

**Agenda for the Trust Board Meeting in Public on
Wednesday 31 July 2019 at 9.00am in the
Education Suite, Florence Nightingale Hospice Charity, Aylesbury**

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: Bridget O'Kelly	Chair	Open the meeting	TB2019/065
	2.	Declaration of Interests	Chair	Good governance	Verbal
09.15	GENERAL BUSINESS				
	3.	Patient Story : Medical Examiner	Chief Nurse	Approve and support	TB2019/066
	4.	Clinical Psychology	Chief Operating Officer	Information and Discussion	TB2019/067
	5.	Minutes of last meeting (29 May 2019)	Chair	Note and approve	TB2019/068
	6.	Matters Arising and Action Matrix <ul style="list-style-type: none"> • Patient Accessibility 	Chair Commercial Director	Note and approve	As above TB2019/069
	7.	Chief Executive's Report	Chief Executive Officer	Assurance	TB2019/070
	QUESTIONS FROM THE PUBLIC				
10.00	QUALITY AND PERFORMANCE				
	8.	Integrated Performance Report <ul style="list-style-type: none"> • Quality • Workforce • Finance 	Chief Operating Officer	Assurance	TB2019/071
	9.	Infection Prevention & Control Annual Report & Monthly Report	Medical Director	Assurance	TB2019/072
	10.	Care Quality Commission Plan	Chief Nurse	Note	TB2019/073
	11.	Safeguarding Annual Report	Chief Nurse	Note and approve	TB2019/074
	12.	Emergency Preparedness, Resilience and Response Assurance Report	Chief Operating Officer	Note	TB2019/075
	13.	Clinical Audit Plan 2019/20	Chief Nurse	Information & approval	TB2019/076

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Time	Item	Subject	Lead	Purpose	Enclosure No TB2019/
	14.	Clinical Negligence Scheme for Trusts (CNST) incentive scheme maternity safety actions	Chief Nurse	Approval	TB2019/077
COMFORT BREAK					
	15.	Medical Appraisal and Revalidation Annual Report	Medical Director	Approval	TB2019/078
	16.	Annual Reports I. Equality, Diversity & Inclusion Annual Report II. Freedom To Speak Up Guardian Annual Report III. Staff Survey IV. Quality Accounts V. Guardian of Safe Working Hours Annual Report	Director of Workforce and organisation development Chief Nurse Chief Executive	Approve Note Note Information Note	TB2019/079 TB2019/080 TB2019/081 TB2019/082 TB2019/083
STRATEGY					
	17.	Corporate Objectives Update: Getting in Right First Time	Medical Director	Information	TB2019/084
	18.	Information, Communication and Technology Strategy 2019	Director of Strategy and business development	Approve	TB2019/085
QUESTIONS FROM THE PUBLIC					
11.00	RISK AND GOVERNANCE				
	19.	Board Assurance Framework	Director for Governance	Assurance	TB2019/086
	20.	Corporate Risk Register	Director for Governance	Assurance	TB2019/087
	21.	National Audit for Care at End of Life	Chief Nurse	Support	TB2019/088
	22.	Board attendance record	Director for Governance	Information	TB2019/089
	23.	Private Board Summary Report	Director for Governance	Information	TB2019/920
	24.	Board Committee Reports I. Quality and Clinical Governance Committee II. Finance and Business Performance Committee III. Audit Committee IV. Charitable Funds Committee, Terms of Reference, Management of Charitable Funds Policy & Investment Policy V. Strategic Workforce Committee	Committee Chairs	Information Information Information Approval Information	TB2019/091 TB2019/092 TB2019/093 TB2019/094 TB2019/095
	25.	Risks identified through Board discussion	Director for Governance	Review	
ANY OTHER BUSINESS					
QUESTIONS FROM THE PUBLIC					
DATE OF NEXT MEETING					
Wednesday 25 September, 9am, Hampden Lecture Theatre, Wycombe Hospital					
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

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Public Board Meeting:
Agenda Item: 1
Enclosure No: TB2019/65

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

Providing a range of acute and community services across Buckinghamshire
Chair: Hattie Llewelyn-Davies Chief Executive: Neil Macdonald

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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

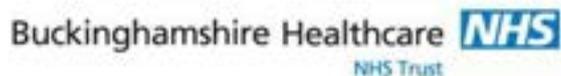
Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

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: TB2019/066



PUBLIC TRUST BOARD MEETING 31st July 2019

Details of the Paper

Title	Patient Story – BHT Medical Examiner Service
Responsible Director	Carolyn Morrice
Purpose of the paper	To evidence learning across care pathways by presenting a patient story and mortality data from over 100 care home admissions with a view to driving further improvements across the ICP.
Action / decision required (e.g., approve, support, endorse)	Approve and Support

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

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

ANNUAL OBJECTIVE

Which Strategic Objective/s does this paper link to?
 To create a culture of improvement, innovation and inclusion

Please summarise the potential benefit or value arising from this paper:
 To integrate care pathways and models of care.

