality Improvement training, internal and external (IA)					
			BHT way programme in place for the year (IC)	Records of content and numbers of staff attending BHT Way (IA)					

Reference	Description of risk to achieving objective	Risk score unmitigated by controls	Key controls	Assurance on controls	Assurance RAG	Gaps in controls or assurance	Current Risk Rating (mitigated by controls)	Action to address gap	Lead
Interventions not yet in place									
BAF 1.3	There is risk that without a culture of quality improvement for staff there will not be the capacity to undertake the transformation required to improve the Trusts services *Board Committee with oversight: Quality and Clinical Goverance??*	26	Fortnightly monitoiring through Quality Improvement (QI) Steering Group. (IC) Reports to Board (IC) Reports to Quality and Clinical Governance Committee (IC) Fortnightly one to one meetings with Assoicate Director for Quality Improvement Improvement (Committee (monthly) (IC) Visible QI progress communicated through internal and external websites (IC)	Meeting Notes, Project Plans, QI update Report (IC)	**Amber**	Evidence that QI programme is making a difference to Quality, People Money Stratgeic priorities . Ensuring staff have sufficient time to enagage in QI projects. Ensuring QI methodolgy is across the Bucks ICS system	**9 (3x3)**	Ensure resources are available for change and transformation. Ensure Directorates are agreeing capacity and backfill for QI project work. Widen the QI 'facualty' and get a standard training programme across the Bucks ICS	Director of Strategy
			Quality improvement training rolled out across the Trust (IC)	Number of staff enrolled in Qulaity Improvement training, internal and external (IA) Number of projects undertakne and evidence of improvement (IA) Quarterly and Annual Staff Survey Communications					
			Systematic self-review programme co-ordinated by the Associate Chief Nurse – patient experience and professional standards, led and driven by senior nurses, matrons and ward managers. (IC) 5 domains are completed each month linked to Care Quality Commission Key Lines of Enquiry. (EC) Perfect Ward App scores the reviews and provides immediate feedback to nursing staff in hospital and community locations. (IC)	Outputs from the Perfect Ward App and internal audit on the App. (IA) Monthly reports to the Quality and Patient Safety Group and minutes from that meeting. (IA) Quarterly reports to the Quality and Clinical Governance Committee and minutes from that meeting. (IA)					

Reference	Description of risk to achieving objective	Risk score unmitigated by controls	Key controls	Assurance on controls	Assurance RAG	Gaps in controls or assurance	Current Risk Rating (mitigated by controls)	Action to address gap	Lead
BAF 1.3a	There is a risk that the Quality Peer Review process established in June 2018 does not reduce variation in quality. *Board Committee with oversight: Quality and Clinical Governance*	16	Escalation process where trends are reported to Divisional Quality Boards for action. (IC)	Trend reports for Divisional Boards. (IA) Minutes from Divisional Board meetings where this has been discussed. (IA)	**Amber**	There is an assurance gap in that we are not yet confident that all the self reviews are done in a consistent way. Variability in the way trends are reviewed at Divisional Quality Boards.	**8 (4x2)**	Internal audit action plan in place including working to embed the process within Divisions. Commence Clinical Accreditation programme by March 2019 based on the outputs from Quality rounds.	Chief Nurse
			Programme of peer review within the organisation using an independent peer review team including external reviewers. (IC)	Peer review reports. (IA)					
			Learning and real time feedback on excellence and areas for improvement. (IC)	Outputs from the Perfect Ward App (IA) Monthly reports to the Quality and Patient Safety Group and minutes from that meeting. (IA) Quarterly reports to the Quality and Clinical Governance Committee and minutes from that meeting. (IA) Excellent reporting in place and increasing over the past 6 months. (IA)					
BAF 4.1a	There is a risk that we will not deliver the NHS Constitution Standards if we do not make it easier to get things done. This will directly impact on patient experience. Specifically: 4 hour A&E performance, Referral to Treatment Times, Access to Diagnostics & Cancer 62 day waits. Risks: Quality - impact on patient experience Financial - link to STF Regulatory	16	IPR and Exception reports monthly Weekly demand and capacity group managing access for RTT, Cancer and diagnostics. (IC) Demand Management Programme to commence with the Buckinghamshire Clinical Commissioning Group Plan for reducing non-elective and elective admissions. (EC) Escalation of all patients within 10 days of a breach to Divisional Directors and Divisional Chairs for cancer pathways. (IC)	Demand and Capacity Group minutes (IA) Operational performance dashboard reported at Divisional, Board and Committee level (IA) Internal audit of performance reporting Service Strategies (IA) Deep dives and performance reviews (IA) Deep dive presentations to Finance and Business Performance Committee (IA)	**Green**		**20 (5x4)**	40% reduction in LLOS requirements on 18/18 baseline by March 2020. Detailed work programme through the Urgent Care Recovery Board & A&E delivery board. Unplanned care forecasting tool launched as planned. RTT recovery plan for specific specialities, including outsourcing. Demand management and scheduling between winter and summer and reduce cancer wait time. New Director of Planning and Performance in post. Build capacity in Accident and Emergency.	Chief Operating Officer
			Planned Care Board (CCG led, launched Sept 2016) (EC)	Meeting minutes (EA)					

Reference	Description of risk to achieving objective	Risk score unmitigated by controls	Key controls	Assurance on controls	Assurance RAG	Gaps in controls or assurance	Current Risk Rating (mitigated by controls)	Action to address gap	Lead
	(Monitored through Finance and Business Performance Committee, F&BP)		Urgent Care Recovery Programme Board chaired by Chief Operating Officer and attended by the Chief Nurse and Medical Director (IC). Support from NHS Improvement on our urgent care pathway and cancer pathways. (EC)	Programme Board actions and minutes. (IA) Daily national reporting on performance. (EA)				Work on improved bed modelling. Implementation of improvement plan for cancer and urgent care.	
			Local A&E Delivery Board (health and social care system). The latter is an action focused meeting. (IC & EC)	Programme Boards action plans and minutes (EA)					
People **We will be agreat place to work where our people have the tight skills and values to deliver excellence in care**									
2 Implement new workforce models **Key Focus:** **2.1 Innovate with new models of care and/or staffing to tackle gaps in workforce (Chief Nurse)** **2.2 Make BHT a great place to work (Director of Workforce and Organisational Development)** **2.3 devlop teams, talent and an inclusive workforce (Director of Workforce and Organisational Development)**									
		9	6 teams engaged in the Go Engage programme in both June and 8 in December (IC) Survey results as part of Go Engage programme (IC)	Outputs from Go Engage programme reported to Strategic Workforce Committee on a quarterly basis - chort of 6 pioneer teams (IA)	Amber	Go Engage programme	6		Nurse

Reference	Description of risk to achieving objective	Risk score unmitigated by controls	Key controls	Assurance on controls	Assurance RAG	Gaps in controls or assurance	Current Risk Rating (mitigated by controls)	Action to address gap	Lead
BAF 2.1	Innovate with new models of care There is a risk that if our leaders do not have the right skills to develop strong teams that teams will not innovate and develop their services, thus negatively impacting on patient care and staff engagement *Board Committee with oversight: Strategic Workforce Committee*		75 Leaders (in 3 cohorts) enrolled in Trust leadership programme during the year (IC)	Cohort numbers reported to SWC (IA) Feedback from cohorts reported to SWC (IA)	Amber	numbers	(2x3)	Separate recruitment plan in place. Actions include: Students final placements to areas that they have expressed an interest in working in Offer letters sent in year 2 Close support for students and line managers by recruitment and education teams	Chief
			Trust-wide programme to transform the clinical workforce: - Recruitment including career pathways and skills mix (IC) - Education and training, including language training (IC) - Promoting excellence (including health & wellbeing) (IC) - Smart working (IC) - Temporary staffing (IC) - Participating in Cohort 4 of NHSI's retention prgramme (EC)	Outcomes of actions from the programme, reported to Executive Management Committee and Strategic Workforce Committee (IA) Nurse turnover rate (IA) Nurse vacancy rate (IA) Sickness absence rate (IA)	Amber	Individuals may choose to apply to other employers or choose to leave the Trust for factors outside our control		Retention action plan in place as part of NHSI work	
	There is a risk that if we do not engage and develop all colleagues in service innovation we will not improve the quality of patient care	20	Minutes of the Workforce Development Committee, Minutes of EMC (IC), Minutes of the Quality Committee (IC)	Service Improvement Training and Development Plan (IA), Communications and Engagement Plan (IA), Action Notes of Service Improvement Taskforce (IA), Monthly Team brief (IA) Quality improvement launch across the Trust at BHT Way in October 2018	Amber	Assurance that rollout has impacted every service, clinical area, acute and community.	12 (3x4)	Ongoing training and communications in the agreed Quality Improvement methodology. Application for the Board to receive training in Leading for Quality submitted in October 2018. Outcome awaited.	Chief Nurse
2.2 Make BHT a great place to work (Pioneering new ways of working) Previous Key Focus: Use apprentices to provide skilled workers for the future 60 Level 3 by March 2019 60 Level 5 by March 2019 20 Level 6 by March 2019									
			Have the right people at the right place with the right skills (IC)	% statutory and mandatory training uptake (IC) % of staff receiving non-mandatory training, learning or development in the last 12 months as reported in annual staff survey(EC) Achieve 100% utilisation of apprenticeship levy funding by end of Year 2 (IC) % vacancy rates for nurses and medical staff (IC) Increase in number of undergraduate nurse students (IC)					

Reference	Description of risk to achieving objective	Risk score unmitigated by controls	Key controls	Assurance on controls	Assurance RAG	Gaps in controls or assurance	Current Risk Rating (mitigated by controls)	Action to address gap	Lead
BAF 2.2	Make BHT a great place to work There is a risk that without us pioneering new ways of working, the numbers and calibre of staff would be impacted and therefore the quality of patient care would be impacted. *Board Committee with oversight: Strategic Workforce Committee*	12	Have the right people at the right place with the right skills (IC)	% statutory and mandatory training uptake (IA) % of staff receiving non-mandatory training, learning or development in the last 12 months as reported in annual staff survey (EA) Achieve 100% utilisation of apprenticeship levy funding by end of Year 2 (IA) % vacancy rates for nurses and medical staff (IA) Increase in number of undergraduate nurse students (IA)	**Amber**	Numbers attendingrelevant training Recruitment timelines not meeting bench mark	**9 (3x3)**	Q1 Go engage – next cohort of 6 pioneer teams NHSI Cohort 4 retention plan actions Value based recruitment training Review of Corporate induction Gather, verify and report on PSED, WDES and WRES data Delivery of Investigation Training for Managers Delivery of first "concerning conversations" training for managers Initiate Wellbeing Calendar events and initiatives Review Occupational Health provision Review recruitment time lines and benchmark within STP and Model Hospital Recruitment into September starters of education programmes Delivery of grass roots conversations by HR director in HR Team	Director of workforce and OD
			Staff feel valued (IC)	Quarterly staff FFT – I would recommend the Trust as a					
			We have inspirational leaders supporting engaged teams (IC)	Increase in positive score of "immediate manager" theme in annual staff survey (EA)					
			Creating a safe place to work	Trust sickness levels of 3.5% or less Flu vaccine uptake of 75% Increase in staff responding "no" to the question "I felt unwell as a result of work related stress" Increase in staff responding "yes to the question "does your organisation take positive action on health and well-being" Increase in staff responding "no" to the question "in the last 12 months have you experienced MSK problems as a result of work activities Further improve Staff survey scores in relation to : raising concerns questions bullying and harassment questions violence at work questions Reduction in number of formal dignity & respect cases (related to bullying & harassment	**Amber**	Sickness Absence levels above target Flu uptake below target % response rate in staff survery not meeting target			

Reference	Description of risk to achieving objective	Risk score unmitigated by controls	Key controls	Assurance on controls	Assurance RAG	Gaps in controls or assurance	Current Risk Rating (mitigated by controls)	Action to address gap	Lead
2.3 Develop teams, talent and an inclusive workforce (Attracting and retaining high calibre and engaged people) **Previous Key Focus:** **Transform our nursing workforce for the future** **Recruitment of 70% of University of Bedfordshire students in September 2018** **Recruit 25 individuals from Portugal by March 2019** **Increase internal appointments from 179 to 230 by March 2019**									
BAF 2.3	There is a risk to the developing teams, talent and an inclusive workforce and delivering all corporate objectives if we don't attract and retain high calibre and engaged people *Board Committee with oversight: Strategic Workforce Committee*	20	All teams and individuals have access to education provision(IC)	% of staff receiving non-mandatory training, learning or development in the last 12 months as reported in annual staff survey (EA) Achieve 100% utilisation of apprenticeship levy funding by end of Year 2 (IA)	**Amber**		**16 (4x4)**	Q1 Recruit 25 senior leaders from across the ICS onto Peak 3 leadership programme, 25 current leaders for peak 2 and 25 new/aspiring leaders for peak 1 programme.	Director of workforce & OD
			Inspirational Leaders, supporting engaged teams (IC)	Increase in positive score of "immediate manager" theme in annual staff survey (EA) Talent management – Named deputy and/or succession plan for each director (IA)				Launch the LGBT & BHT VIBES (Spirituality) networks	
			Everyone is treated fairly (IC)	Staff survey question – does your organisation act fairly with regard to career progression/promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age? (EA)				Extend BHT leadership programme to ICS partners	
								Equality Delivery System activities take place and draft equality objectives drawn up	
Quality, People Money?									
Tackling inequalities and variation **Key Focus:** **3.1 Build Community Partnerships (Chief Operating Officer/Director of Strategy)** **3.2 Get It Right First Time and reduce clinical variation** **3.3 Modernise outpatient services** **3.4 Embed use of accurate data across the Trust**									

Reference	Description of risk to achieving objective	Risk score unmitigated by controls	Key controls	Assurance on controls	Assurance RAG	Gaps in controls or assurance	Current Risk Rating (mitigated by controls)	Action to address gap	Lead
BAF 3.1a	There is a risk if we do not build partnerships with our stakeholders and the community, we will not make an impact on improving health outcomes and reducing health inequalities	**12**	BHT health Inequalities Taskforce (IC) Bucks Health and Well being Stratey and Work Plan (EA) Bucks ICS population Health Steering Group, Primary Care Network Steering Group (EA) Involvement in Wycombe and Aylesbury Primary Care Networks (EA) Annual Public health Report (EA) Acheivemnt of CQUINs linked to alcohol and smoking (IA). Publicity and posters linked to Health Promotion (IA) CCG Health Inequalities Group (EA)	Monitoring of CQUINs (Quarterly) (IC), Action Plan from Health Inequalities Taskforce (IC),Population Health Indicators (Annual) (EA), Minutes of PCN Steering Groups (EA)	**Green**	Focus of acute and community resource into areas of the highest health inequalities (Wycombe and Aylesbury) Active engagement in Primary Care Networks development	**6 (2x3)**	Work with partners across the ICS and PCNs to focus resources and support into areas of highest health inequalities in the county	Director of Stratagey
BAF 3.1b	There is a risk if we do not engage partners in community hub developments we will not make sustainable changes to community services	**16**	Bucks HASC (EA), Business case and case for change on community development options (IA), Board (IA), Engagement meetings within localities, NHS England assurance process on service change (EA), Thame, Marlow and Buckingham Stakeholder Groups (EA)	Board Minutes (IA), Business cases (IA), CCG Governing Body Minutes and papers (EA), Bucks HASC Minutes, Stakeholder Group Minutes (EA)	**Amber**	Case for change for community hubs including Thame, Marlow and Buckingham, Engagement Strategy, CCG to provide resources and leadership for engagement processS	**8 (4x2)**	CCG Lead Authority, Develop case for change (Q2), case for change for Buckingham hub (Q2), Engage and consult communities (Q4), approve changes in Thame and Marlow and agree principles for other localities (2019/20 Q1),	Director for Strategy
BAF 3.1c	There is a risk that if we do not launch a Buckinghamshire Lifesciences Innovation Hub supporting businesses we will not be able to develop their healthcare products and services in conjunction with our patients and clinicians.	16	Buckinghamshire Lifesciences Partnership Board (EC), LEP Capital Investment (EC), 2018/19 Capital Plan (IC), Business case for Innovation Hub (IC), European funding confirmed (EC) Health and Social Care Ventures launched 10 September 2018. (IC)	Minutes Buckinghamshire Lifesciences Partnership Board (EA), Business case for capital changes at SMH (IA), Memorandum of Understanding and Partnership Agreements (IA), LEP Grant Letter (EA), European Funding grant letter (EA)	**Green**	Full Business case yet to be agreed, Robust capital estimate.	**4 (4x1)**	Robust business case for redesign	Director of Strategy
3.2 Getting It Right First Time Key Focus:									
BAF 3.2	There is a risk that we will not implement the top two 'Getting it Right First Time' recommendations in each speciality which will impact on quality and efficiency.	20	GIRFT and Clinical Variation Board chaired by Deputy Medical Director who is the lead for GIRFT. Meets on a monthly basis and reports into Quality and Patient Safety Group. (IC) National guidance in place to implement this work. Trust has adopted NHS Improvement Plymouth model. (IC)	Minutes of the GIRFT and Clinical Variation Board showing progress reports from each speciality lead and that we are working to national guidance. (IA) Review of Trust data in specific GIRFT specialities resulting in a report back to the Trust from NHS Improvement GIRFT team and from this an action plan is developed and returned to NHS improvement GIRFT team. (IA)	**Green**	Level of project management support within the Trust.	**8 (4x2)**	The deficit in project management support is being redressed through close scrutiny by the Deputy Medical Director and support from the Head of Medical Quality.. This will continue throughout the 19/20 financial year.	Medical Director