RISK

Are there any specific risks associated with this paper? If so, please summarise here.	<i>Non-Financial Risk:</i> Risk to reputation, public engagement, quality and safety, patient experience
	<i>Financial Risk:</i> Lost opportunity for quality improvement programmes

LINK TO CARE QUALITY COMMISSION ESSENTIAL STANDARDS OF SAFETY AND QUALITY

Which CQC standard/s does this paper relate to?	Patient-centred care, safety and good governance <i>(if you need advice on completing this box please contact the Director for Governance)</i>
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Authors of paper: Dr Helen Pegrum Lead Medical Examiner and SDU Palliative Care Lead Julia Phillips Clinical Nurse Lead Mortality Review and Sepsis
Presenters of Paper: Dr Helen Pegrum/Julia Phillips
Other committees / groups where this paper / item has been considered: Mortality Reduction Group,

Agenda item: 3
Enclosure no: TB2019/066

Quality and Clinical Governance Committee
Date of Paper: 31st July 2019

BHT Medical Examiner Service

A Patient's Story

Dr Helen Pegrum Lead Medical Examiner and SDU Palliative Care Lead
Julia Phillips Nurse Lead Mortality Review and Sepsis

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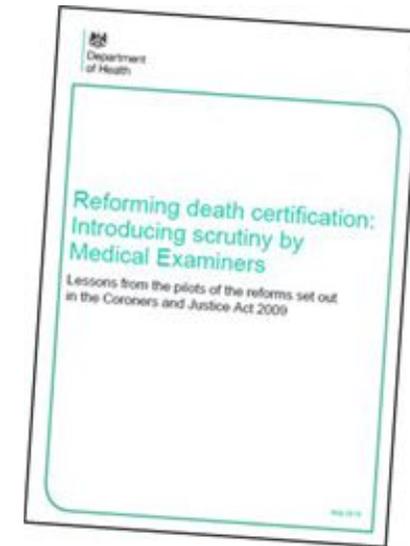
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The Role of Medical Examiner

- Accurate MCCD completion
- Timely and accurate reporting to the coroner
- Early detection and notification

Clinical Governance

- Support for the bereaved



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Learning across Care Pathways

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Patient Story



- Elderly patient with advanced dementia
- Lived in a Nursing Home
- Unable to communicate
- Bedbound

- SCR- Patients Wishes
- No further escalation is intended or considered appropriate, EOL care record, DNACPR

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Acute Presentation

- Emergency via ED
- **NEWS 9- Acutely unwell**
- Family in attendance agreed - EOL pathway
- Treatment Escalation Plan completed
- Died within 24 hrs

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ME Screen

- EOL recognition in secondary care
- Relatives concern
- NO GP visit- 999 by care home

- Patient with clear pathway in primary care
- EOL care commenced in ED

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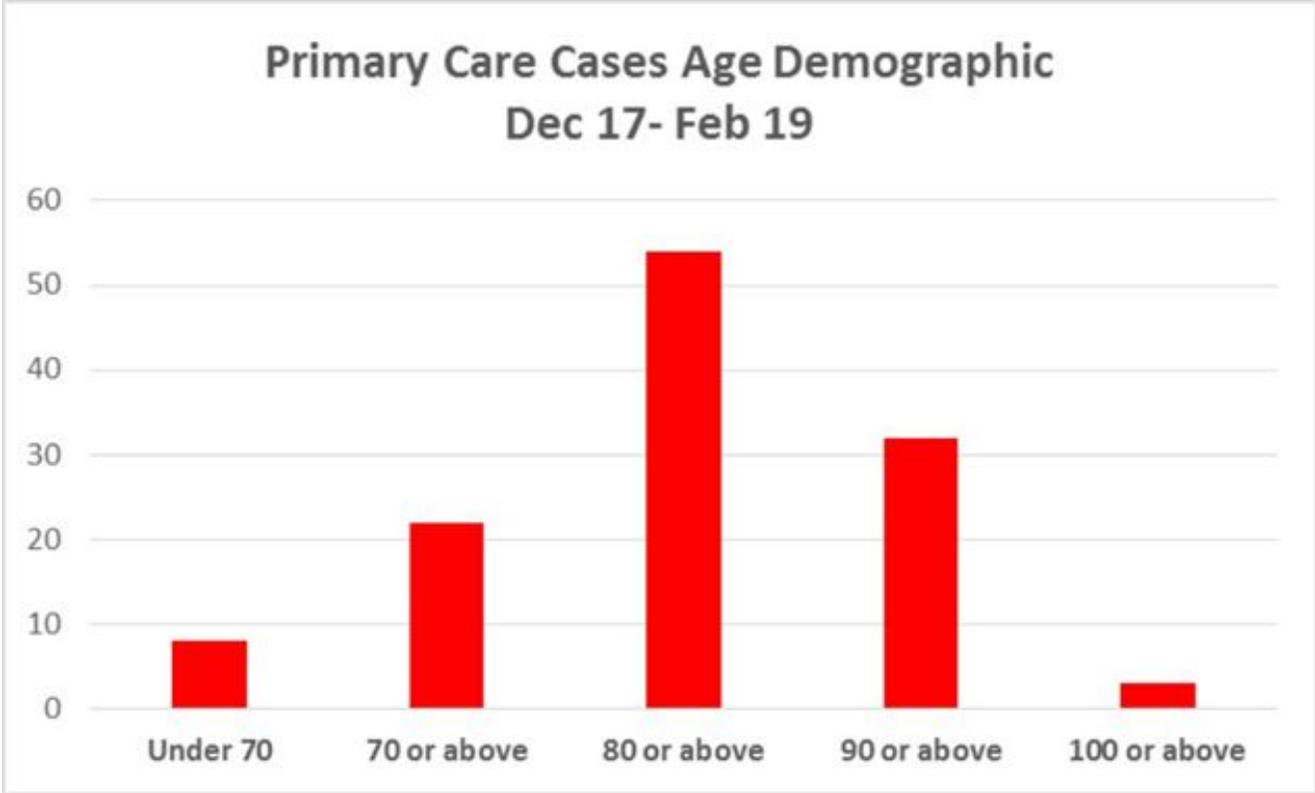
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Could EOL be better placed in the Community?