Reference	Description of risk to achieving objective	Risk score unmitigated by controls	Key controls	Assurance on controls	Assurance RAG	Gaps in controls or assurance	Current Risk Rating (mitigated by controls)	Action to address gap	Lead
3.3 Modernise outpatient services Key Focus									
BAF 3.3	The risk of not modernising the Trust Out patient Service will affect the Trut's ability to achieve the NHS Long term plan of a 33% reduction in face to face appointments. This willalso affect productivity and efficiency	20	Information and BI support to demonstrate productivity gains (IC) ICS support for Demand and Capacity Modelling (EC) Medical Personnel support for cancellation reduction stream across the focussed specialities (IC) Finance support for costing elements. (IC) Patient engagement team to provide advice and guidance. (IC) Workforce and OD support for implementation of alternative roles. (IC) CCG/GP Federation support to liaise with General Practice on alternatives and referral criteria's and pathways (EC) GM attendance in all project stream meetings (IC)	Reduce clinic cancellations (contained in the IPR) (IA) Improve clinic slot utilisation by speciality (IA) Reduce low value appointments measured through new to follow up ratios (IA) Increase alternative practitioner appointments reduction in Consultant led RTT size (IA) Reduced attendances due to self-management pathways (IA) Increase in the number of non- face to face appointments with the use of technology (IA) Productivity opportunity – clinicians diverted to non-outpatient duties by reducing inefficiencies within system (IA)	**Amber**	Lack of technology investment to reduce face to face appointments Patient and Staff engagement required	**9 (3x3)**	Recruitment of the entire Programme team by end of April, Project Initiation Plan and overall mandate signed off – end of May 2019 BHT Consultant and GP Led – Clinical Audit Workshops/ Clinical Audit is conducted to identify and test assumptions and gather the evidence base – End of July Analyse outpatient activity by specialty and by type and agree outturn/baseline upon which activity needs to be improved – End of April Complete demand and capacity modelling for agreed specialties with the view to expand to wider range of specialties. – End of May Each specialty to sign off 2019/20 activity targets per month/week – End of May Analyse the impact of change weekly/fortnightly and adjust actions to ensure targets are met.	Chief Operating Officer/Medical Director
3.4 Embed use of accurate data across the Trust Key Focus									
BAF 3.4	There is a risk that if we do not embed the accurate use of data we will make evidenced based deicisons	20	Information Strategy (IA), Integrated Performance Report (IA), Divisional Meetings and Performance Reports (IA), Audit Reports (EA), Data Quality Group (IA), Quickview (IA)	Quickview (IA), Integrated Performance Report (IA),Audit reports (EA)	**Green**	Comprehensive and complete Data Warehouse and BI Solution. Ensure staff are using Quickview	**8**	Review tools to be used to access information Build dashboards etc. required by the Trust internally so as not to exacerbate the situation. Implement CareCentric and Population health databases first as part of the overall ICS solution. Approve Information Strategy. Create Business Case to build a fresh BI/Data Warehouse that covers all aspects of reporting for the future including consolidation of existing reports during 2019/20 financial year.	Director of Strategy
4. Money We will be financially sustainable, will make the best use of our buildings and be at the forefront of innovation and technology:									

Reference	Description of risk to achieving objective	Risk score unmitigated by controls	Key controls	Assurance on controls	Assurance RAG	Gaps in controls or assurance	Current Risk Rating (mitigated by controls)	Action to address gap	Lead
4 Deliver our system control total Key Focus: 4.1 Manage within agreed budget and agency cap 4.2 Improvement on prior year underlying position and meeting control surplus of £9.9m including STF. 4.3 Staff costs not exceeding 2018/19 budget of £250m 4.4 Meet our total agency spend annual cap of £10.5m									
BAF 4.1a (link to CRR 32)	The failure to deliver the annual financial plan has the potential to jeopardise the future of the organisation. It is also a breach of the statutory duty to break even. Receipt of the Provider Sustainability Funding is dependent on achieving the financial plan trajectory on a quarterly basis. This will have a negative impact on the Trust Segmentation score (Monitored through Finance and Business Performance Committee, F&BP)	20	Compliance with Standing Orders and Standing Financial Instructions. (IC)	Financial report to Board. (IA) Monthly FIMS forms for NHSI. (EA) External audit programme. (EA) Internal audit programme (EA) Minutes of NHS I Integrated Delivery Meeting. (EA) Audit Committee review of compliance with Standing Financial Instructions (waivers, losses etc.)	**Amber**	Cost improvement programme not yet delivering to target. (C) Nursing and medical agency staffing still running above internal targets. (C) Delivery against Accident and Emergency trajectory. Bank and agency run rate exceeding cap	**20** **(5x4)**	Continued focus on financial control and accountability at all levels of the organisation. Accident and Emergency delivery plan. Cost Improvement Programme Oversight groups established and CEO FRP group.	Director of Finance
			Signed Service Level Agreements (EC)	Performance management process against service / contractual specifications both internal and external with Buckinghamshire Clinical Commissioning Group. (IA & EA)					
			Divisional Performance Management process including monitoring, review and actions to address variances on Key Performance Indicators. (IC)	Deep Dive process each month for Divisions. (IA) Internal Audit of Divisional performance in 17/18 EIA) Income deep dive. (IA) Workforce deep dive. (IA) Run rate analysis and actions.					
			Delivery of action plan for Bank and Agency reduction.	Performance against NHS Improvement cap reviewed monthly (IA)					

Reference	Description of risk to achieving objective	Risk score unmitigated by controls	Key controls	Assurance on controls	Assurance RAG	Gaps in controls or assurance	Current Risk Rating (mitigated by controls)	Action to address gap	Lead
BAF 4.1b (Links to CRR 38)	There is a risk that if we do not deliver the financial plan we will not have sufficient cash to make repayments to facilities and loans and fund capital requirements. (Monitored through Finance and Business Performance Committee, F&BP)	20	Compliance with Standing Orders and Standing Financial Instructions. (IC)	Financial report to Board. (IA) Monthly FIMS forms for NHSI. (EA) External audit programme. (EA) Internal audit programme (EA) Minutes of NHSI Integrated Delivery Meeting. (EA)	**Amber**	Cost improvement programme not delivering to target. (C) Nursing and medical agency staffing still running above internal targets. (C)	**20** **(5x4)**	Debtor review and focus on collection. Cash forecast and ongoing discussions with NHSI Capital and Cash re loan drawdown. FRP to improve financial position and reduce cash requirements	Director of Finance
			Signed Service Level Agreements (EC)	Performance management versus contractual specification. (IA)					
			Divisional Performance Management process (IC)	Deep Dive process each month for Divisions. (IA) Internal Audit of Divisional performance in 18/19 (IA) Divisional performance monthly reviews by exception and quarterly reviews. (IA)					
			Prioritisation of cash payments and cash forecast. (IC)	Finance report which includes a section on cash forecast, debt and liquidity to Finance and Business Performance Committee and Board. (IA)					
BAF 4.1c	There is a risk that if we spend more than £10.5m on agency costs that this will impact on financial targets and will impact on NHSI segmentation *Board Committee with oversight: Finance and Business Performance Committee*	20	Escalated sign off by Senior Managers for all agency spend. (IC) Week-end agency signed off by Gold command. (IC) Monthly meetings reviewing agency usage for specific staff groups against agreed targets for the year. Remedial action taken as necessary. (IC)	Weekly reported nurse / doctor agency spend. (IA) Divisional targets monitored through deep dives. (IA) Performance trajectory and monthly targets in place for specific staff groups. (IA) Exception report on agency spend to Improving Performance Group monthly (IA)	**Amber**	No interface between rostering systems and temporary staffing systems, which would allow triangulation of demand	**16** **(4x4)**	Continue rollout of the Allocate system which enables the interface to work.	Director of Workforce and Organisational Development
			All requests for admin/ clerical agency is signed off by the Director of Finance or the Director of Human Resources as part of the vacancy control panel (IC)	Reconciliation of agency ledger to request process confirmed monthly. (IA) Weekly review by vacancy panel. (IA)					
			Process for booking and managing locum doctors is in-house, with senior sign off. (IC)	Monthly reporting of agency spend provides an indication of how effective this change has been. (IA) Medical agency spend reviewed by Medical Director and Director of workforce & OD on a weekly basis. (IA)					
			National Guidelines on bank and agency usage (EC)	Weekly report on non-compliance to NHS Improvement. (EA)					
			Clear process for booking agency and agency usage policy. (IC)	Weekly reporting internally and to NHS Improvement. (IA)					

Reference	Description of risk to achieving objective	Risk score unmitigated by controls	Key controls	Assurance on controls	Assurance RAG	Gaps in controls or assurance	Current Risk Rating (mitigated by controls)	Action to address gap	Lead
			Roll-out of Allocate rostering system (led by Chief Nurse)	Monthly reporting of allocate project to EMC (IA)					
4.2 Improve our operational productivity Key Focus: Use model hospital data to highlight areas for improvement and take actions Reduction in cost per Weighted Unit of Activity ("WAU") across all specialties.									
BAF 4.2a	There is a risk to delivery of the financial plan if the Cost Improvement and Waste Efficiency Plan is not achieved. This could affect future sustainability of the organisation. (Monitored through Finance and Business Performance Committee, F&BP)	**20**	Programme Management Office (PMO) Lead and PMO function in place (IC).	Monthly financial reporting to Board, divisions, EMC, corporate services and NHSI (IA). Transformation Board minutes. (IA) Project Initiation Documents (IA) Quality Impact Assessment process (IA) Planning and documentary evidence of CIPS. (IA) Monitoring of delivery. (IA)	**Amber**	Further schemes required. All schemes not rated Green or Amber.	**20** **(5x4)**	Continued focus on financial control and accountability at all levels of the organisation. Specific actions to manage risks and deliver mitigating actions.	Director of Finance
			Full governance methodology and process in place for cost improvement plans (IC).	Reports of internal and external audit (EA).					
			Performance management framework for divisions and corporate services (IC).	Financial control totals agreed for divisions and corporate services. Monthly performance meetings by exception and quarterly monitoring review process and action plans.					

Reference	Description of risk to achieving objective	Risk score unmitigated by controls	Key controls	Assurance on controls	Assurance RAG	Gaps in controls or assurance	Current Risk Rating (mitigated by controls)	Action to address gap	Lead
4.3 Deliver our capital plan Key Focus: Manage and mitigate risks in capital backlog									
BAF 4.3a (Link to CRR 27, CRR 60, 73 and 79)	There is a risk that we will not deliver the capital programme in the most effective way, or deliver the Capital Resource Limit if the programme is not managed effectively. (Monitored through Finance and Business Performance Committee, F&BP)	**20**	Governance structures: Estates CMG; IT CMG; Medical Equipment CMG; CMG. (IC) Risk assessed prioritisation of schemes. (IC) Prioritised IT and medical equipment replacement strategy developed to inform 5 year capital plan. (IC)	Meeting minutes for CMG (IA) Monthly monitoring of capital programme through Capital Management Group and F&BP (IA) Deferral risk assessment and reported to Capital Management Group, Executive Management Committee and Finance and Business Performance Committee. (IA)	**Amber**	The monitoring of tendering, procurement and contracts needs to be strengthened to provide greater assurance. Assurance around post project reviews to be developed.	**20 (5x4)**	Prioritised IT and medical equipment replacement strategy in development to inform 5 year capital plan. Potential risk of breaching Capital Resource Limit Review process, training, support from interim Transformation Director. Trying to obtain additonal funding within year to sustain capital programme	Director of Finance
			Business cases and tendering and procurement process. (IC)	Business cases (IA) Cycle of internal audit of procurement (EA)					
			Project management of implementation using Prince 2 type methodology. (IC)	Property Services PMO . (IA) Resourcing plan for implementation. (IA)					
BAF 4.3b	There is a risk that the available capital budge will not achieve all the high priority requirements relating to the estates backlog, medical equipment backlog, and the Information Technology national, statutory and local requirements. (Monitored through Finance and Business Performance Committee for business risk and Quality Committee for clinical risk)	**20**	Prioritisation of capital projects based on risk for 18/19 financial year. This is carried out at Capital Management Group and reviewed by Executive Management Committee . (IC) Monitoring of risk impact through the incident reporting process and updates to Capital Management Group, Executive Management Committee, Finance and Business Performance Committee and Board.. (IC) Preparation of business cases for potential external funding. (IC)	Capital Management Group minutes. (IA) Risk profiled capital bids. (IA) Incident reporting trends reports to Quality Committee. (IA) 18/19 prioritisation reviewed by Capital Management Group in February. (IA) Ongoing monthly review. (IA) Business case review process through Trust governance structure.	**Amber**	Capital allocation less than amount required.	**20 (5x4)**	Development of initiatives to increase Capital Resource Limit in 18/19 and 19/20.	Director of Finance

Reference	Description of risk to achieving objective	Risk score unmitigated by controls	Key controls	Assurance on controls	Assurance RAG	Gaps in controls or assurance	Current Risk Rating (mitigated by controls)	Action to address gap	Lead
HORIZON SCANNING									
BAF 5	There is uncertainty about the potential impact of Brexit on the Trust's ability to deliver objectives in the coming year.	25	Close attention to direction from the Department of Health and Social Care with regard to any actions to minimise risk. (IC)	Supportive advice around the status of employees from the European Union in 2019/20. (EA)	**Red**	The situation is uncertain.	**10 (5x2)**	Acknowledgement of the risk. No specific actions at present.	Chief Executive Officer

	Consequence Score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical / psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/ audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards

		Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Major patient safety implications if findings are not acted on		
Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices	Multiple breeches in statutory duty Prosecution Complete systems change required

				Low performance rating Critical report	Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million

Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur <0.1 %	Do not expect it to happen/recur but it is possible it may do so **<0.1 – 1%**	Might happen or recur occasionally 1 – 10%	Will probably happen/recur but it is not a persisting issue **10 – 50%**	Will undoubtedly happen/recur,possibly frequently >50%

Appendix A continued

Risk Scoring Matrix

	Severity				
Likelihood	**1 Insignificant**	**2 Minor**	**3 Moderate**	**4 Major**	**5 Catastrophic**
1 Rare	**1**	**2**	**3**	**4**	**5**
2 Unlikely	**2**	**4**	**6**	**8**	**10**
3 Possible	**3**	**6**	**9**	**12**	**15**
4 Likely	**4**	**8**	**12**	**16**	**20**
5 Almost Certain	**5**	**10**	**15**	**20**	**25**

Assurance Evaluation Tool

The purpose of this tool is to ensure that a consistent approach is used when assessing the quality of assurances that populate the Board Assurance Framework (BAF). The tool recognises that the overall quality of an assurance is dependent on a combination of its **timeliness/durability**, its **relevance** to the associated control and how **objective** it is.

The timeliness and relevance factors are assessed and combined to give a 'value' to the assurance. The 'strength' of the assurance is determined based on how objective the source is. Strength and value are then combined to give an overall quality rating. The quality rating appears in the assurance framework.

Table 1
How enduring is the assurance?

Strong

↕

Weak

A	Received within the last 12 months and minimal organisational change in this areas since assessment
B	Received within the last 12 months and significant organisational change in this areas since assessment
C	Greater than 12 months old and minimal organisational change in this areas since assessment
D	Greater than 12 months old significant organisational change in this areas since assessment

Table 2
How relevant is the assurance?

Strong

↕

Weak

A	From a piece of work specifically commissioned/designed to examine the effectiveness of the control(s).
B	From a piece of work that includes examination of the effectiveness of the control(s).
C	From a piece of work that includes limited examination of the effectiveness of the control(s).
D	Deduced/analysed from various reviews which indirectly address the control(s)

Table 3
Value of the assurance

Combine tables 1 & 2		Timeliness			
		A	**B**	**C**	**D**
Relevance	**A**	**1**	**1**	**2**	**3**
	B	**1**	**2**	**2**	**3**
	C	**2**	**2**	**3**	**4**
	D	**3**	**3**	**4**	**4**

Table 4
How strong is the assurance?

Internal management assurances are generally less strong compared to independent, usually external, assurances. Some examples are given below, the scoring is allocated on a 'less strong' v 'more strong' basis.

Internal	Score	Independent 3rd party	Score
Performance scorecard	2	External audit	1
Training records	2	Internal audit	1
Satisfaction surveys	2	Royal College inspections	1
Infection control audits	2	NHSLA assessments	1
Minutes of meetings	2	Health & Safety Exec inspections	1
	2	National patient/staff surveys	1

Table 5
Overall quality of assurance

		Strength of assurance (Table 4)	
		1	2
Value of assurance (Table 3)	1	1	2
	2	2	4
	3	3	6
	4	4	8

- Green = high quality
- Amber = medium quality
- Red = low quality = gap in assurance

Agenda item: 15
Enclosure no: TB2019/58

Safe & compassionate care, every time

Buckinghamshire Healthcare NHS
NHS Trust

PUBLIC BOARD MEETING
29th May 2019

Details of the Paper

Title	Organisational Risk Profile
Responsible Director	Director for Governance
Purpose of the paper	To inform the Board informed of the organisation's top risks and how they are being managed.
Action / decision required (e.g., approve, support, endorse)	Confirm top risks

IMPLICATIONS AND ISSUES TO WHICH THE PAPER RELATES (PLEASE MARK IN BOLD)					
Patient Quality	*Financial Performance*	*Operational Performance*	*Strategy*	*Workforce performance*	*New or elevated risk*
Legal	***Regulatory/ Compliance***	***Public Engagement /Reputation***	*Equality & Diversity*	***Partnership Working***	***Information Technology / Property Services***

ANNUAL OBJECTIVE	
Which Strategic Objective/s does this paper link to? Relates to all objectives	
Please summarise the potential benefit or value arising from this paper: A sound knowledge of the organisations strategic risks enables the Board to make informed decisions.	
RISK	
Are there any specific risks associated with this paper? If so, please summarise here.	*Non-Financial Risk*: All risks of the Board Assurance Framework
	Financial Risk: All risks of the Board Assurance Framework
LINK TO CARE QUALITY COMMISSION ESSENTIAL STANDARDS OF SAFETY AND QUALITY	
Which CQC standard/s does this paper relate to?	Well led Domain; Outcome 17 Good Governance *(if you need advice on completing this box please contact the Director for Governance)*
Author of paper: Sue Manthorpe	

15

Presenter of Paper: Sue Manthorpe
Other committees / groups where this paper / item has been considered: The Executive Management Committee moderates the Corporate Risk Register and Board Assurance Framework. The Quality and Clinical Governance Committee and the Finance and Business Performance Committee review the Corporate Risk Register. The Strategic Workforce Committee considers workforce and Health and Safety risk.
Date of Paper: 20 May 2019

RISK PROFILE

1. PURPOSE

The purpose of this paper is to inform the Board of the top organisational risks and how they are being managed. The range of assurance information reviewed at the Board and its Committees provides an insight into how the various risks are being mitigated and managed throughout the organisation at a greater level of detail.