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Demographics

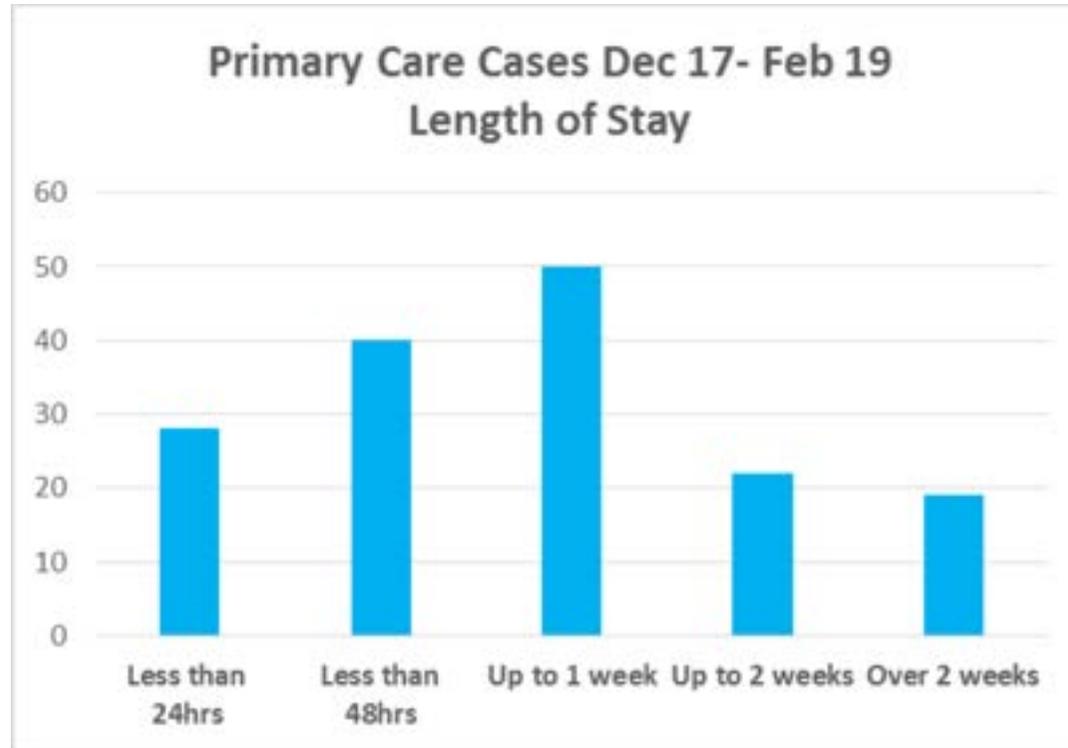


75% of patients 80 years or above

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Length of Stay

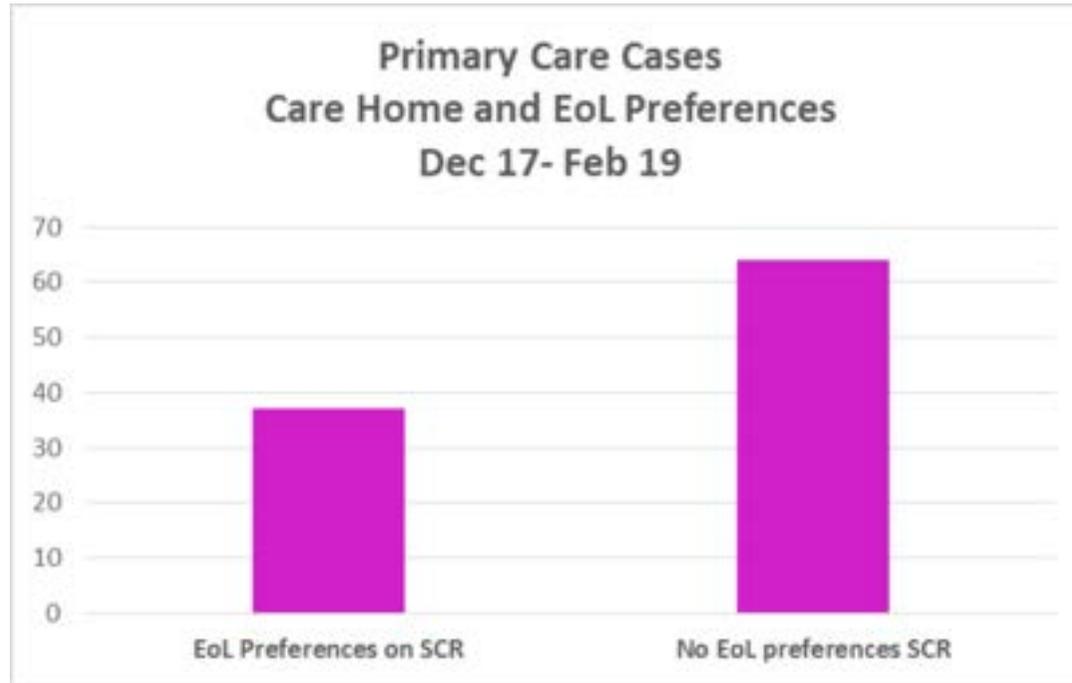


33% LOS less than 48 hours

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EOL Preferences

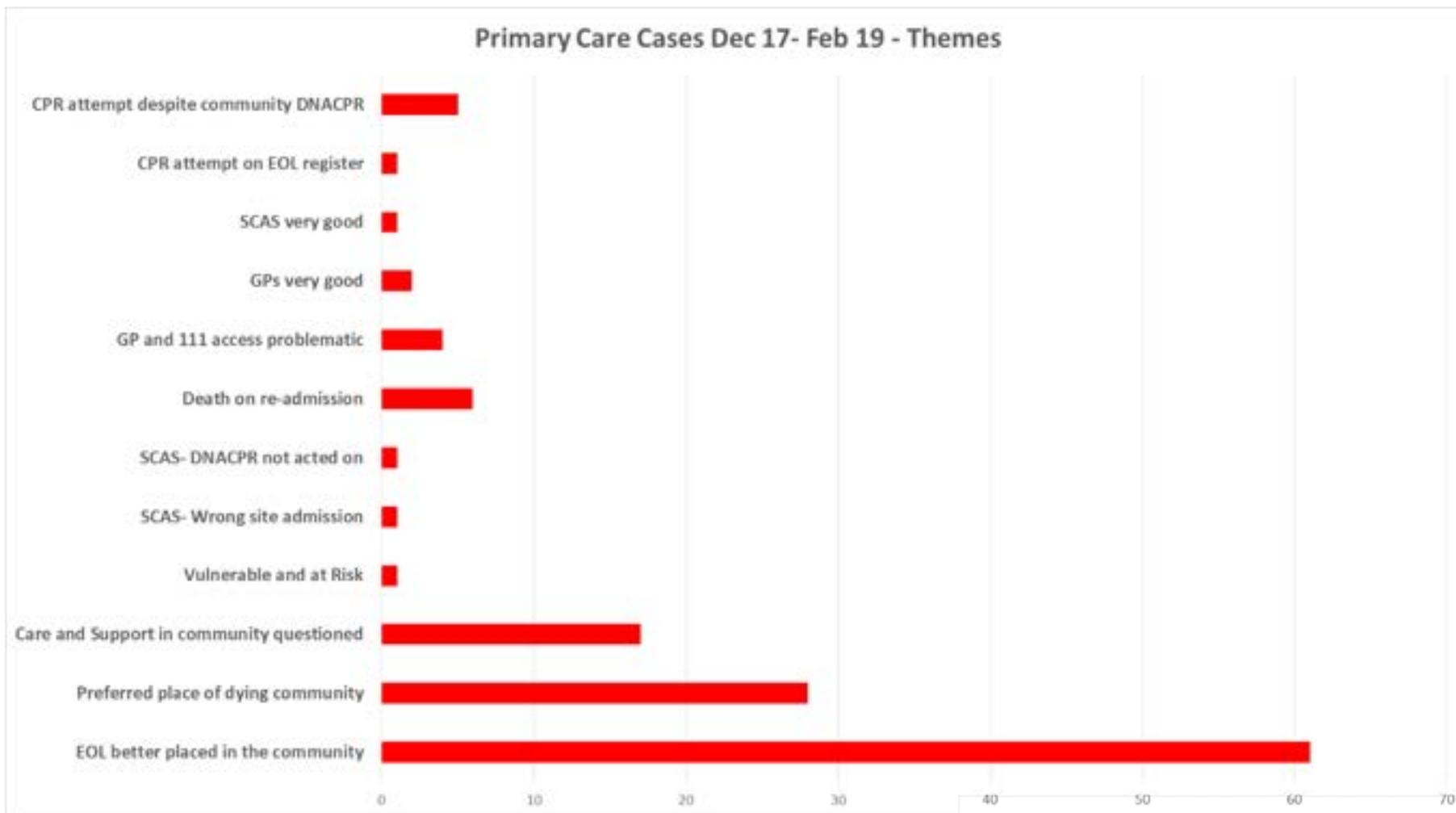


37% had EOL preferences on SCR

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Themes



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ME and Relatives Feedback

“ Family disappointed that she could not be cared for at care home with support and needed admission”

“Elderly lady from care home, should not have come into hospital”

“Unclear why admitted from nursing home despite advanced care planning”

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Learning Points

- Access summary care record to identify patient wishes
- Care homes to routinely give EOL care plans to GPs
- Paramedics role in decision making
- 147 admissions from nursing home 2017- Buckinghamshire to acute trusts leading in death- **the need**
- Routine visits to care homes - time and resource required- care home staff to escalate need
- Soft signs of deterioration- RESTORE2- Nursing Home Project



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Actions



- Frailty Assessment
- The big conversation
- Community Hubs
- Silver Phone
- Community TEP
- Community support for EOL care
- 24hr Palliative Care advice via Hospice
- CCG regional Mortality Group



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The Team



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FOR HEALTHCARE LEADERS
HSJ AWARDS

Agenda item: 4
Enclosure no: TB2019/067

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PUBLIC BOARD MEETING 31ST JULY 2019

Details of the Paper

Title	Buckinghamshire Healthcare NHS Trust Psychological Services
Responsible Director	David Williams, Interim Chief Operating Officer
Purpose of the paper	To share with the Board the current and future context for psychological services at BHT
Action / decision required (e.g., approve, support, endorse)	For information and discussion

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

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

ANNUAL OBJECTIVE

Which Strategic Objective/s does this paper link to?