2. BACKGROUND

The Board Assurance Framework (BAF) provides the structure and process that enables the Trust to focus on those key risks that might compromise achieving the Trusts corporate objectives and strategic priorities. It maps the key controls that should be in place to manage those corporate objectives and confirm the organisation has gained sufficient assurance about the effectiveness of these controls.

Following the development of the Trust corporate objectives for the next two years, the BAF has been completely refreshed to reflect the new objectives and the potential risk to their achievement.

Each Executive Director has reviewed the risks against the delivery of the corporate objectives for which they are the lead and these risks are set out in the BAF appended to this paper.

Committees of the Board will receive regular updates on the relevant BAF risks linked to the corporate objectives they will monitor. This will improve oversight of all BAF risks to improve awareness and provide triangulated reporting. The Executive Management Committee (EMC) will receive both the BAF and Corporate Risk Register monthly.

The Corporate Risk Register will be considered monthly at the Risk and Compliance Group.

The Audit Committee has delegated authority from the Board to oversee the Trusts risk management processes. It will receive the BAF at each meeting.
.

3. TOP RISKS

• Risk around the delivery of the Financial Recovery Plan.

Key actions are in place to promote efficiency and effectiveness; to closely monitor financial delivery at all levels of the organisation; and a framework of controls is in place.

The limited availability of capital resource is creating risk around medical equipment replacement, maintenance of the environment, and ability to move forward with improvements in information technology.

The Finance and Business Performance Committee monitors the assurance relating to this risk.

• Risk to delivery of corporate objectives relating to the implementation of new workforce models if we do not have the right number of staff with the right skills and talent.

To address this risk there is a comprehensive recruitment and retention plan in place to attract new staff and keep existing staff. In addition a review of the required skill mix of staff and new models of care is underway to support innovation.

Safe staffing is managed on a day to day basis and the Trust untilises temporary staff from bank and agency when necessary. Over-reliance on temporary staff has a quality and cost implication for the Trust.

The Strategic Workforce Committee and the Quality and Clinical Governance Committee monitor the assurance relating to this risk.

• Risk to patient experience due to pressures on the urgent care pathway.

The mitigations to this risk and other risks around delivery of NHS Constitution standard are set out in the exception reports for the Integrated Performance Report.

The Quality and Clinical Governance Committee monitors the assurance relating to this risk.

4. RECOMMENDATION

The risks contained within the BAF are recommended to the Board for discussion and action as necessary.

Sue Manthorpe

Director for Governance,

Agenda item: 16
Enclosure no: TB2019/59

Safe & compassionate care, every time

Buckinghamshire Healthcare NHS
NHS Trust

Public Trust Board
29 May 2019

Title	Corporate Risk Register
Responsible Director	Director for Governance
Purpose of the paper	To provide the Board with assurance the risk management process is complied with in the management and mitigation of the risks on the Corporate Risk Register .
Action / decision required (e.g., approve, support, endorse)	For Approval

IMPLICATIONS AND ISSUES TO WHICH THE PAPER RELATES (PLEASE MARK IN BOLD)					
Patient Quality	***Financial Performance***	*Operational Performance*	*Strategy*	*Workforce performance*	*New or elevated risk*
Legal	***Regulatory/ Compliance***	*Public Engagement /Reputation*	*Equality & Diversity*	*Partnership Working*	*Information Technology / Property Services*

ANNUAL OBJECTIVE	
Which Strategic Objective/s does this paper link to?	
Please summarise the potential benefit or value arising from this paper:	
RISK	
Are there any specific risks associated with this paper? If so, please summarise here.	*Non-Financial Risk*: There is a risk to the governance process of joint working if an appropriate methodology is not in place.
	Financial Risk: There is a risk to the financial sustainability of both organisations if an appropriate methodology for joint working is not in place.
LINK TO CARE QUALITY COMMISSION ESSENTIAL STANDARDS OF SAFETY AND QUALITY	
Which CQC standard/s does this paper relate to?	Well led

Author of paper Sue Manthorpe
Presenter of Paper: Sue Manthorpe
Other committees / groups where this paper / item has been considered: Quality Committee and IPC committee
Date of Paper: 21/05/2019

Agenda item: 16
Enclosure no: TB2019/59

1. Purpose

This report provides the Board with assurance the risk management process is complied with in the management and mitigation of the risks on the Corporate Risk Register

2. Background

The CRR has been reviewed at Divisional level. Following the review the following o actions have been taken against each risk:

CRR27A: Update: there started date for the project has changed and is end of June 2019

CRR 27B: The Director responsible has changed from the Director of Strategy and Business Development to the Commercial Director

CRR39: The projected completion date has been updated to 30/10/19 to reflect the changes in the project plan

CRR 45: The projected date completion date has been extended

CCR 49: The risk will need further review when the national review of the Clinical Standards is published. The projected target date at Divisional Level has been changed

CRR53: Changes to the referral process appears to be having a positive impact, therefore this risk is being monitored and will be for review

CRR 60: This has been reviewed and the projected completion date has been updated to reflect the changes to the project plan

CRR 63: Additional mitigation has been added relating to Disability Nurses and patient services

CRR 68: The risk has been updated and the projected completion date changed.

CRR73: The risk actions have been updated as work has commenced on the project

CRR 70: the projected completion date has been extended to reflect the complexity of the project to mitigate the risk.

CRR 85: Additional mitigations added relating to the successful recruitment of two Paediatric Consultants

CRR 88: The risk has been updated and the projected completion date extended

CRR 90: The Director responsible has changed from the Director of Strategy and Business Development to the Commercial Director

CRR91: the risk has been reviewed and now has a completion date of 31st March 2020

CRR95: The risk projected completion date has been amended due to the complexity of the project

CRR100: Changes to the projected completion date due to changes in the Brexit timetable.

CRR103: the risk actions have been reviewed and the 62 day target has been achieved. Consider removing from CRR if risk remains controlled.

Agenda item: 16
Enclosure no: TB2019/59

3. **Risk recommended for removal (shaded grey on the CRR) from the CRR following improved mitigations**

CRR 34: This risk has been mitigated by the following actions:

- NEWS2 is now embedded across the Trust
- E-Obs has been rolled out
- There is now increased visibility of deteriorating patients
- E-Obs links directly to the on-call teams supported by critical care outreach who respond to deterioration
- Hospital at Night is supported by e-obs.
- Hospital at Night conference is being planned.

CRR41: The mitigations for this risk link to CRR 34 reducing the level of risk score below that required to remain on the CRR.

4. **Consider whether there are any additional risks that need to be added to the CRR.**

Following the introduction of new standards to the NHS Counter Fraud Authority's (NHSCFA) standards for providers, released in January 2019. Updated standard 1.4 now requires fraud risks to be reviewed and monitored in line with the organisational risk registers and methodology. Attached in Appendix b is the current version of the Fraud risk register for information and comment.
The LCFS will work with the Director for Governance to ensure, during 2019/20, this standard is complied with.

5. **Recommendation**

The Board is asked to note the report and approve the removal of the identified risks

Risk Tracking Reference	Date Added to Register	Division	Description of risk	Unmitigated Risk	Key controls	Risk Score (S x L)	Gaps in controls	Action plan to address risk including timescales for completion	Predicted residual score	Lead	Projected completion date.	Trust Objective
CRR 10 (HR 4/14)	24/11/2014	Trust wide	Shortage of qualified nursing and AHP staff, which results in high reliance on temporary staffing (Bank and Agency) in some areas which could impact on the quality of patient care and the Trust financial position	25 (5x5)	Performance management of Recruitment Service - HR & Workforce Group Performance management of Divisions and Corporate Services Performance management of NHSP to ensure quality of temporary staff and high proportion of bank rather than agency staff Daily safe staffing huddles Weekly safe staffing meeting to identify and review hot spots Monthly vacancy heat map by cost centre Weekly review by Executive Management Committee Detailedl recruitment plan Active retention strategy (recognised nationally) Monitored through Strategic Workforce Committee.	**20 (5X4)**	National shortage of registered nurses Drop in numbers recruiting to nurse degree programmes higher than expected levels of nurse attrition in July and August Delays in conversion of overseas recruits due to the requirements of the IELT and the time it takes to register with the NMC.	Trust-wide Recruitment plans in place - this includes, local, national and international recruitment of nurses from Portgual (from Erasmus students); Philippines (10 in January) Longer term plans: expansion of partner universities - cohort of 20 students from Bucks New University; 38 students from University of Bedfordshire Use of apprenticeships: 40 individuals being recruited onto Nursing associate apprenticeship programmes; 10 individuals to start accelerated nurse degree apprenticeships Retention plan - includes: Part of NHSI Cohort 4 Local plans for hotspot areas focussing on skill mix review and recruitment to a wider range of roles; plans to be reviewed by EMC	**10**	Director of Workforce and Organisational Development	30/09/2019 (changed from 31/12/2018)	Attracting and retaining high calibre and engaged people
CRR 27A (S195, PS117)	27/07/2014	Surgery - Theatres	Risk to patients and staff posed by the New Wing theatre infrastructure, specifically the outdated electrics. The electrical circuit boards do not have miniature circuit breakers or residual current devices and are fitted with cartridge type fuses which are slower to react to an overcurrent situation or a short circuit	20 (4x5)	Electrical installations are checked in accordance with the Electricity at Work regulations. Regular maintenance checks. BHT approved extension leads are the only ones in use. Full infrastructure report completed and used to advise the business case relating to remedial work on electrics. Monthly safety rounds with Property services and theatre manager Daily checks by matrons/Lead ODP to ensure that fire exits are clear Divisional Director leading the steering group as SRO for capital works to ensure that the risk to activity is minimised and to ensure clinical involvement.	**16 (4X4)**	£4m allocated to be spent £2.5m in year 2018/19 and the other £1.5m in the year 2019/20.The project will take 60 weeks from proposed start date of March 2019 .	£4m allocated to be spent £2.5m in year 2018/19 and the other £1.5m in the year 2019/20.The project will take 60 weeks from proposed start date of June 2019 The Estates ten year strategy has been approved by the Board. The one public etstate funding initiative due to be completed in October 2019	**4**	Commercial Director	Project will run for 60 weeks from the start date, which will now not be before March 2019. The end date is, therefore, likely to be June 2020.	Estates: Delivery of theatres electrical resilience. Safety: Enhance our culture of safety.
CRR 27B (PS153)	20/10/2017	Property Services	The Stoke Mandeville Hospital main High Voltage electrical supply carries significant infrastructure risks which could result in overload of the network or power failure impacting on clinical services.	25 (5x5)	We have a well-structured generator supply system which will provide emergency power to critical parts of the trust in the event of critical power failure.	**20 (5x4)**	• The requirement to contract increased electricity capacity to safeguard supply • A requirement to replace the UKPN outdated switchboard with dual Ring Main supply units. • A requirement to replace the outdated Hospital HV intake switchboard from single switch and supply to dual switch board options and supply.	The risk will be reduced by increasing our contractual arrangement with UKPN to supply increased capacity; a business case is being developed to meet this requirement. A feasibility study is underway to develop an options appraisal based on • The upgrade of contract arrangements for the supply of Electricity from 1500KVA to 3000KVA. • Replacement of UKPN HV intake switch gear and Hospital HV intake switch gear including the provision of dual switching capabilities. • The development of Electricity dual supply options.	5	Commercial Director	30/6/2020	Trust wide electrical resilience and safe supply source to give critical infrastructure and services the supply they require to deliver patient services

Risk Tracking Reference	Date Added to Register	Division	Description of risk	Unmitigated Risk	Key controls	Risk Score (S x L)	Gaps in controls	Action plan to address risk including timescales for completion	Predicted residual score	Lead	Projected completion date.	Trust Objective
CRR 32	18/19	Trust wide	Trust control total will have an adverse impact on the reputation of the Trust and the ability to deliver strategic objectives relating to quality, people and money	20 (4x5)	Trust governance arrangements. Financial Recovery Plan governance and actions. Quality impact assessment. Cash management and loan drawdown. Commissioning of external reviews. Control over expenditure. Workforce recruitment and retention. System demand management plan. Working capital strategy and loan repayment, working capital and liquidity strategy.	**20 (5x4)**	Delay in Cost Improvement Programme delivery. Detailed financial recovery plan required.	Continued weekly focus on financial delivery, including CIPs and controls on temporary staff spend. Focus on key milestones to ensure CIP delivery. Interim support to finance recovery plan.	**15**	Director of Finance	31/03/2019	Achieve financial targets
CRR34	21/04/2015	Trust wide	There is a risk to all aspects of quality for patients if there is not a consistent, effective, timely recognition of clinical deterioration with appropriate actions.	25 (5x5)	Organisation-wide use of the national early warning score tool with inherent escalation process. Disseminated learning from Serious Incident reports and cardiac arrest monitoring. Learning from mortality review process. Charitable Funds funding for e-observations which will support clinicians in the early recognition of deterioration and support them in taking appropriate action. Incident reporting for any situations where escalation has not appropriately taken place. New sepsis lead in post who is a consultant in emergency medicine. New sepsis nurse in post in emergency department. Use of Outreach service.	**9 (3x3)**	Clinical audit is not able to provide assurance that the early warning score is being used in a consistent way in all areas.	• NEWS2 is now embedded across the Trust • E-Obs has been rolled out • There is now increased visibility of deteriorating patients • E-Obs links directly to the on-call teams supported by critical care outreach who respond to deterioration • Hospital at Night is supported by e-obs. • Hospital at Night conference is being planned.	**6 (2x3)**	Medical Director	31/03/2019 for introduction of NEWS2 and April 2020 for full roll out of e-Obs	Reduce Harm Great Patient Experience
CRR 38	18/19	Trust-wide	The Trust has insufficient cash with which to support its strategic and operational objectives	25 (5x5)	Daily and monthly forecasts maintained and reported Ongoing discussions with NHS Improvement. Prioritisation of payment runs. Review of aged debtors. Cash prioritisation, cash forecasting and loan drawdown. Debtor review to maximise recovery.	**6 (3x3)**	Operational pressures and delay in CIP delivery, mean I&E is not delivered Contractual and other challenges mean that receivables are delayed Receipts for asset sales are not delivered	Working capital loan application. NHSI engagement on liquidity and 2019/20 planning round. Estates disposal strategy.	**15**	Director of Finance	31/03/2019	4. Efficiency - be a highly effective, sustainable Trust through maximising efficiency, productivity and cost effectiveness.

Risk Tracking Reference	Date Added to Register	Division	Description of risk	Unmitigated Risk	Key controls	Risk Score (S x L)	Gaps in controls	Action plan to address risk including timescales for completion	Predicted residual score	Lead	Projected completion date.	Trust Objective
CRR 39 (RAD03)	19.12.2015	Trust-wide	The current use of paper reporting for imaging results does not allow for a satisfactory audit trail or monitoring of reporting A recent SI highlighted an issue and continuing risk that Imaging and Pathology reports are not acted upon	20 (4x5)	Most Pathology and Radiology reports are now requested electronically on ICE. The facility to send reports to clinical teams electronically is in place. Any severely abnormal results are phoned through to the requesting clinician. Where a radiologist completes a review where they identify a concern they can put this into the Multi-disciplinary Team review process directly.	**16 (4x4)**	Some clinical services have a Standard Operating Procedure in place, however insufficient assurance that electronic reports from Radiology and Pathology will be acted on and hence allow for the discontinuation of paper reports. IT issues need to be resolved with regards to filling inthe ICE system and monitoring of compliance. Clarification required on the location of requests in ICEand how these are allocated.	The monitoring of compliance is with every SDU, going through to the relevant Divisional Board. The IT staff supporting this work have been deployed in a high priority programme. The IT departmentwill clarify the timescale to re-establishment of this support Specific SunQuest issues to be addressed • Action: issued logged with SunQuest Clarification regarding ICE/Winpath locations. Action: ICE project teamare workign to resolve this. • There is a data quality issue in WinPath, the locations are not accurate. For example, the 'chest office' is a location in WinPath but is not available in ICE – this means that when it is selected in pathology it will show as an unknown location in ICE. This will also affect the compliance report. Action: ICE project team are working to resolve this	**8**	Medical Director	30/11/2019	Reduce harm
CRR 41 (IM 127)	11/01/2016	Division Wide	Risk that medical patients will not have appropriate medical review when information systems are not effective in tracking patients. Affected by issues of integration between Medway and PMS.	20 (4x5)	Ward based care provides mitigation Mon-Fri but not at weekends or for unusual escalation areas. Weekend plans completed for all patients requiring review. Consultant led specialty reviews at weekends on Respiratory and Gastroenterology. Bed managers are manually entering ward moves into PMS out of hours and for clinical areas used for escalation. Weekend POD 3 and ward registrar uses PMS to identify patients requiring review	**8 (4x2)**	Not all specialty areas have consultant led review at weekends	Further work with eObs required to ensure appropriate functionality. Implementation of Medical support workers will provide mitigation at weekends.	**4**	Chief Operating Officer	31/03/2019; Extended to 30/04/19	Driving up safety and quality
CRR 45 S199	27/10/2014	Surgery	Due to an increase in GP referrals there is a risk that ophthalmology capacity is unable to meet demand resulting in appointment delays for First and Follow -up appointments with the medical retinal speciality the most affected. This has resulted in compromised patient outcomes.	20 (5x4)	Booking standards in place and monitored through key performance indicators Provision of One -Stop Acute Macular Degeneration (AMD) clinic in Amersham AMD patient tracking system in place which includes a weekly review Weekly access meetings with daily reporting in place Clear patient guidance for appointment schedule Additional Fellows in place Mobile answer-machine for the AMD coordinator All letters have this telephone number on so that patients/GP's will have a direct point of access Daily safety huddles introduced at the beginning and the end of all One Stop clinics Medisight Steering group, chaired by the Divisional Director for Surgery, meeting fortnightly to ensure robust project oversight. Recruitment of a retinal failsafe co-ordinator in 18/19 to ensure that clinics are managed and patients who DNA are followed up. Two additional retinal consultants appointed in December 2018. Identified backlog of retinal patients (718) were clinically reviewed in December 2018, and the 200 identified as 'high risk' have been seen in clinic. Completed by 14 February 2019. No serious harm identified.	**15 (5x3)**	Space for booking teams to be housed in one central location Availability of physical space in the Mandeville Wing to accommodate the required activity Challenge to recruit high quality Fellows.	Medisight business case, approved in September 2017, which will introduce electronic software for tracking and monitoring retinal patients. Implementation date (June 2018) delayed due to the company being unable to deliver part of the agreed scope of work - Finance Director in discussion with Medisght CEO Divisional Director working with Director of Property Services to review space and capacity in the Mandeville Wing for a one stop retinal clinical. this will require capital funding which needs to be agreed. Engaged with Getting It Right First Time team for NHS Improvement to implement the high impact interventions for ophthalmology. This is a year's programme commencing in July 2018 overseen by the Elective Care Steering Group Reconfiguration of Amersham space (replicating the efficient clinic set – up currently used for AMD) to create a Retinal hub with increased workflow and capacity. This would future proof the service for the next ten years	5	Chief Operating Officer	31/07/2019 (changed from 31/03/2019)	Ensure we are meeting NHS Constitutional standards

Risk Tracking Reference	Date Added to Register	Division	Description of risk	Unmitigated Risk	Key controls	Risk Score (S x L)	Gaps in controls	Action plan to address risk including timescales for completion	Predicted residual score	Lead	Projected completion date.	Trust Objective
CRR 49 (IM128 formerly MD46)	25/05/2017	Hospital wide	Risk that the Trust will not meet the national access/quality standards for emergency care due to the rise in demand on the urgent care pathway. Any delays potentially have an adverse impact on patient and staff experience. The use of escalation areas is not optimal for patients or staff. This is in the context of significant increase in activity.	25 (5x5)	• Ensuring staffing is in place in accordance with agreed levels. • Daily breach meetings with cross divisional input held to understand cause of breaches and actions required • Escalation protocol in place with support out of hours from on-call managers • Issues of flow and bed capacity managed internally and with partners. GP streaming in place System wide weekly escalation meeting in Place. Length of Stay intiatives. Winter System Winter Director	**20 (5x4)**	Lack of control in the number of attendances at A&E Higher acuity and higher patient attendance during the winter period Delays in discharge Higher reliance on temporary staffing due to vacancies	Monthly urgent care transformation action plan driving key changes led by the Divisional Director for Integrated Medicine. Examples of these actions are Use of Acute Medical Unit for Medical Take, Extra Emergency Observation Unit space, Use of Ambutalory Emergency Care for Ambulatory Patients, Community Transofrmation, Discharge to Assess, Reduction in Length of Stay. Reporting weekly into EMC and monthly to the System wide A&E delivery board. This standard is part of a natiional review of Clinical Standards	**10**	Chief Operating Officer	31/10/19: Extended to 31/07/19	Ensure we are meeting NHS Constitutional standards
CRR 53 (C&YP 14)	07/12/2015	Women and Children	Waiting times for community paediatrics and paediatric Speech and Language Therapy due to low capacity due to staffing issues, high demand and number of Looked After Children and Emergency Department referrals that have statutory target of 28 days.	25 (5x5)	Monthly meetings with commissioners. Weekly highlight report sent to Chief Operating Officer and commissioners. Commissioners have been informed of risk via written communication. RTT pathway has been removed. CHAMS and BHT pathway commenced.	**16 (4X4)**	Clinical risk to patients whose treatment might be delayed as a result of capacity	Improvement plan produced. Vacant posts filled. Demand and capacity pathways complete. Service manager in post. Priority list of work in place. Pyschologist commeced 1/12/18. Joint working with CCG, OUH and CAMHS. Launch of joint SPA 31/03/19. Referasl noew being received at SPA not BHT. trajectory indicates positive impact on waiting list	**8**	Chief Operating Officer	31/12/2018; date extedned 31/03/20	Reduce Harm
CRR 54 (IT061)	22/06/2016	Information Technology	There is a risk around availability of management information due to: - capacity of the information team - systems and technological platform (some of the systems are obsolete) - models of data reporting are under-developed	20 (4x5)	Defined list of information deliverables for Information Department Encourage staff requiring information to use self-service wherever possible through Qlikview	**20 (4X5)**	Comprehensive and complete Data Warehouse and BI Solution.	Review tools to be used to access information Build dashboards etc. required by the Trust internally so as not to exacerbate the situation. Implemente CareCentric and Population health databases first as part of the overall ICS solution. Create Information Strategy before 31/3/2019. Create Business Case to build a fresh BI/Data Warehouse that covers all aspects of reporting for the future including consolidation of existing reports during 2019/20 financial year.	**8**	Director of Strategy	30/9/2019 Extended from 30/11/2018	Implement Digital Transformation to support our Clinical Strategy
CRR 59 (IT054)	26/04/2016	Information Technology	There is a risk of cyber attack and potential disruption to IT systems and services of the Trust	25 (5x5)	Monitoring of carecert notices from HSCIC. Monitoring of the Trust network intruder detection system Application of Cisco patches as they become available to ensure network software is up to date. Continued monitoring of the network and external bulletins. Maintain patches to network software. Maintain systems at latest levels wherever possible (Caldicott 3/CQC requirements moving forward) Anti-Ransomware software in place (heuristic monitoring of devices).	**20 (5x4)**	Cyber Security strategy not yet in place.	NHS digital pilot cyber security programme supporting the Trust with detailed risk assessment.	**10**	Director of Finance	31/12/2019	Implement Digital Transformation to support our Clinical Strategy

Risk Tracking Reference	Date Added to Register	Division	Description of risk	Unmitigated Risk	Key controls	Risk Score (S x L)	Gaps in controls	Action plan to address risk including timescales for completion	Predicted residual score	Lead	Projected completion date.	Trust Objective
CRR 60 (IT071)	22/01/2014 13/06/16	Information Technology	No notice loss of significant telecommunications infrastructure (internal and External) . Including loss of bleeps and landlines resilience: - Main switch became obsolete in 2017 - Bleep systems at WH and SMH not compatible and old (PS only) Loss of telephoney due to age of equipment at SMH, Wycombe and Amersham. Risk also includes bleep system and switchbaord	25	IT and Estates currently running regular Resilience meetings to address risks and look at mitigating strategies. Disaster recovery plan on contract looks to provide a back up of 50 set lines within 24hrs Utilisation of 2-way radio devices and/or mobiles Work underway with Sodexo/Unify to carry out repairs to SMH main switch required to reactivate failover equipment. This requires several hours downtime, Sodexo in discussion with senior management to arrange a convenient time to do this. Ongoing monitoring of the systems. Parts specialist external support via support contracts in place. Network/Telephony replacement programme will address the replacement of the telephony and bleep systems. Red emergency phones available across wards.	**20 (5x4)**	SMH main switch currently identified as relying on single ISDN lines and switchboards. Trust currently has no spare mobile phones identified for use in landline failure. Unified switchboard identified as becoming obsolete in 2017 Requires significant work and budget to plan migration to IPT. Given the age of the systems, it may at some stage become difficult to source technical suppport or parts. The new network/telephony programme will address the replacemnt devices before loss of technical support. However, the risk of a complete outage which requires a replacemnt product is high and being managed with the technical syppliers to ensure down time will be kept to a minimum.	Business case being developed to replce all telephony in line with wider ICS to obtain economies of scale and greater capacity in tecnical skills. Procurement of new solutions as appropriate. Support contract in place. Red emergency phones in place on wards. Working with Cisco to provide a design solution that will manage the system across Buckinghamshire and provide greater resiliance in the future.	**15**	Director of Strategy and Business Development	30/10/2019	Improving Communication Focus on Estates and Technology
CRR 63 (HR 4/2016)	Jul-16	HR	Regulations on Accessible Information standard came into force on 1 August 2016. Although the Trust is compliant with the regulations there are improvements still to be made	20 (4x5)	AIS e-learning in place for all staff - compliance at 31 October 93% 50 different cascade routes for AIS information across the Trust Implementation of SMS texting Communication-need alerts are established on the Trust primary patient administration system (PAS) for acute (SystemC Medway) and community services (Servelec RiO) Brousealoud on public website Bulk mail went live end June 2018, including yellow paper and large font for opthalmology letters Learning Disabillity Nurses revieiwing opportunities for further support the Trust can offer to patients	**12 (4 x 3)**	Accessibility of patient records"flags" to all front line clinical staff sytematically, in particular in outpatients - flags are currently available systematically to reception staff. Testing of awareness of AIS across the organisation	Review of IT systems used by clinicians re use of flags Regular communications - monthly - staff bulletin	**8**	Director of Workforce and Organisational Development	30/3/2019	High quality care
CRR 68 (S228)	23/09/2016	Trust-wide	There is a risk to the delivery and sustainability of the national standard for Referral to Treatment Time (RTT) as per the 19/209 NHS Guidance ie waiting list size in March 2019 must be less than that submitted in March 2020 and there must be half the number of 52 week breaches. Two main factors contributing to this are increased demand and insufficient capacity to meet this demand. The possible adverse outcomes for this risk are: - poor patient experience if their waiting times are extended, - possible harm to patients if there are delays - negative financial impact affecting sustainability due to loss of activity and potential non-achievement of the Strategic Transformation Funding. -reputational issue for the Trust there are 2 areas which have significant	20 (4x5)	BHT recovery and sustainability plan submitted to NHSE. Plan is monitored though: Weekly Patient Tracking List (PTL) meetings. Weekly Access Performance Management Group (APMG) meetings. Weekly performance escalation meetings chaired by the Chief Operating Officer. Recruitment of additional consultants/Fellows in ophthalmology/Plastics Training programme established for IFR funding process and adherence to CCG criteria Additional Waiting List Initiatives to manage demand Outsourcing completed of additional 200 cataracts to the private sector Full demand and capacity review of all specialities underway Performance RTT trajectory submitted to NHS Improvement in April 2019. Contractual Review of IAP by the end of Q1	**16 (4x4)**	Outpatient Clinic capacity does not currently meet demand. Inability to recruit to nursing and medical vacancies in theatres and ophthalmology. Rise in demand for ophthalmology and orthopaedic procedures. NHSE expectation to reduce elective operating in times of pressure in the system.	Moving almost all elective in patient activity to WH - except gynae and some orthopaedic spinal and increasing the amount of day case surgery to reduce cancellations due to operational pressures on the SMH site Data quality request submitted to NHS Improvement. Feedback report received on 13 June 2018. Action plan in place based on feedback to be completed by the end of year . Frontload the activity plan to increase elective in-patient operations in the first eight months of the year Demand, capacity and efficiency programme	8	Chief Operating Officer	31/03/2020	Improve access and efficiency. Reduce harm, great patient experience

Risk Tracking Reference	Date Added to Register	Division	Description of risk	Unmitigated Risk	Key controls	Risk Score (S x L)	Gaps in controls	Action plan to address risk including timescales for completion	Predicted residual score	Lead	Projected completion date.	Trust Objective
CRR 73 (S196)	21.4.17	Division of Surgery and Critical Care	There is a risk that the age and condition of the Sterile Services plant and equipment including the washer disinfectors , boilers and autoclaves and construction of the clean room do not meet the standards required in HBN13 as well as compliance with MDD93/42/EEC. The faults are now occurring on a daily basis, is expensive to keep resolving and needs a system upgrade to resolve on a long term basis. If the current system cannot be rectified prior to an upgrade we would have to outsource sterilisation of theatre equipment with a cost, time and efficiency implication	20	Business Continuity Plans being followed to keep service running. This means that services are running from Wycombe Hospital. Business case for the rebuild approved by the Board July 2017 Confirmation of a third party support in the event of catastrophic failure at WGH with no CSSD service at SMH. MMM company awarded the work.	**16 (4x4)**	None	Work has comenced IT to formulate options for phone lines Once contract finalised – will take 33 weeks to build. Expected completion date TBC	4	Chief Operating Officer	31/11/2019	Quality and Safety
CRR 76 (IT045)	21.4.17	IT	As the use of technology increases within the Trust, there is a risk that the Servers that enable systems to run could fail unnecessarily due to lack of monitoring of key electronic processes. This is particularly important for solutions such as community mobile working and Evolve which are key solutions now in use within the Trust. The risk score will grow over time as more technology is used within the Trust.	15 (3x5)	Manual monitoring of servers in the interim which is very time-consuming and cannot accurately predict when servers will fail (in certain circumstances). Progress project to implement server monitoring. Care to be taken when monitoring lone-workers through the community mobile solution.	**9 (3x3)**	None at present	Bucks IT review includes assessment of infrastructure issues Cost estimates provided and to be build in to 18/19 capital plans. Other funding remains under consideration. Procure a server and infrastructure monitoring tool to help automate the processes for monitoring systems. A health check of server and network infrastructure has taken place in order to fully assess the risk and the actions required for mitigation. Data centre review outstanding and recommendation of Bucks IT review.	**6 (3x2)**	Director of Finance	31/03/2019	Improving Communication Value for Money Service Standards Quality
CRR 79 (RAD 19)	12.6.17	Specialist Services	Risk to continuity of service as the MRI scanner at Wycombe Hospital is no longer fit for purpose and is producing imaging that is of unacceptable quality in some areas. This means that some patients will not be possible to image some patient at Wycombe and they will be required to travel to SMH. This also has a negative effect on overall capacity and means that more patients will need to diverted to Care UK resulting in lost income.	20 (4x5)	Constant review of image quality. Patients redirected to SMH or outside providers as necessary. Business continuity plans in place based on individual clinician judgement and how long the scanner is likely to be down	**16 (4x4)**	Lack of capital funding for replacement	Funding agreement with Scanappeal 26/06/2018. Implementation plan being developed. Scanners were ordered at the end of October. However we are waiting on the time lines from Scannappeal to raise the money for WGH scanner, and we will work from this date to generate a start date for the project. Until we hear this, there will be no movement on this project, although we are working with both Canon and Scanappeal in the background for the fundraising. Estates surveys are being completed	4	Chief Operating Officer	31/10/2019	Quality & Safety
CRR 81 HAEM09/ CAN07	12.6.17	Specialist Services	Risk of financial sanctions due to delay in full implementation of an effective e-Prescribing system for chemotherapy . Sanction is 5% of the Actual Monthly Value for the Services provided under Service Specification B15/S/a (Cancer: Chemotherapy (Adult) per month (approx. £25000 per month) until full implementation is achieved)	16 (4x4)	Intrathecal chemotherapy to being retrospectively prescribe on ARIA by a Haematology consultant. Allows compliance with SACT data requirements as an interim measure New IT solution in place that includes the ability to transfer Urology prescribing data to Aria helping to meet SACT requirements. System in place from April 2018.	**8 (4x2)**	Process not yet fully embedded.	Training has been completed on the use of eprescribing for nursing and medical staff. Use needs to be embedded. Urology are working with IT on a solution to select to right patients for e-prescribing (any movement on this is this going to be completed by the end of September 2018) Deadline changed to end of October, but still waiting for Varian (ARIA) to make necessary changes to the program for Urology to begin prescribing.	4	Chief Operating Officer	30/3/2019 Extended from 30/11/2018	Financial Stability IT interoperability

Risk Tracking Reference	Date Added to Register	Division	Description of risk	Unmitigated Risk	Key controls	Risk Score (S x L)	Gaps in controls	Action plan to address risk including timescales for completion	Predicted residual score	Lead	Projected completion date.	Trust Objective
CRR 83	22/09/2017	Trust-wide	There is a risk that payroll processes are not sufficiently robust.	25 (5x5)	Quality assurance by Payroll department to reduce risk of errors. Trust process reminders sent out to all staff. Contractual review to determine legal options.	**15 (5x3)**	Additional payroll resource to be recruited.	Payroll transformation project under development to include process automation. Serious Incident investigation into 24 hour delay in paying staff in August 2018. This will result in learning and action.	5	Director of Finance	31/12/2018	Financial stability
CRR 85 (Paed 20)	20/10/2017	Trust-wide	We have a shortage of junior doctors in the organisation. The specialities most affected are the medical specialities and paediatrics. This has the potential to have a negative impact on patient care.	20	Existing staff asked if they would like to work extra shifts. Use of temporary staff where possible. This is usually through the bank and often doctors who know the organisation. The switch from agency to bank has created a more stable temporary workforce. Consultants acting down policy in place. Resident Medical Officer (RMO) service in place in National Spinal-cord Injuries Centre to offer additional cover. RMO post incorporated into night rota for acute surgery at Wycombe and Stoke Mandeville Hospitals. Revised middle grade rotas in order to make them more resilient. Controls around leave booking is held at local level. Review of staffing levels against new Royal College of Physicians guidance. medical rotas have been revised to increase cover to the out of hours teams. safe medical Staffing review of the acute medical rota at Stoke Mandeville identified a shortage of specilaist Registrar grade time in the week.	**15 (5x3)**	National shortage of doctors from key groups. Internal audit has identified the need for more central oversight of leave management. There are identified gaps in rotas in medicine.	Two new Paediatric Consultants in post, two being recruited to. Active recruitment to vacant posts happening continually. (Led by Associate Director of Workforce with responsibility for medical Human Resources.) Action plan to address findings of review against new Royal College of Physicians guidance. (Led by Deputy Medical Director. Goal to achieve changes by end of Q2 19/20.) Develop policy for leave management including central oversight. (Led by Associate Director of Workforce with responsibility for medical Human Resources. June 2019.) Move to electronic rostering system in medicine. (Led by Associate Director of Workforce with responsibility for medical Human Resources. June 2019.) Continued development of new roles to support medical rotas e.g. associate physicians, extended nurse practitioners. (Divisional Chair and Director, Integrated Medicine.)	5	Medical Director	30/09/2019	Attracting and retaining high calibre and engaged people
CRR 87	20/10/2017	Trust-wide	Some of our staff are at risk in relation to their personal safety because they work alone for much of the time. This includes community staff and some hospital staff who work unsocial hours or in locations away from main buildings.	20 (4X5)	RiO diaries to show where visits are planned Ipads so visits can be monitored during the day If RiO is down staff will follow business continuity plan. Buddy system phone in place Risk assessments for patients/ areas with known risks with specific actions, e.g. double handed visits, ringing in back to office Mobile phones and contact lists for colleagues Safe phrase Conflict resolution training Processes explained to staff as part of induction, Staff are empowered to risk assess on each visit and to leave if they feel they should Monitoring DATIX incidents and working in collaboration with safeguarding.	**16 (4x4)**	Poor assurance that controls are being followed. Not all staff use RIO so the local procedures need to be very clear and managed thoroughly. The staff use "diaries" and move meetings regularly. The Management of visits is sporadic and a central control system needs to be implemented. We do not know where staff are as they are not tracked by GPS or other means. The contact of staff is not centrally managed with check calls.	Introduction of lone working devices for identified staff ordered All staff to have access to GPS function through IT for IPADs Reinforce use of buddy system and responsibilities of buddy pairs Explore practicalities of using Alert on RiO and Total Mobile and explore how best to communicate between teams Reinforce to staff to notify number changes Timely divisional sign off required Reinforce to staff to call 999 if required even if no reception it is still possible. Share safe phrase with teams, share escalation procedures with teams, Use of 999 and 55 if indicated; update escalation chart Request more sessions so the Trust can put on more sessions; empower staff to make attendance a priority Standardised induction pack Reinforce employees responsibilities for their own health and safety Continue to support as managers Plan for allocate roster system to be enabled to track staff visits effectively.	**8**	Director of Finance	31/12/2018: extended 30/06/19	Safety of staff in operational clinical environments being managed and controlled safely.