Quality, People, and Money

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

To increase the profile of the BHT Psychological Service; gain support and advice from the Board; begin to move forward with streamlining and developing the service, with the aim of providing a high quality psychological service to more BHT patients

RISK

Are there any specific risks associated with this paper? If so, please summarise here.	<i>Non-Financial Risk:</i> It will be harder to move forward without the Board's understanding and support
	<i>Financial Risk:</i> None at present. The first stage is to ascertain if more could be done with the same financial resources

LINK TO CARE QUALITY COMMISSION ESSENTIAL STANDARDS OF SAFETY AND QUALITY

Which CQC standard/s does this paper relate to?

All

Author of paper: Dr Clare Daniel

Presenter of Paper: Dr Clare Daniel

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

Date of Paper: 31 July 2019



Buckinghamshire Healthcare
NHS Trust

Buckinghamshire Healthcare NHS Trust Psychological Services

Dr H Clare Daniel
Consultant Clinical Psychologist & Lead of BHT Psychological Services

31 July 2019

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Introduction

The Psychological Service

- What we do and don't do

The interaction between physical and psychological health

- Effects on physical health and healthcare cost

Where we work in BHT

- Positives and challenges

A way forward

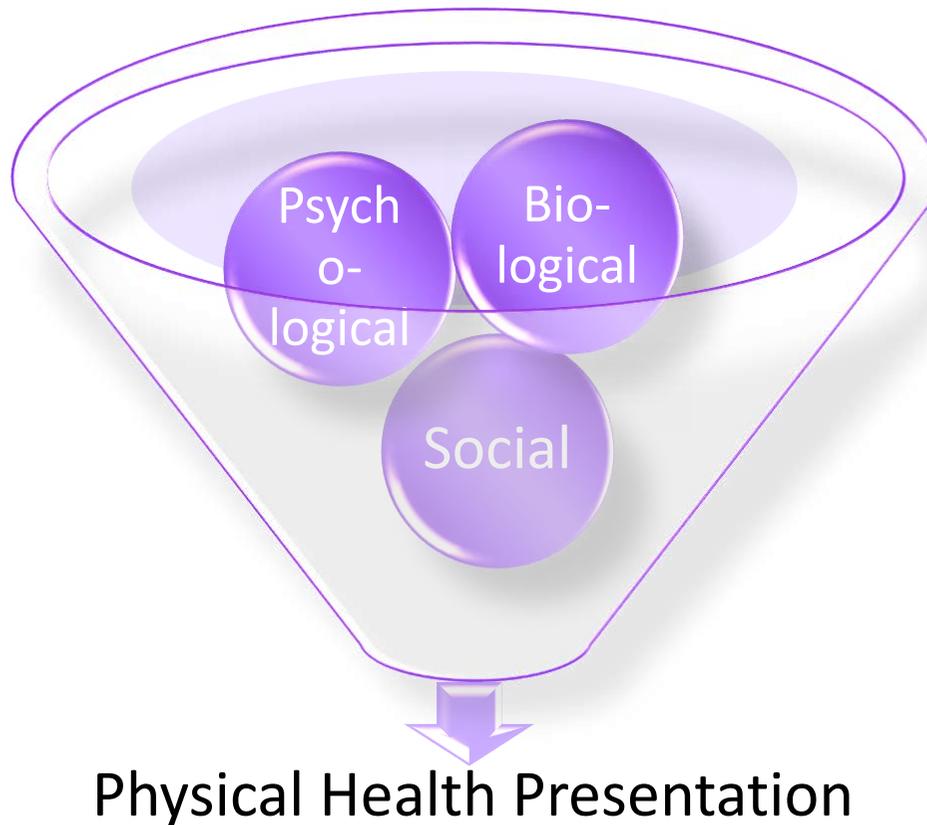
What psychologists in physical health don't do...

We don't work with patients who have a mental health problem and also happen to have a physical health condition

→ Healthy Minds (IAPT), CMHT/CAMHS,
Psychiatry
(i.e. Oxford Health)

What we do.....

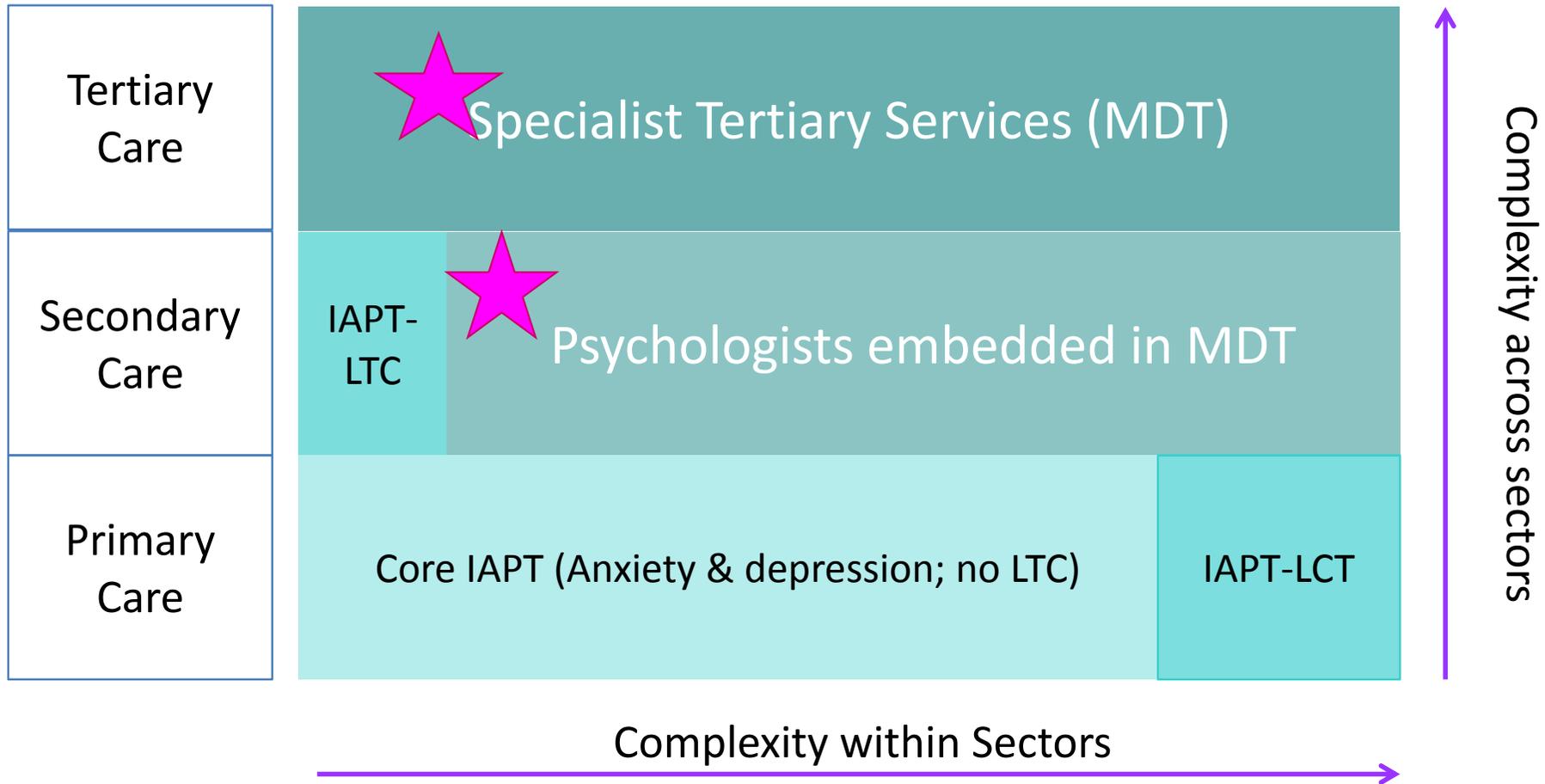
- All health conditions and presentations are a combination of physical, psychological and social factors



- We work with people who are
 - Having difficulty managing their physical health condition in the context of their lives
 - Having difficulty adhering to treatment
 - Distressed as a result of the condition and its physical, psychological and social impact

Aim: To help people live well with a physical health condition(s)

Where we sit

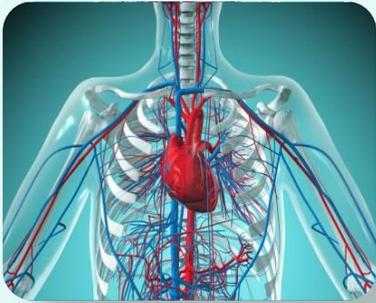


We are different from, and sit on a continuum with Healthy Minds (IAPT)

We have skills in addition to working directly with patients; We're trained to take a systems/organisation approach

- Direct patient work
- Joint working
- Consultancy
- Supervision
- Teaching & training
- Leadership & management
- Research & audit

Health + psychological problems = worse physical health & worse outcomes of physical treatment



CARDIOVASCULAR

- Higher mortality rate
- 50% more acute exacerbations/year
- 2-3 fold increase in negative physical outcomes
- Double the likelihood of dying within 5 years of heart bypass surgery
- Outcomes of cardiovascular care are worse



ASTHMA

- Asthma plus associated distress → Two times greater mortality rates than those with only asthma



DIABETES

- 36–38% more likely to die over a two year period
- Worse glycaemic control, more diabetic complications, lower med adherence
- Children with type I diabetes are more likely to suffer from retinal damage if they also have depression



COPD

- Worse health status and breathlessness (independent of COPD severity)

If people do not receive the appropriate psychological intervention there is a significant increase in the costs of care



£8 to £13 billion of the NHS budget is spent on co-morbid long-term conditions/mental health problems



Cardiovascular plus mental health problems:

- Increases the average length of hospital stay from 8.9 days to 13.2 days
- Total costs increase by 49 %.
- Emergency admission rates are 2-3 times higher



Diabetes plus depression:

- Increases diabetic costs by 70 % over 6 months, 48 % over 3 years, 103% over a year