Risk Tracking Reference	Date Added to Register	Division	Description of risk	Unmitigated Risk	Key controls	Risk Score (S x L)	Gaps in controls	Action plan to address risk including timescales for completion	Predicted residual score	Lead	Projected completion date.	Trust Objective
CRR 88 (S220, IM138 and IM 139)	19/02/2018	Organisation wide	There is a risk that harm can come to patients if they are not tracked robustly and given appointments in a timely fashion. This includes: -Monitoring of hospital initiated cancellations -Tracking follow up appointments -oversight of patients put 'on hold' - incomplete clinic outcome forms This has become increasingly visible through new reporting via Medway	25 (5X5)	On hold' project and data validation exercise ongoing Tracking of data at consultant level Availability of a follow up patient tracking list Ability to be able to track non compliance with agreed standard operating procedures Outpatient capacity Weekly Access and Performance Management Group Outpatient modernisation project Secretaries review all 'On Hold' entries when typing up patient letters. E-referral programme -elimination of paper in outpatients by October 18	**20 (5X4)**	Availability of a follow up patient tracking list Ability to be able to track non compliance with agreed standard operating procedures Outpatient capacity	Validation of outpatient records in an 'on hold' state Expected completion date July 2019 All 2015 patients have been reviewed and removed from their On Hold state if safe to do so. Review of 2016 Patients in progress. Redesign the booking processes e.g. not leaving patients 'on hold' once they have been added to a waiting list to limit the number of surgical patients on hold. All clinicians to be written to by the Medical Director around the importance of eCO form completion Agree filters to be applied to historic entries with System C involvement. this has been completed ans rolled out Funding agreed and equipment purchased for SMH. Estates are iniating set up.	**10**	Chief Operating Officer	31/03/2020	Patient safety and re-education of harm
CRR 91 (RAD24)	23/03/2018	Specialist Services	We are currently experiencing reliability issues with the 3 Dental X-Ray units across BHT. All 3 units are over 20 years old and are failing on a regular basis and this is affecting the dental clinics and patients and resulting in delays. Sourcing parts for these units is difficult due to their age and they are all obsolete.	20 (4x5)	If X-ray down, extra appointment made for patients at another site of another day Business case to replace the three units has been written.	**16 (4x4)**	Poor patient experience. Extra clinic appointments. If units fail completely patients will need to be sent to as yet unidentified private providers at high cost to the Trust.	Ammersham Dental unit is now in service SMH dental unit - issue with instalation currently being reviewed by DD and Estates.	**8**	Chief Operating Officer	31/10/2020	Improving quality
CRR 94 (CYP 30)	04/05/18	Children and Young People	Attendance at Child Protection case conferences is increasing beyond capacity for School Nurse team.	20 (4x5)	Monitored and managed through the Service Delivery Unit business and governance meeting, contract monitoring meetings, and audits. HAPI portal enables health assessments to be completed and then triaged online, provides early warning alerts to potential issues so services can be targeted to need.	**16 (4x4)**	Lack of capacity to deliver HCP and reduced delivery of screening services.	`	12	Chief Operating Officer	31/03/2019	Reduce Risk
CRR 95 (IM137)	04/05/2018	Endoscopy	Waiting room at Wycombe Endoscopy Unit too small therefore not fit for purpose, Low Pendulum in room 2 and restricted imaging capacity. This is linked to JAG accreditation that is due for renewal July 2019.	20	Currently managing on a day to day basis to keep patient experience at the best possible level given the space issue.	**12 (4x3)**	Lack of suitable alternative space, unable to transfer work to alternative site. If this cannot be resolved there is a possibility that JAG will not be achieved in 2019.	Recognition that new Endoscopy unit required, business case developed, strategy to be revisited for a final solution.	0	Chief Operating Officer	30/08/2019	To excel in the delivery of clinical care, safety and patient experience To be a highly effective, sustainable Foundation Trust through maximising efficiency, productivity and cost effectiveness

Risk Tracking Reference	Date Added to Register	Division	Description of risk	Unmitigated Risk	Key controls	Risk Score (S x L)	Gaps in controls	Action plan to address risk including timescales for completion	Predicted residual score	Lead	Projected completion date.	Trust Objective
CRR 98	31/07/2018		Gaps in assurance of compliance with NHS Patient Safety Alert D 2017 006 - Cannula flushing	20	Comprehensive plan in place to assure compliance with Patient Safety Alert.	**15 (5x3)**	Not yet able to demonstrate compliance in all areas.	Endoscopy -The department are rewriting their procedure work book at present and adding the required elements to ensure compliance. Stickers to be provided to the department to add to current booklet in January 2019. Paediatrics – rewording / adaption to current paperwork. A&E – Adaptions being made to current booklet. Stickers to be provided to the department to add to current booklet in the meantime. Theatres to re-instate posters in recovery area.	**5**	Chief Nurse	31/03/2019	Quality and Safety
CRR 99	07/09/2018	Estates	Risk of non compliance with HTM (engineering) requirements in retained estate. HTM covers a range of safety matters including water management, Asbestos management, electricity management, and air flow in clinical areas including theatres. This has been declared a Serious Incident.	25	Review of HTM compliance by external expert in August/September 2018. Any areas where there is weak assurance of compliance have been acted on. Weekly monitoring by the Executive Management Committee. Monthly review by the Finance and Business Performance Committee.	**15 (5x3)**	Assurance processes have not been sufficiently systematic.	Risk based approach to confirming compliance and acting on any identified gaps. Serious Incident investigation exploring compliance, governance processes and culture in the estates department. This will result in recommendations and actions. Due to be completed in October 2018. Capsticks investigation still ongoing. Premises Assurance Model is in the process of being populated which will provide a systematic and rigorous approach to compliance and the monitoring of compliance.	**5**	Commercial Director	31/03/2019 Extended from 30/11/2018	Safety
CRR 100	07/09/2018	Trust wide	There is a risk that Brexit could have an adverse impact on workforce supply and procurement of essential clinical supplies.	20	Monitoring of leavers from EU Communication with EU nursing staff	**15 (5x3)**	There is a high level of uncertainty about the impact of Brexit.	Attention to communication from the Department of Health and Social Care and any resulting action. HRBP lead allocated Action plan drawn up Trust to pay for EU Staff settled status application Capstick workshops for EU staff - 17 Dec Drop in clinics planned for early 2019	**5**	Director of workforce & OD	31/10/2019	Quality and Safety
CRR 102 (CYP 36)	26-Oct-18	Children and Young People	Staffing issues in the School Nurse service, which will affect being able to deliver the core service.	20	The contract with commissioners has been amended so year 9 HAPI will not be delivered. Dec 18 JC and AW met with Commissioners to agree focus of work will be safeguarding and to be reviewed in Mar 19. School nurse referal process has been amended regarding attendance at child protection case conferences. Enuresis service provision is being reviewed to ensure an equitable service according to capacity. Workshops for Staff groups completed. project manager JM in post and monthly project Board meetings with Commisioners taking place School Nurse referral process has been amended regarding	**16 (4x4)**	Potential not to deliver to contract.	Chalfonts and Amersham teams to merge. New safeguarding refferral process since Sept 2018. Project Manager in post since january 2019 to redesign service. Buckingham and Aylesbury teams to merge. Posts for school nurses out to advert. Teacher training is being reviewed so that this can be offered quarterly in partnership with Buckinghamshire County Council. JC meeting bi-monthly with SN team leads.	**8**	Chief Nurse	JC to review at Project b	Safe staffing. High quality care.
CRR 103 (S232)	26-Oct-18	Urology	There is a risk to patient outcomes if we do not deliver the national 62 day cancer standard for urology.	20	Cancer tracking co-ordinator appointed for urology. Daily safety huddles for cancer focused on two week wait for urology. Working with NHS Improvement to identify improvement actions.	**16 (4x4)**	It is difficult to determine 62 day performance by sub-speciality.	Action plan for prostate cancer has been developed following review by NHS Improvement in July 2018. Completed by end of January 2019. Working with the Thames Valley Cancer Alliance to ensure compliance across the network Recruiting a Oncology Consultant Demand and capacity work continuing until July 2019 Escalation x2 weekly on 10 day prebreach to CD and DD's 62 Day Cancer Target acheived in May	**8**	Chief Operating Officer	31/03/2020	High quality care
CRR 104	21/12/2018	Trust-wide	There is a risk of healthcare associated infection rates rising if clinical environments are not cleaned effectively.	20	Contract with Private Finance Initiative Partners for cleaning of PFI areas. Cleaning of retained estate is managed through property services. Joint cleaning audits carried out on a monthly basis for defined high risk areas. 'Back to the Tools' audits carried out Cleaning supervisors in place. Automated cleaning (enhanced cleaning) thas taken placeat front door	**10 (5x2)**	The way the contract is written does not enable us to enforce the 'output' elements required. As at December 2018 there is inconsistency in audit results, but with no specific trend.	Confirm calibre and training of cleaning supervisors. (Matron for Infection Prevention and Control. 31 March 2019). Audit results to be presented to monthly stakeholder cleaning meetings chaired by Director of Infection Prevention and Control with a view to specific actions being taken in response to findings. (Commencing January 2019) Make the case for increasing the enhanced cleaning programme in 19/20. (Medical Director. 31 March 2019). Commercial Director and Chief Executive liaising with PFI Partner Executive team.	**5**	Medical Director / Director of Infection Prevention and Control	31/07/2019	Enhance our culture of safety.

Agenda item: 17
Enclosure no: TB2019/60

Safe & compassionate care, every time

Buckinghamshire Healthcare NHS
NHS Trust

PUBLIC BOARD MEETING
29th May 2019

Details of the Paper

	Buckinghamshire, Oxfordshire and Berkshire West STP/ICS Governance Arrangements
Responsible Director	David Williams, Director of Strategy
Purpose of the paper	To highlight governance structure and workstreams, including setting out accountabilities, roles and responsibilities for the BOB STP.
Action / decision required (e.g., approve, support, endorse)	Support

IMPLICATIONS AND ISSUES TO WHICH THE PAPER RELATES (PLEASE MARK IN BOLD)					
Patient Quality	*Financial Performance*	*Operational Performance*	***Strategy***	*Workforce performance*	*New or elevated risk*
Legal	*Regulatory/ Compliance*	*Public Engagement /Reputation*	*Equality & Diversity*	***Partnership Working***	*Information Technology / Property Services*

ANNUAL OBJECTIVE	
Which Strategic Objective/s does this paper link to? All	
Please summarise the potential benefit or value arising from this paper: The paper outlines the priorities and workstreams associated with the work of the Trust within the BOB STP. It ensures workstreams are only created for priorities where the STP has a delivery or oversight role.	
RISK	
Are there any specific risks associated with this paper? If so, please summarise here.	*Non-Financial Risk*:
	Financial Risk:
LINK TO CARE QUALITY COMMISSION ESSENTIAL STANDARDS OF SAFETY AND QUALITY	
Which CQC standard/s does this paper relate to?	Well -Led *(if you need advice on completing this box please contact the Director for Governance)*

Author of paper: BOB STP
Presenter of Paper: David Williams
Other committees / groups where this paper / item has been considered: **EMC**

Agenda item: 17
Enclosure no: TB2019/60

Date of Paper: 22nd May 2019

Governance arrangements

Buckinghamshire, Oxfordshire, Berkshire West STP/ICS
April 2019

pwc

Overview

We have been working with the STP/ICS central team to streamline and refine the governance structure and workstreams, including setting out accountabilities and roles and responsibilities.

Approach

Buckinghamshire, Oxfordshire and Berkshire West (BOB) STP/ICS's draft governance infrastructure and priorities were agreed at the Chief Executives' Group (CEG) meeting on the 3 April 2019, subject to more detailed work.

We undertook work to further define the purpose of proposed workstreams and refine the governance structure further, particularly in terms of defining accountabilities, and roles and responsibilities.

We conducted our work through a range of interviews, document reviews and comparisons to good practice in other STPs.

Contents

1

Priorities and workstreams

Priorities and workstreams

We have streamlined the workstreams to ensure they focus on delivery of transformation at STP-level.

To support strategic delivery, we identified a need to streamline existing priorities and ensure workstreams are only created for priorities where the STP has a delivery or oversight role.

As such, we have identified 9 STP-level workstreams. These are:

1. Strategic planning, resource allocation and system design
2. Acute collaboration on planned care
3. Workforce
4. Capital & Estates
5. Primary Care (including PCNs and Personalised Care)
6. Mental health
7. UEC
8. Cancer
9. Maternity

Where the priority falls into the fourth category, i.e promoting collaboration and learning, we have proposed that separate workstreams are not required.

Instead, locality MDs should attend the Delivery Oversight Group to share learning on priorities being delivered at place-level.

Where necessary, the STP/ICS should facilitate learning sets. These priorities will include Children and Young People, Population Health and Digital.

Recommendations:

1. Workstreams should only be created where the STP has a delivery or significant oversight role

2. All workstreams will be accountable to the Chief Executives' Group via the Chief Executive Sponsor.

3. The Delivery Oversight Group will provide assurance on performance of workstreams

Proposed STP/ICS level workstreams

STP role	Description	Clarification and rationale
System design & delivery	Design approach to a problem at STP level. Deliver solution at STP level	Acute collaboration; Strategic planning, resource allocation & system design
System design & place/org delivery	Design approach to a problem at STP level but leave places/ organisations to deliver	Workforce; Capital & estates
Set or confirm ambition and hold to account	Agree STP ambition (or confirm STP signs up to nationally set ambition) and hold places to account for/support delivery	Primary care, inc. PCNs; Mental health; UEC; Cancer Alliance for BOB catchment area; Maternity

STP/ICS oversight running through all strategic priorities
Partnerships & Engagement, including patient and public involvement

Overview of priorities (1/3)

STP role	Priorities	Purpose/remit
Design approach to a problem at STP level. Deliver solution at STP level	**Strategic planning, resource allocation and system design**	• This workstream will have responsibility for the overall delivery of the BOB strategy, delivering the roadmap to ICS, understanding the long-term consequences for service reconfiguration, and supporting cross-border working with Milton Keynes and Frimley. • It will be attended by the Directors of Strategy across the BOB footprint. • The workstream will report into the Delivery Oversight Group.
	Acute collaboration	• The purpose of this workstream is to reconfigure services to match elective capacity with demand. • In addition, the workstream will focus on procurement, pathology, pharmacy and sterilisation. As such the scope is wider than just Acute collaboration and the workstream should be renamed Provider Collaboration. • The workstream will report into the Delivery Oversight Group.
	Population and economic growth	• This priority should be a main function of the STP and does not currently require a separate workstream. • Its remit includes strategic horizon-scanning to determine external factors that will influence the planning and delivery of care for the STP. Currently these include the planned expansion at Heathrow, the development of the East West Rail and proposals for the development of housing along the East West corridor. • The priority should be linked to the roles of the Independent Chair and STP/ICS Lead, working with local authorities.
Design approach to a problem at STP level but leave places/ organisations to deliver	**Workforce**	• The work programme for this priority is administered through the Local Workforce Action Group (LWAB), coordinated by HEE. • At system level, the LWAB will support the development of the support workforce, improve recruitment and retention, and deliver the workforce elements of the future STP strategy. • The workstream will oversee the development of three local workforce coordinating groups. • The workstream will report into the Delivery Oversight Group.
	Capital and Estates	• The workstream is responsible for managing the delivery of the commitment on disposals and capital bids. • The group should also be responsible for the primary care estates, linking into the Primary Care Board. • The workstream will report into the Delivery Oversight Group.

Overview of priorities (2/3)

STP role	Workstream	Purpose/remit
Agree STP ambition (or confirm STP signs up to nationally set ambition) and hold places to account for/support delivery	**Primary Care including PCNs**	• The Primary Care Programme Board will provide support to the CCGs to implement the agreed primary care strategy and each CCGs' local implementation plan, as well as run STP-wide work programmes. • It will provide oversight for the development of Primary Care Networks • The proposed ToR includes the remit for workforce and estates. This duplicates the remit of the Workforce and Capital & Estates workstream – further work is required to align these, • The workstream will report into the Delivery Oversight Group, and also have lines running to the CCGs.
	Financial balance and efficiency	• This priority forms part of the remit of the Financial Oversight Group, and a separate workstream is not required. See Financial Oversight Group Terms of Reference.
	Mental Health	• Following on from the NHS Long Term Plan, Mental Health has been identified as a priority for the STP. • The STP will provide oversight for place-based delivery, share good practice and learning across the footprint and support the unblocking of challenges to the delivery of mental health improvement. • The workstream will report into the Delivery Oversight Group.
	UEC	• The UEC workstream brings together the three A&E delivery boards to provide oversight and ensure consistency across place. • It will deliver a number of priorities at scale including the roll out of 111. • The workstream will also respond to regional opportunities that require an STP response • The workstream will report into the Delivery Oversight Group.
	Maternity	• Local Maternity System (LMS) set up aligned to the STP footprint as part of the Maternity Transformation Programme • Three locality-level maternity steering groups which are responsible for delivery • There is currently a disconnect between the Maternity workstream and the wider STP leadership. This is because the LMS is directly accountable to NHS England, with separate funding streams. As such, there is a risk that learning and collaboration opportunities may be lost. • The workstream will report into the Delivery Oversight Group, as well as NHS England.
	Cancer Alliance for BOB catchment area	• Workstream runs under a national mandate as part of the Thames Valley Cancer Alliance. Its remit includes planning and leading the local delivery of the national cancer strategy; and overseeing, coordinating and monitoring progress of both the Thames Valley and its constituent CCGs' place-based plans based on agreed metrics and performance indicators. • The workstream will report into the Delivery Oversight Group and the National Cancer Programme Commissioning, Provision and Accountability Oversight Group.

Overview of priorities (3/3)

STP role	Priority	Purpose/remit
Coordinate, share good practice, encourage collaboration	**Research and Innovation**	• This priority should be incorporated as part of the Terms of Reference of individual workstreams rather an as a separate workstream. • Oxford AHSN should provide support to workstreams to ensure they go through a process of identifying relevant research and innovation in the scoping and running of their programmes.
	Children and Young People	• This priority will be delivered at place and a workstream is not currently required at STP level. • Where appropriate, locality MDs to provide updates to the Delivery Oversight Group to share learning and encourage collaboration.
	Personalised Care	• This priority should be delivered as part of the remit of the Primary Care workstream, rather than a stand-alone workstream. • The majority of delivery will happen at place, but the Primary Care workstream has a role in providing oversight. • It may make sense to deliver a number of priorities at STP-level, for example, personalised care for patients with diabetes. • It will include working closely with clinical networks and PCNs.
	Digital	• This priority will be delivered at place-level and a workstream is not currently required at STP level. • Where appropriate, locality MDs to provide updates to the Delivery Oversight Group to share learning.
	Preventing and reducing inequalities	• This priority requires localities to come together to share learning rather than drive delivery. As such we propose that this does not become a workstream but a learning set is held quarterly. • Oversight should be carried out as part of the Primary Care workstream.
	Population health	• This priority will be delivered at place-level and a workstream is not currently required at STP level. • Where appropriate, locality MDs to provide updates to the Delivery Oversight Group to share learning.

2

Groups and sub-committees

Delivery Oversight Group

Purpose	The group's purpose is to: • Providing oversight to constitutional and mandated requirements; • Provide assurance and support to workstreams and place-based delivery; and • Promoting learning, sharing good practice and collaboration
Remit	• Providing assurance, strategic challenge and support to workstream and place-based delivery; • Managing interdependencies, reduce the risk of duplication and encouraging collaboration, through providing a forum for sharing of information across workstreams; • To act as an escalation point for resolution of any workstream issues unable to be resolved through local place-based systems; • Ensuring risks and issues associated with the delivery of the workstream programmes are being identified, assessed and managed, and that strategic risks and issues are escalated to the Chief Executives' Group; • Developing an assurance framework to support oversight by the Chief Executives' Group; • Encouraging learning, sharing good practice and collaboration.
Membership	• The group comprises of the STP Lead, the workstream SROs, the STP Finance Lead, a senior representative from the AHSN, the 2 ICP MDs and a Director of Strategy. The meeting will quorate when 50% of members are present. • It is expected that members will prioritise these meeting and make themselves available. Where this is not possible a Deputy may attend, with sufficient seniority for delegated authority to make decisions on behalf of their organisation/Place. • The Chair of the group is the STP Lead. • The minutes of meetings will normally be taken by a member of the STP Programme Team.

Finance Oversight Group

Purpose	The group's purpose is to provide financial leadership and financial assistance in supporting BOB STP to develop and deliver a five year STP plan aimed to improve health and care outcomes for the population of BOB through the best utilisation of system resources.
Remit	• Providing collective financial leadership across BOB STP. • Developing and managing a shared system control total, including identifying system risks and opportunities. • Providing challenge and support to organisations/places in delivering efficiencies, including, where appropriate, through use of benchmarking and setting targets. • Providing appropriate scrutiny of the underlying financial assumptions for funding bids. • Ensuring financial risks associated with the delivery of the workstream programmes are being identified, assessed and managed, and that strategic risks and issues are escalated to the Chief Executive's Group; • To monitor the delivery of any agreed centrally funded capital.
Membership	• The group comprises of the Finance Lead for each Place, or where there is no Finance Lead at Place level – the Directors of Finance in Place. The meeting will quorate when 50% of members are present. • It is expected that members will prioritise these meeting and make themselves available. Where this is not possible a Deputy may attend, with sufficient seniority for delegated authority to make decisions on behalf of their organisation/Place. • The Chair of the group is the STP Finance Lead. • The minutes of meetings will normally be taken by a member of the STP Programme Team.

Chief Executives' Group

Purpose	The STP Chief Executive Group is the Chief Executives' strategic leadership group that sets the direction and articulates a clear vision for heath and care systems across Buckinghamshire, Oxfordshire and Berkshire West (BOB).
Remit	• Agree a vision for health and social care across BOB • To generate effective partnership working and a sense of common purpose between the system partners • To promote the STP through effective communications and engagement with internal and external stakeholders • To hold the workstreams to account for the delivery of the plans via the Delivery Oversight Group, review and monitor progress against the STP objectives and outcomes, challenge each other to put system before organisation, ensure services are of a similar high standard across the area, and share best practice across the BOB STP. • To act as an escalation point for resolution of any issues unable to be resolved through local place-based systems or the Delivery Oversight Group • Work together to provide assurance to NHSE/ NHSI in relation to the delivery of the plan • Commit financial and human resources to implement the plan • To provide oversight and assurance of the budget and funding for the STP
Membership	• The group comprises of the STP/ICS Lead, Accountable Officers of local CCGs (2), Chief Executives of local NHS Provider organisations, including SCAS (6), Chief Executive representation from Local Authorities (3) and Chief Executive Officer, Oxford Academic Health Science Network and a clinical representative from each place (acute (1), primary care (1) and community/mental health (1)) • The Group will have a rotating Chair. Chairing arrangements will be reviewed every 6 months. • A Vice-Chair will be identified as needed.

Recommendations

1	NHS England/Improvement will be invited to attend the Financial Oversight Group or the Chief Executives' Group as appropriate when there is a relevant agenda item.
2	The Delivery Oversight Group will be attended by STP Lead, the workstream SROs, the STP Finance Lead, a senior representative from the AHSN, the 2 ICP MDs and a Director of Strategy.
3	The Financial Oversight Group will be attended by the Finance Lead for each Place, or where there is no Finance Lead at Place level, the Directors of Finance in Place.
4	There will be clinical leadership at the Chief Executive Group through the three place-level clinical leads. There will be a representative for acutes, primary care and community/mental health.
5	Responsibilities for signing off revenue and capital bids to be agreed, as part of the development of a MoU.

3

Roles and responsibilities

Roles and Responsibilities

Role	Responsibilities
Independent Chair	An external part-time independent Chair will provide leadership and high-level constructive challenge to the STP/ICS leaders. The Independent Chair will take a lead role in shaping the long term requirements of a Partnership Board. They will work with the STP/ICS Lead to engage key stakeholders across and outside the STP, including, for example, politicians and the media. The Chair will chair the Chairs' Group.
STP/ICS Lead	The STP/ICS lead is a strategic leader, responsible for driving STP business, being a key link into the regulators through sitting on the NHSI/E Regional Director's management board. They will be responsible for signing off STP/ICS deliverables and assuring through the Chief Executives' Group, the Delivery Oversight Group and the Financial Oversight Group that plans are being delivered and STP funding spent as planned/required. The lead will chair the Delivery Oversight Group and attend the Chief Executives' Group. Where the STP Lead is also a Chief Executive sponsor, they will be accountable to the Chief Executives' Group via the Delivery Oversight Group.
Chief Executive Sponsor	Each workstream will have a Chief Executive Sponsor who will be accountable for and provide strategic direction to the workstreams, including: • Agreeing workstream priorities and objectives; • Signing off agendas for workstream meetings; • Raising the profile of the work programme across the STP; • Being the point person for risk escalation to the Chief Executives' Group. • Reporting back and providing the link into the Chief Executives' Group. The Chief Executive sponsor is accountable to the Chief Executive Group. Responsibilities for signing off revenue and capital bids to be determined as part of the development of an MoU.
Senior Responsible Officer (SRO)	Each workstream will have an Executive Senior Responsible Officer (SRO) responsible for the delivery of that workstream and its use of resources. The SRO will provide assurance that the workstream is delivering in line with plan. The SRO will attend the Delivery Oversight Group to ensure any risks and issues are appropriately managed. All workstreams will need to appoint an SRO going forward.
STP/ICS Programme Team	The STP/ICS will be supported through the STP/ICS Programme Team who will act as a single PMO across the system. The PMO will be overseen by the STP Lead. It will support the Chief Executives' Group and will drive delivery of the work across the workstreams. It will also ensure that all necessary data and information sharing arrangements are put in place. The team will be comprised of: • The STP Lead • STP Finance Director (x2 a week) • Financial Planner • Programme Director • PMO

STP collaboration should be supported through a Memorandum of Understanding

We identified a need for a refreshed Memorandum of Understanding between ICS/STP partners setting out key principles for decision-making at STP level.

These may include:

- The Chief Executives' Group will have delegated authority to take decisions on the programme of work in terms of the structure, priorities and processes of that work programme [within the authority delegated to officers who are members of the Board].
- The Chief Executives' Group has the delegated authority to take decisions about the use of resources that have been identified as being at its disposal
- The Chief Executives' Group may not take any formal decisions about any matter that is a statutory requirement for an organisation.
- Decisions made by the Chief Executives' Group will seek to benefit all parties, where possible.

Memorandum of Understanding – key elements

- A clear, cohesive vision for the future setting out key aspirations.
- Key principles for collaborative working with respect to:
  - System leadership;
  - System finances; and
  - Information sharing.
- Values, behaviours and ways of working
- Principles for decision making, including delegations from statutory organisations and responsibilities for signing off revenue and capital bids.
- Commitment of all partners to resourcing
- Governance arrangements
- Roles and responsibilities including the role of the STP Lead and the relationship to the CE sponsors
- An escalation process for disputes
- Key stakeholders

4

Next steps

Next steps

1	Agreeing the governance structure and the functions of the workstreams
2	Developing an overarching Memorandum of Understanding
3	Develop and agree resourcing strategy for the Programme Team
4	Following the appointment of the Independent Chair, finalising the governance and the function of the Partnership Board.

Appendix

Delivery Oversight Group – Terms of Reference (1/2)

These terms of reference set out the membership, remit responsibilities and reporting arrangements of the Delivery Oversight Group for Buckinghamshire, Oxfordshire and Berkshire West (BOB).	
Purpose	The group's purpose is to: • Providing oversight to constitutional and mandated requirements; • Provide assurance to the Chief Executive Group and support to workstreams and place-based delivery; and • Ensure continuous improvement through interrogation, sharing of learning, innovation and good practice, and promotion of improvement approaches.
Remit and responsibilities	• Providing assurance, strategic challenge and support to workstream and place-based delivery; • Managing interdependencies, reduce the risk of duplication and encouraging collaboration, through providing a forum for sharing of information across workstreams; • To act as an escalation point for resolution of any issues unable to be resolved through local place-based systems; • Ensuring risks and issues associated with the delivery of the workstream programmes are being identified, assessed and managed, and that strategic risks and issues are escalated to the Chief Executives' Group; • Developing an assurance framework to support oversight by the Chief Executives' Group; • Encouraging continuous improvement across workstreams and place through partnership with the AHSN to promote the use of improvement approaches.
Membership	• The group comprises of the STP Lead, the workstream SROs, the STP Finance Lead, a senior representative from the AHSN, the 2 ICP MDs and a Director of Strategy. The meeting will quorate when 50% of members are present. • It is expected that members will prioritise these meeting and make themselves available. Where this is not possible a Deputy may attend, with sufficient seniority for delegated authority to make decisions on behalf of their organisation/Place. • The Chair of the group is the STP Lead. • The minutes of meetings will normally be taken by a member of the STP Programme Team.

Delivery Oversight Group – Terms of Reference (2/2)

Attendance	• Other colleagues and/or NHSI/E will be invited to attend where appropriate and with their agreement. • Guest speakers will be invited when specific challenges or items of interest are being discussed.
Frequency of meetings	• The Group will meet formally on a monthly basis. The chair may call additional meetings as necessary. • Meetings are to be interactive and last no longer than two hours.
Authority, accountability and decision-making	• The group will have a degree of delegated authority from the Chief Executives' Group to make decisions on behalf of the STP, where appropriate. • The Delivery Oversight Group will make recommendations on strategic issues for the Chief Executives' Group. • The group will seek to make decisions by consensus. • All decisions that have a direct financial and/or strategic impact on an organisation will require the support of that organisation. • All other decisions will be taken on the basis of a majority view. • Where there are disputes, these will be resolved through the escalation process set out in the Memorandum of Understanding.
Reporting	• The group will report to the Chief Executive's Group through the STP Lead, and provide a monthly updates on risks and issues (supported by a dashboard). • Quarterly, the Delivery Oversight Group Chair will produce a formal report with a summary of activities and decisions made. The report will be presented to the CEG by the Chair.
Ground rules	• Requests for Agenda items should be sent to the Chair a minimum of two weeks in advance. The Chair will decide when and if items can be added.
Confidentiality	• Documents circulated by the Group, and the notes from meetings, can be shared within the system and partner organisations unless expressly stated as confidential or in draft form.
Review date	• Membership and chairing arrangements will be reviewed every six months. • At the end of each meeting, the Chair will review of the effectiveness of the meeting.

Finance Oversight Group – Terms of Reference (1/2)

These terms of reference set out the membership, remit responsibilities and reporting arrangements of the Finance Oversight Group for Buckinghamshire, Oxfordshire and Berkshire West (BOB).	
Purpose	The group's purpose is to provide financial leadership and financial assistance in supporting BOB STP to develop and deliver a five year STP plan aimed to improve health and care outcomes for the population of BOB through the best utilisation of system resources.
Remit and responsibilities	• Providing collective financial leadership across BOB STP. • Developing and managing a shared system control total, including identifying system risks and opportunities. • Providing assurance to the Chief Executives' Group, and challenge and support to organisations/places in delivering efficiencies, including, where appropriate, through use of benchmarking and setting targets. • Providing appropriate scrutiny of the underlying financial assumptions for funding bids. • Ensuring financial risks associated with the delivery of the workstream programmes are being identified, assessed and managed, and that strategic risks and issues are escalated to the Chief Executive's Group; • Monitoring the delivery of any agreed centrally funded capital. • Link into the Delivery Oversight Group through the STP Finance Lead to provide scrutiny of workstreams from a financial perspective.
Membership	• The group comprises of the Finance Lead for each Place, or where there is no Finance Lead at Place level – the Directors of Finance in Place. The meeting will be quorate when 50% of members are present. • It is expected that members will prioritise these meeting and make themselves available. Where this is not possible a Deputy may attend, with sufficient seniority for delegated authority to make decisions on behalf of their organisation/Place. • The Chair of the group is STP Finance Lead. • The minutes of meetings will normally be taken by a member of the STP Programme Team.
Attendance	• Other colleagues will be invited to attend where appropriate and with their agreement. • Representatives from NHS England/Improvement may be invited as appropriate. • Guest speakers will be invited when specific challenges or items of interest are being discussed.

Finance Oversight Group – Terms of Reference (2/2)

Frequency of meetings	• The Group will meet formally once a month. The chair may call additional meetings as necessary. • Meetings are to be interactive and last no longer than two hours.
Authority, accountability and decision-making	• The group will have a degree of delegated authority from the Chief Executive's Group to make decisions on behalf of the STP (e.g. as part of the planning exercise). • Strategic decisions (e.g. proposed changes to the control total) will be recommended to the Chief Executive Group for approval. • The group will seek to make decisions by consensus. • All decisions that have a direct financial and/or strategic impact on an organisation will require the support of that organisation. • All other decisions will be taken on the basis of a majority view.
Reporting	• The group will report to the Chief Executive's Group through the STP Finance Lead. • The STP Finance Lead will attend the Delivery Oversight Group to ensure that there is adequate scrutiny and oversight of workstreams from a finance perspective. • The group will also have connections to all workstreams to provide support or advice on finances, and especially Capital & Estates and Digital.
Ground rules	• Requests for Agenda items should be sent to the Chair a minimum of two weeks in advance. The Chair will decide when and if items can be added, depending on previous commitments and time restraints.
Confidentiality	Documents circulated by the Group, and the notes from meetings, can be shared within the system and partner organisations unless expressly stated as confidential or in draft form.
Review date	Membership and chairing arrangements will be reviewed every six months.