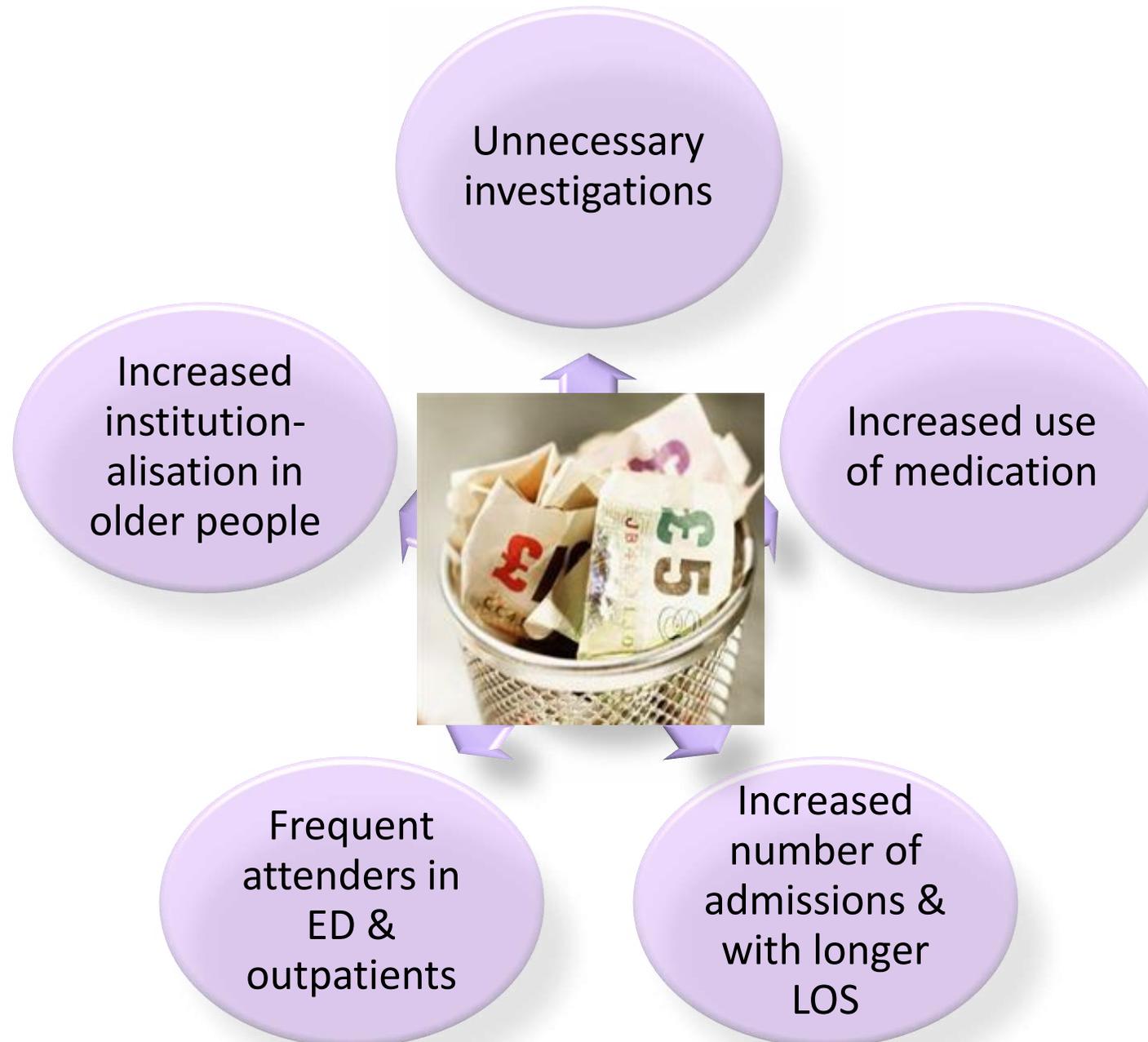
Asthma plus depression:

- Increases medical costs by 253 % over one year



Also shown in chronic pain, neuro rehab, cancer, burns, gastroenterology, ED, facial pain, etc etc etc (across the life span)

Financial waste due to....



Psychology in physical health reduces health care costs by about 20 % per patient by reducing...