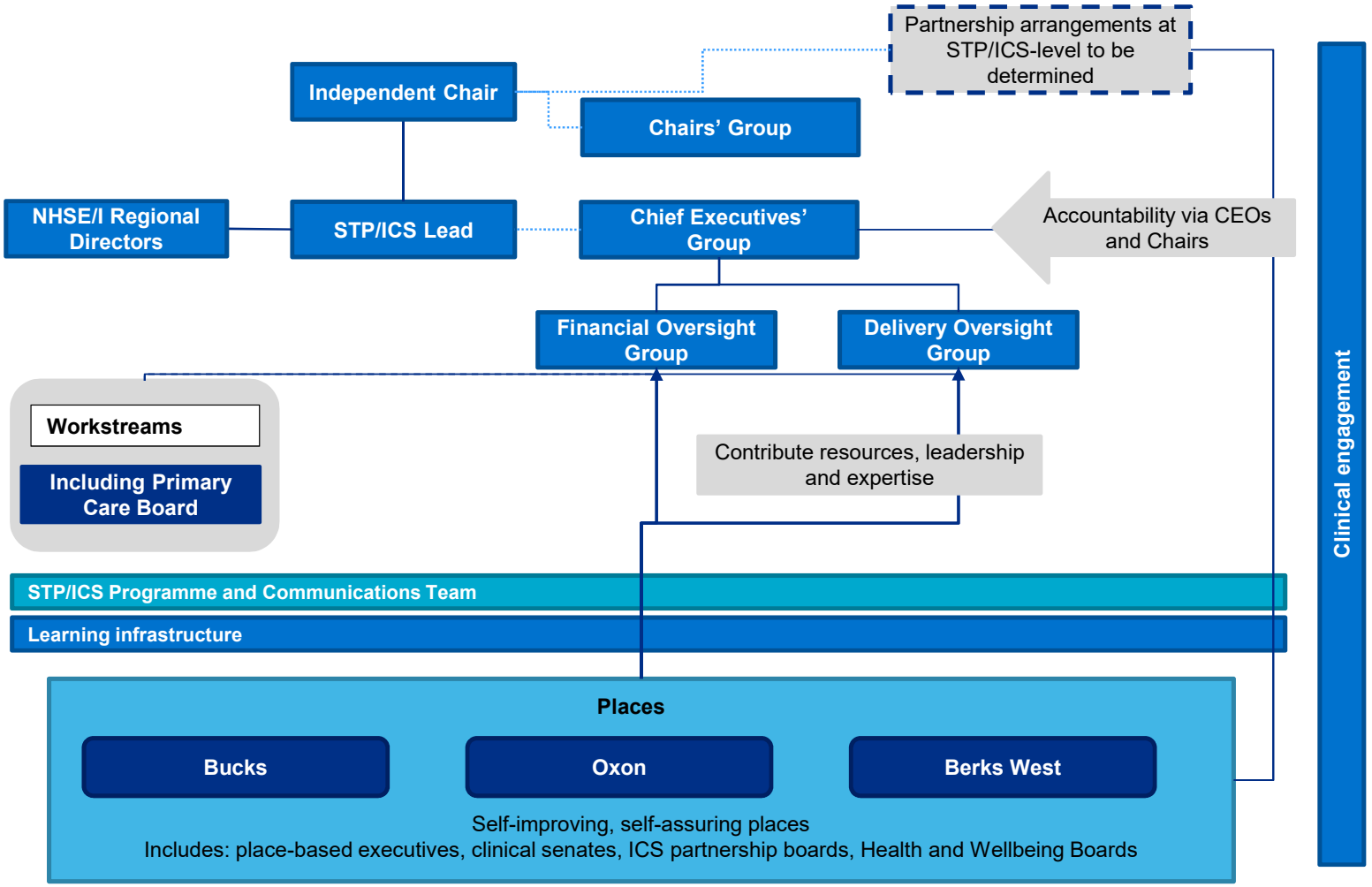
Chief Executives' Group – Terms of Reference (1/2)

These terms of reference set out the membership, remit responsibilities and reporting arrangements of the Chief Executives' Group (CEG).	
Purpose	The STP Chief Executive Group is the Chief Executives' strategic leadership group that sets the direction and articulates a clear vision for heath and care systems across Buckinghamshire, Oxfordshire and Berkshire West (BOB).
Remit and responsibilities	• Agree a vision for health and social care across BOB • To generate effective partnership working and a sense of common purpose between the system partners • To promote the STP through effective communications and engagement with internal and external stakeholders • They will hold the workstreams to account for the delivery of the plans, review and monitor progress against the STP objectives and outcomes, challenge each other to put system before organisation for the benefit of our population, ensure services are of a similar high standard across the area, and share best practice across the BOB STP. • To act as an escalation point for resolution of any issues unable to be resolved through local place-based systems or the Delivery Oversight Group • Work together to provide assurance to NHSE/ NHSI in relation to the delivery of the plan, supported by the Delivery Oversight Group and the Financial Oversight Group. • Commit financial and human resources to implement the plan • To provide oversight and assurance of the budget and funding for the STP through the powers delegated to the Delivery Oversight Group and the Financial Oversight Group.
Membership	• The group comprises of the STP/ICS Lead, Accountable Officers of local CCGs (2), Chief Executives of local NHS Provider organisations, including SCAS (6), Chief Executive representation from Local Authorities (3), Chief Executive Officer, Oxford Academic Health Science Network and a clinical representative from each place (acute (1), primary care (1) and community/mental health (1)) • The Group will have rotating Chair. Chairing arrangements will be reviewed every 6 months. • A Vice-Chair will be identified as needed. • The minutes of meetings will normally be taken by a member of the STP Programme Team, and circulated to members for dissemination in their organisations.
Attendance	• STP Head of Assurance & Delivery and STP Lead Finance Director (Quarterly) will be in attendance. • Other colleagues will be invited to attend where appropriate and with their agreement. • Representatives from NHS England/Improvement may be invited as appropriate • Guest speakers will be invited when specific challenges or items of interest are being discussed.

Chief Executives' Group – Terms of Reference (2/2)

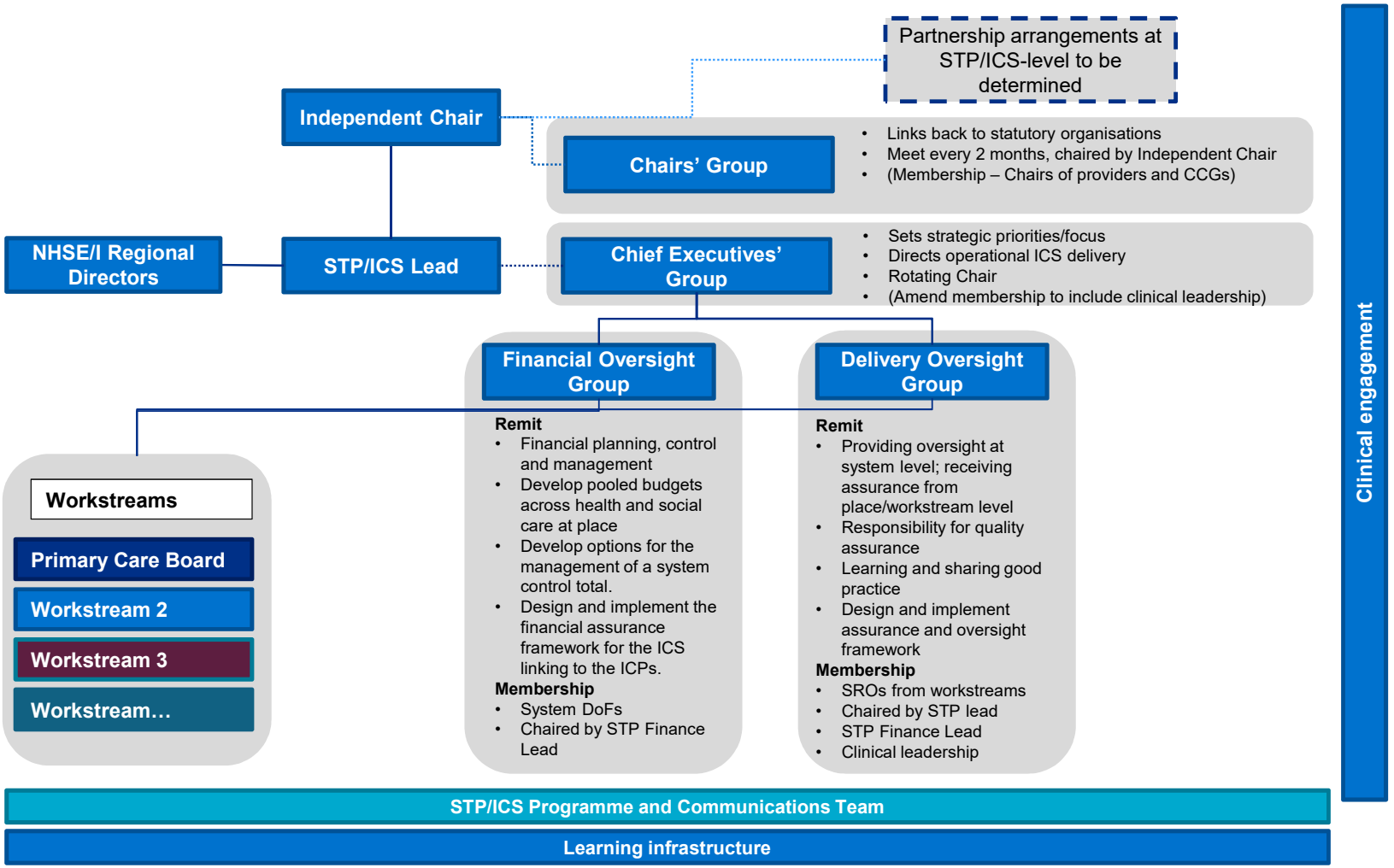
Frequency of meetings	• The Group will meet formally once a month. The STP/ ICS Lead may call additional meetings as necessary.
Authority, accountability and decision-making	• The Chief Executive Group will ensure it engages with Boards of partner organisations within the health, local government, voluntary and independent sectors and meets the requirements of NHSE and arm's-length bodies. • The group will seek to drive the implementation of the NHS Long Term Plan, and provide assurance for the system. • The group will seek to make decisions by consensus. • All decisions that have a direct financial and/or strategic impact on an organisation will require the support of that organisation. • All other decisions will be taken on the basis of a majority view.
Reporting	• The Chief Executive Group will provide a regular communication to partner organisation boards or equivalent. • The Chief Executive Group will receive regular reports on workstream progress against the agreed performance and outcomes framework and exception and escalation reports from the Delivery Oversight Group.
Ground rules	• The agenda will be set by the STP/ ICS Lead. Requests for Agenda items should be sent to the STP/ ICS Lead a minimum of two weeks in advance. The STP/ ICS Lead will decide when and if items can be added. • Apologies must be notified to the STP/ ICS Lead in advance of the meeting • Meeting minutes, of all decisions and recommendations, in draft, will be circulated 5 working days after the meeting and agreed at the following meeting • Papers will be tabled only in exceptional circumstance.
Confidentiality	• Documents circulated by the Group, and the notes from meetings, can be shared with the system and partnership organisations unless expressly stated as confidential or in draft form.
Review date	• Membership and chairing arrangements will be reviewed every six months.

Governance structure



Note: As the STP/ICS sets up a Specialised Commissioning Planning Board, this will need to be reflected in the governance structure. The Planning Board will provide a forum for collaboration, but NHSE will remain accountable for specialised commissioning.

Governance structure



Note: As the STP/ICS sets up a Specialised Commissioning Planning Board, this will need to be reflected in the governance structure. The Planning Board will provide a forum for collaboration, but NHSE will remain accountable for specialised commissioning.

pwc.com

181130-152727-AP-UK

Agenda item: 18
Enclosure no: TB2019/61

18

Safe & compassionate care, every time

Buckinghamshire Healthcare NHS
NHS Trust

TRUST BOARD IN PUBLIC
29 May 2019

Title	NHS Provider Licence Self-Certification for NHS Trusts
Responsible Director	Director for Governance
Purpose of the paper	The purpose of the paper is to seek Board approval for the NHS Provider licence self-certification as required by NHS Improvement for 2018/19 going into 19/20
Action / decision required (e.g., approve, support, endorse)	Decision to Approve

IMPLICATIONS AND ISSUES TO WHICH THE PAPER RELATES (PLEASE MARK IN BOLD)

Patient Quality	*Financial Performance*	*Operational Performance*	*Strategy*	*Workforce performance*	*New or elevated risk*
Legal	***Regulatory/ Compliance***	*Public Engagement /Reputation*	*Equality & Diversity*	*Partnership Working*	*Information Technology / Property Services*

ANNUAL OBJECTIVE

Which Strategic Objective/s does this paper link to? All objectives

Please summarise the potential benefit or value arising from this paper:
Good governance process

RISK

Are there any specific risks associated with this paper? If so, please summarise here	*Non-Financial Risk*: Although the licence only applies to Foundation Trusts, most of the conditions within the licence apply as best practice in NHS Trusts and if we do not meet those conditions this could result in a negative impact on quality, people and money and potentially result in enforcement action from the Regulators.
	Financial Risk: Potential for financial penalties where there are issues of compliance which are not being addressed. As the Trust's financial position has continued to fluctuate throughout the year, the Trust regulator NHS Improvement (NHSI) has sought increasing assurance. This has led to the Trust being notified at year end its Segmentation level under the Single Oversight Framework would be reassessed.

LINK TO CARE QUALITY COMMISSION ESSENTIAL STANDARDS OF SAFETY AND QUALITY

Which CQC standard/s does this paper relate to?	Well Led Domain; Regulation 15 Good Governance

Author of paper: Sue Manthorpe

Presenter of Paper: Sue Manthorpe

Other committees / groups where this paper / item has been considered: Audit Committee

Date of Paper: 17/05/2019

Agenda item: 18
Enclosure no: TB2019/61

UPDATE ON COMPLIANCE WITH REGULATION

1. PURPOSE

The purpose of the paper is to seek Board approval for the NHS Provider licence self-certification as required by NHS Improvement.

2. BACKGROUND

Although NHS trusts are exempt from needing the Monitor NHS provider licence, directions from the Secretary of State require NHS Improvement to ensure that NHS Trusts comply with conditions equivalent to the licence as it deems appropriate.

To this end the Board is required to self-certify against the following NHS provider licence conditions:

- The provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution (**condition G6(3)**)
- The provider has complied with required governance arrangements (**Condition FT4 (8)**)

A summary of the range of obligations in the licence is shown in Appendix 1.

3. CONDITION G6

This condition requires NHS trusts to have processes and systems that identify risks to compliance and take reasonable mitigating actions to prevent those risks and a failure to comply from occurring. Providers must annually review whether these processes and systems are effective.

The Board has been assured through the following mechanisms that Condition G6 is in place:

- Preparation and publication of an Annual Governance Statement which sets out mechanisms of control and risk management for the trust
- Head of Internal Audit opinion confirms that the organisation has an adequate and effective framework for risk management, governance and internal control. Further enhancements have been identified to ensure that it remains adequate and effective
- Performance reporting on a monthly basis through Board and Committees which includes monitoring of the requirements within the NHS Constitution and compliance with financial duties
- Board Assurance Framework updated on a quarterly basis, and Corporate Risk Register updated on a monthly basis and risk escalation processes in place
- Self-assessment using the Well-led Framework. The Board has recently been inspected under the Well Led Domain by the Care Quality Commission (CQC) in March 2019. This will be followed by a report from the regulator in June 2019.
- External reviews, including the annual Staff Survey and the annual National Inpatient Survey
- At year end the Trust current Segmentation is level 2 in the Single Oversight Framework. However NHS Improvement (NHSI) has raised a number of concerns about the continued fluctuations in the Trusts finical position throughout the year. As a result NHSI have informed the Trust at year end, the appropriateness of Trusts segmentation level is being

reviewed. The Trust will still continue to receive significant support from NHSI to improve the gap in compliance with its licence

- Expected external audit opinion on financial accounts and quality accounts

The NHS Improvement sign off template for condition G6 is shown in Appendix 2.

4. CONDITION ST4

This condition requires the provider to comply with required governance arrangements. These are summarised below with reference to the sources of assurance which confirm compliance:

Statement	Sources of Assurance
The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	• Director for Governance and Director of Finance provide expertise on standards of governance as they apply to the NHS and advise the Board and organisation accordingly • Review of elements of governance by CQC, NHS Improvement, External Audit, Internal Audit • Declaration of Interests
The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	• Board and relevant Committees are briefed on guidance issued by NHS Improvement in relation to governance. For example the grip and control spread sheet for financial management. This can be identified through meeting minutes
The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	• Board and Committees set up in line with Monitor's Code of Governance for Foundation Trusts as far as it applies to NHS Trusts • Standing Orders, Standing Financial Instructions and Committee Terms of Reference reviewed in year by the Board • Self-reflection on effectiveness evident in minutes of Board meetings and Committees • Review of effectiveness of Audit Committee and performance in each committee • Chair's observation of each Committee and feedback to each Committee Chair • Board development programme including Board self-review • Organisational structure charts showing lines of accountability • Performance Management Framework
The Board is satisfied that the Licensee has established and effectively implements systems	• Board and committee forward plans • Board agendas and minutes

Agenda item: 18
Enclosure no: TB2019/61

Statement	Sources of Assurance
and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	• Annual Governance Statement • Internal and External Audit • Local Counter Fraud Specialist Annual report • Auditor review of going concern declaration • Risk Management Strategy and Policy • Board Assurance Framework • Corporate risk Register • Comprehensive business planning process involved Board and Committee sign off • Emergency Planning, Resilience and Response compliance reported to Finance and Business Performance Committee • Weekly Financial Recovery Boards compliance reported to Finance and Business Performance Committee • Information Governance Toolkit submission • Compliance with laws and regulations paper to the Board
The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board,	• Board development programme including Board self-review • Quality Impact Assessment process • Leadership programme • Quality report to Board • Range of internal and external assurances to Quality and Clinical Governance Committee including clinical audit and other reviews • Monthly mortality reporting • Patient Experience Group • Programme of patient and public involvement reported to the Board • Feedback processes such as Friends and Family Test and complaints process • Range of patient stories to Board • Engagement with Healthwatch and the

Statement	Sources of Assurance
actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Health and Adult Health and Social Care Select Committee
The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	• Strategic Workforce Committee forward plan and meeting minutes • Workforce performance reports • Staff survey • CQC reports

The NHS Improvement sign off template for Condition FT4 is shown in Appendix 3.

5. CONCLUSION

The Board and Committees have received a range of assurance through 18/19 and into 19/20 which confirms compliance with the licence conditions relevant to NHS Trusts.

6. RECOMMENDATION

It is recommended that the Board approve the self-certification statements to confirm compliance with G6 and FT4 Conditions.

Sue Manthorpe
Director for Governance
May 2019

Agenda item: 18
Enclosure no: TB2019/61

Appendix 1 Summary of Obligations in the NHS Provider Licence

- Provide information to regulators as required
- Publish information as required by regulation
- Fit and Proper persons as Directors
- Comply with NHS Acts
- Have regard to the NHS Constitution in providing health care services for the purposes of the NHS
- Systems and process to identify risks to compliance and guard against their occurrence and regular review of those processes and systems
- Register with the Care Quality Commission
- Set and publish transparent patient eligibility and selection criteria and to apply these in a transparent manner
- Continuity of Services
- Pricing: record information about cost; information systems in place; provide information to regulator as required; compliance with National Tariff; engage constructively with Commissioners
- Patient choice
- Competition oversight
- Provision of integrated care
- Provision of Commissioner Requested Services
- Maintain asset register and follow appropriate regulation for disposal of assets
- Adopt and apply systems and standards of corporate governance and financial management
- Risk pool levy

Agenda item: 18
Enclosure no: TB2019/61

Appendix 2 Sign off template G6

Worksheet "G6 & CoS7"

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with license conditions (FTs and NHS trusts)

1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.		Please Respond

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Agenda item: 18
Enclosure no: TB2019/61

Appendix 3 Sign off template FT4

Worksheet "FT4 declaration"

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

1	Corporate Governance Statement	Response	Risks and Mitigating actions
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.		[including where the Board is able to respond 'Confirmed']
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time		[including where the Board is able to respond 'Confirmed']
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.		[including where the Board is able to respond 'Confirmed']

4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.		[including where the Board is able to respond 'Confirmed']

5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.		[including where the Board is able to respond 'Confirmed']
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	**Confirmed**	[including where the Board is able to respond 'Confirmed']

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Agenda Item: 19
Enclosure No: TB2019/62

Safe & compassionate care, every time

Buckinghamshire Healthcare NHS
NHS Trust

PUBLIC BOARD MEETING
29 MAY 2019

Details of the Paper

Title	Use of the Trust Seal
Responsible Director	Chief Executive
Purpose of the paper	The purpose of this paper is to inform the Board of the use of the Trust Seal in accordance with Standing Orders (Sealing of Documents paragraph 8.2)
Action / decision required (e.g., approve, support, endorse)	The Board is asked to note the occasions and purposes for which documents have been executed under Trust Seal.

IMPLICATIONS AND ISSUES TO WHICH THE PAPER RELATES (PLEASE MARK IN BOLD)					
Patient Quality	*Financial Performance*	*Operational Performance*	*Strategy*	*Workforce performance*	*New or elevated risk*
Legal	***Regulatory/ Compliance***	*Public Engagement /Reputation*	*Equality & Diversity*	*Partnership Working*	*Information Technology / Property Services*

ANNUAL OBJECTIVE	
Which Strategic Objective/s does this paper link to? Nothing specific.	
Please summarise the potential benefit or value arising from this paper: Good governance	
RISK	
Are there any specific risks associated with this paper? If so, please summarise here.	*Non-Financial Risk*:
	Financial Risk:
LINK TO CARE QUALITY COMMISSION ESSENTIAL STANDARDS OF SAFETY AND QUALITY	
Which CQC standard/s does this paper relate to?	*(if you need advice on completing this box please contact the Director for Governance)*

Author of paper: Director for Governance
Presenter of Paper: Chief Executive
Other committees / groups where this paper / item has been considered:
Date of Paper: 14 May 2018

Agenda Item: 19
Enclosure No: TB2019/62

USE OF TRUST SEAL

19

The Board is asked to note the use of the Trust seal on the following document under delegated powers in accordance with Standing Orders (Sealing of Documents paragraph 8.2).

No 98 Sealing of a DSI in relation to 39 London Road High Wycombe HP11 1BN and the lender Buckinghamshire NHS Trust. Removal of registered charge relating to over age agreement dated 25.11.2055 following expiry of agreement.

The documents were signed by the Director of Finance and the Chief Executive Officer on 7 August 2018.

No 99 Sealing of a Nominations Agreement with Thames Valley Housing Association – now Metropolitan & Housing Trust Ltd following a merger in October 2018.

The documents were signed by the Director of Strategy and Business Development and the Chief Executive Officer on 16 November 2018.

No 100 Sealing of a lease agreement Wycombe Hospital – Wye Valley Surgery

The documents were signed by the Director of Strategy and Business Development and the Director for Workforce and Organisational Development (acting CEO) on 29 March 2018

No 101 Sealing of Unit 3 Midshires Business Park - underlease

The documents were signed by the Director of Strategy and Business Development and the Commercial Director.

Buckinghamshire Healthcare NHS
NHS Trust

Board Attendance Record: March 2019 to May 2019

	Strategic Workforce Committee	Finance and Business Performance Committee		Quality & Clinical Governance Committee			Trust Board Seminars	Commercial Development Committee	Audit Committee			Trust Board
	5 Mar	26 Mar	23 Apr	5 Mar	2 Apr	7 May	24 Apr	30 Apr	21 Mar	23 Apr	9 May	27 Mar
Hattie Llewelyn-Davies Trust Chair *	✓	✓	✓				✓					✓
Neil Macdonald, Chief Executive Officer *		x	✓	x	x		✓					✓
Dipti Amin NED*				✓			x		✓	x	x	x
Natalie Fox Chief Operating Officer*		✓	✓	x			✓					✓
Rajiv Jaitly NED *		x	✓				✓		✓	✓	✓	x
Graeme Johnston NED * (SID)		✓	✓				✓		✓	✓	✓	✓
Tina Kenny Medical Director *	✓			✓			✓					✓
Mary Lovegrove NED *	✓			✓			x					✓
Carolyn Morrice Chief Nurse *	✓	✓	✓	✓			✓					✓

	Strategic Workforce Committee	Finance and Business Performance Committee		Quality & Clinical Governance Committee			Trust Board Seminars	Commercial Development Committee	Audit Committee			Trust Board
	5 Mar	26 Mar	23 Apr	5 Mar	2 Apr	7 May	24 Apr	30 Apr	21 Mar	23 Apr	9 May	27 Mar
Bridget O'Kelly Director of Workforce & Organisational Development	x	x	✓				✓					x
Tom Roche Associate NED	✓	x	✓				✓	✓	x	✓	✓	x
David Sines Associate NED	✓			✓			x					✓
Caroline Trevena Director of Finance *		✓	✓				✓		✓	✓		✓
Wayne Preston Deputy Director of Finance			✓				✓		✓	✓	✓	
David Williams Director of Strategy & Business Development	✓	✓	✓				✓					✓
Ali Williams Commercial Director	✓	✓	✓				✓	✓				✓

NB: greyed out fields indicate committees the individual would not be expected to attend. NED = Non-Executive Director. A * indicates a voting member of the Board

Agenda item: 20
Enclosure number: TB2019/63

Safe & compassionate care, every time

Buckinghamshire Healthcare NHS
NHS Trust

20

PUBLIC BOARD MEETING
29 MAY 2019

Details of the Paper

Title	Board Attendance Record
Responsible Director	Director for Governance
Purpose of the paper	To keep the Board informed of the attendance of Board members at Board meetings and Board committees.
Action / decision required (e.g., approve, support, endorse)	None

IMPLICATIONS AND ISSUES TO WHICH THE PAPER RELATES (PLEASE MARK IN BOLD)					
Patient Quality	*Financial Performance*	*Operational Performance*	*Strategy*	*Workforce performance*	*New or elevated risk*
Legal	***Regulatory/ Compliance***	***Public Engagement /Reputation***	*Equality & Diversity*	*Partnership Working*	*Information Technology / Property Services*

ANNUAL OBJECTIVE	
Which Strategic Objective/s does this paper link to? Relates to all objectives	
Please summarise the potential benefit or value arising from this paper:	
RISK	
Are there any specific risks associated with this paper? If so, please summarise here.	*Non-Financial Risk*:
	Financial Risk:
LINK TO CARE QUALITY COMMISSION ESSENTIAL STANDARDS OF SAFETY AND QUALITY	
Which CQC standard/s does this paper relate to?	Well led Domain *(if you need advice on completing this box please contact the Director for Governance)*

Author of paper: Elisabeth Jones
Presenter of Paper: Sue Manthorpe
Other committees / groups where this paper / item has been considered: No other committee
Date of Paper: 20 May 2019

Agenda item: 21
Enclosure number: TB2019/64

Safe & compassionate care, every time

Buckinghamshire Healthcare NHS Trust

BOARD MEETING IN PUBLIC

29 MAY 2019

21

Details of the Paper

Title	Private Board Summary 27 March 2019
Responsible Director	Trust Chair
Purpose of the paper	The purpose of this report is to provide a summary of matters discussed at the Board in private on the 27 March 2019. The matters considered at this session of the Board were as follows: • Operational Plan 2019/20 • Financial Recovery Plan • Serious Incident Report and Tracker • Excluded Practitioners • A&E Business Case • Trust Energy Supply Contract • HV/LV Project 2018/19
Action / decision required	The Board is asked to note the contents of this report.

IMPLICATIONS AND ISSUES TO WHICH THE PAPER RELATES (PLEASE MARK IN BOLD)					
Patient Quality	*Financial Performance*	*Operational Performance*	***Strategy***	*Workforce performance*	*New or elevated risk*
Legal	***Regulatory/ Compliance***	*Public Engagement /Reputation*	*Equality & Diversity*	***Partnership Working***	*Information Technology / Property Services*

ANNUAL OBJECTIVE	
Which Strategic Objective/s does this paper link to? Relates to all objectives	
Please summarise the potential benefit or value arising from this paper:	
RISK	
Are there any specific risks associated with this paper? If so, please summarise here.	*Non-Financial Risk*:
	Financial Risk:
LINK TO CARE QUALITY COMMISSION ESSENTIAL STANDARDS OF SAFETY AND QUALITY	
Which CQC standard/s does this paper relate to?	Relates to outcome 4, Care and Welfare of Persons using our service
Author of paper: Elisabeth Jones	
Presenter of Paper: Director for Governance	
Other committees / groups where this paper / item has been considered: No other committee	
Date of Paper: 14 May 2019	

Safe & compassionate care, every time

Buckinghamshire Healthcare NHS
NHS Trust

Acronym 'Buster'

- A&E - Accident and Emergency
- AD - Associate Director
- ADT - Admission, Discharge and Transfer
- AfC - Agenda for Change
- AGM - Annual General Meeting
- AHP - Allied Health Professional
- AIS – Accessible Information Standard
- AKI - Acute Kidney Injury
- AMR - Antimicrobial Resistance
- ANP - Advanced Nurse Practitioner

B

- BBE - Bare Below Elbow
- BME - Black and Minority Ethnic
- BMA - British Medical Association
- BMI - Body Mass Index

C

- CAMHS - Child and Adolescent Mental Health Services
- CAS - Central Alert System
- CCG - Clinical Commissioning Group
- CCU - Coronary Care Unit
- Cdif / C.Diff - Clostridium Difficile
- CEA - Clinical Excellence Awards
- CEO - Chief Executive Officer
- CHD - Coronary Heart Disease
- CIO - Chief Information Officer
- CIP - Cost Improvement Plan
- CQC - Care Quality Commission
- CQUIN - Commissioning for Quality and Innovation
- CSU - Commissioning Support Unit
- CT - Computerised Tomography
- CTG - Cardiotocography

D

- DBS - Disclosure Barring Service
- DGH - District General Hospital
- DH / DoH - Department of Health
- DIPC - Director of Infection Prevention and Control
- DNA - Did Not Attend
- DNACPR - Do Not Attempt Cardiopulmonary Resuscitation
- DNAR - Do Not Attempt Resuscitation
- DNR - Do Not Resuscitate
- DoLS - Deprivation of Liberty Safeguards
- DPA - Data Protection Act
- DSU - Day Surgery Unit
- DVT - Deep Vein Thrombosis

E

- E&D - Equality and Diversity
- EBITDA - Earnings Before Interest, Taxes, Depreciation and Amortization
- ECG - Electrocardiogram
- ED - Emergency Department
- EDD - Estimated Date of Discharge
- EIA - Equality Impact Assessment
- ENT - Ear, Nose and Throat
- EOLC - End of Life Care
- EPR - Electronic Patient Record
- EPRR - Emergency Preparedness, Resilience and Response
- ESD - Early Supported Discharge
- ESR - Electronic Staff Record

F

- FBC - Full Business Case
- FFT - Friends and Family Test
- FOI - Freedom of Information
- FTE - Full Time Equivalent

G

- GI - Gastrointestinal
- GMC - General Medical Council
- GP - General Practitioner
- GRE – Glycopeptide Resistant Enterococci

H

- HAI - Hospital Acquired Infection
- HASU - Hyper Acute Stroke Unit
- HCA - Health Care Assistant
- HCAI - Healthcare-Associated Infection
- HDU - High Dependency Unit
- HETV - Health Education Thames Valley
- HSE - Health and Safety Executive
- HSMR – Hospital-level Standardised Mortality Ratio
- HWB - Health and Wellbeing Board

I

M

- I&E - Income and Expenditure
- IC - Information Commissioner
- ICP - Integrated Care Pathway
- ICU - Intensive Care Unit
- IG - Information Governance
- IGT / IGTK - Information Governance Toolkit
- IM&T - Information Management and Technology
- IPR - Individual Performance Review
- ITU - Intensive Therapy Unit / Critical Care Unit
- IV - Intravenous

J

- JAG - Joint Advisory Group

K

- KPI - Key Performance Indicator

L

- LA - Local Authority
- LCFS - Local Counter Fraud Specialist
- LD - Learning Disability
- LHRP - Local Health Resilience Partnership
- LiA - Listening into Action
- LOS / LoS - Length of Stay
- LUCADA - Lung Cancer Audit Data

M

- M&M - Morbidity and Mortality
- MDT - Multi-Disciplinary Team
- MIU - Minor Injuries Unit
- MRI - Magnetic Resonance Imaging
- MRSA - Meticillin-Resistant Staphylococcus Aureus

N

- NBOCAP - National Bowel Cancer Audit Programme
- NCASP - National Clinical Audit Support Programme
- NED - Non-Executive Director
- NHSE - NHS England
- NHSLA - NHS Litigation Authority
- NICE - National Institute for Health and Care Excellence
- NICU - Neonatal Intensive Care Unit
- NMC - Nursing and Midwifery Council
- NNU - Neonatal Unit
- NOGCA - National Oesophago-Gastric Cancer Audit
- NRLS - National Reporting and Learning System / Service

O

- O&G - Obstetrics and Gynaecology
- OBC - Outline Business Case
- ODP - Operating Department Practitioner

- OHD - Occupational Health Department
- OOH - Out of Hours
- OP - Outpatient
- OPD - Outpatient Department
- OT - Occupational Therapist/Therapy

P

- PACS - Picture Archiving and Communications System / Primary and Acute Care System
- PALS - Patient Advice and Liaison Service
- PAS - Patient Administration System
- PbR - Payment by Results
- PDC - Public Dividend Capital
- PDD - Predicted Date of Discharge
- PE - Pulmonary Embolism
- PFI - Private Finance Initiative
- PHE - Public Health England
- PICC - Peripherally Inserted Central Catheters
- PID - Patient / Person Identifiable Data
- PID - Project Initiation Document
- PLACE - Patient-Led Assessments of the Care Environment
- PMO - Programme Management Office
- PPE - Personal Protective Equipment
- PPI - Patient and Public Involvement
- PSED - Public Sector Equality Duty

Q

- QA - Quality Assurance
- QI - Quality Indicator
- QIP - Quality Improvement Plan
- QIPP - Quality, Innovation, Productivity and Prevention
- QIA - Quality Impact Assessment
- QOF - Quality and Outcomes Framework

R

- RAG - Red Amber Green
- RCA - Root Cause Analysis
- RCN - Royal College of Nursing
- RCP - Royal College of Physicians
- RCS - Royal College of Surgeons
- RIDDOR - Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
- RTT - Referral to Treatment

S

- SAU - Surgical Assessment Unit
- SCAS / SCAmb - South Central Ambulance Service
- SHMI - Summary Hospital-level Mortality Indicator
- SI - Serious Incident
- SIRI - Serious Incident Requiring Investigation
- SIRO – Senior Information Risk Owner
- SID - Senior Independent Director
- SLA - Service Level Agreement
- SLR - Service-Line Reporting
- SLT / SaLT - Speech and Language Therapy
- SMR - Standardised Mortality Ratio
- SoS - Secretary of State
- SSI(S) - Surgical Site Infections (Surveillance)

- SSNAP - Sentinel Stroke National Audit Programme
- STF – Strategic Transformation Fund
- STP - Sustainability and Transformation Plan
- SUI - Serious Untoward Incident

T

- TIA - Transient Ischaemic Attack
- TNA - Training Needs Analysis
- TPN - Total Parenteral Nutrition
- TTA - To Take Away
- TTO - To Take Out
- TUPE - Transfer of Undertakings (Protection of Employment) Regulations 1981

U

- UGI - Upper Gastrointestinal
- UTI - Urinary Tract Infection

V

- VfM - Value for Money
- VSM - Very Senior Manager
- VTE - Venous Thromboembolism

W

- WHO - World Health Organization
- WTE - Whole Time Equivalent

Y

- YTD - Year to Date