Hospital admissions



Excess lengths of stay in acute settings



Attendance at and time spent in A&E



Exacerbations of long term conditions



Excess morbidity and mortality



Unnecessary medical investigations



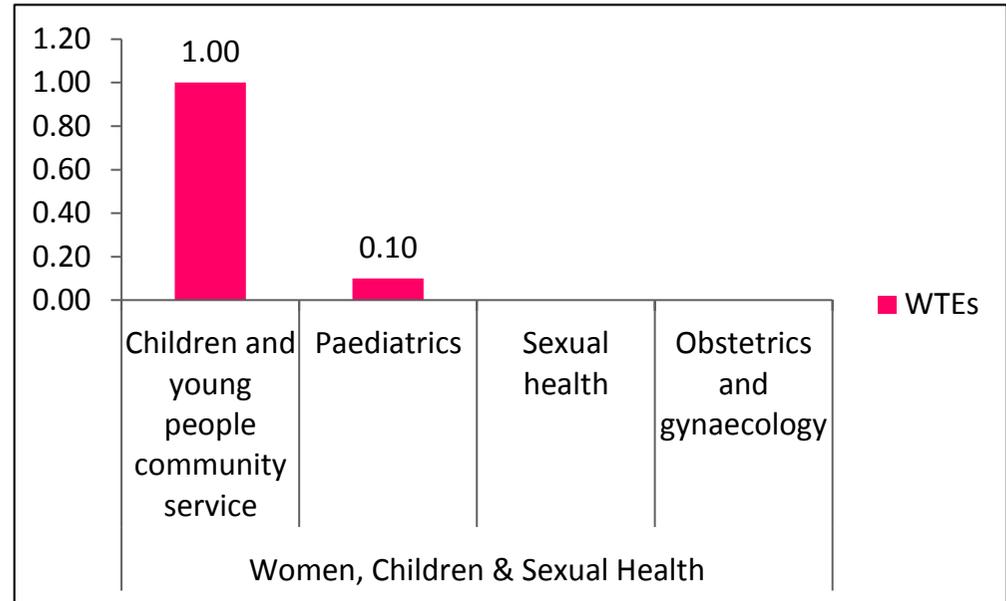
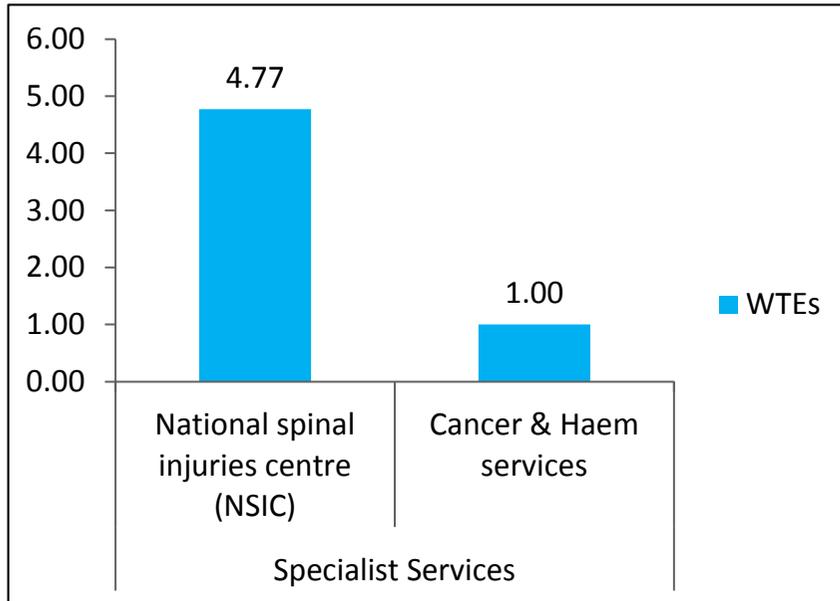
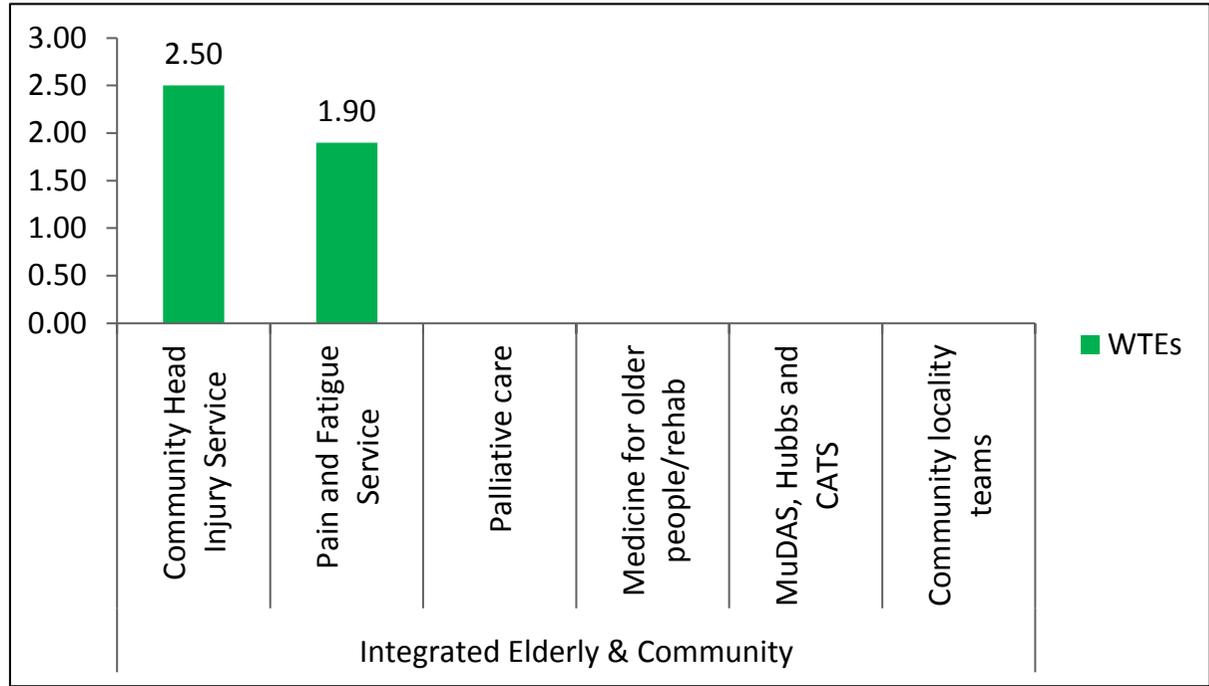
Use of outpatient facilities

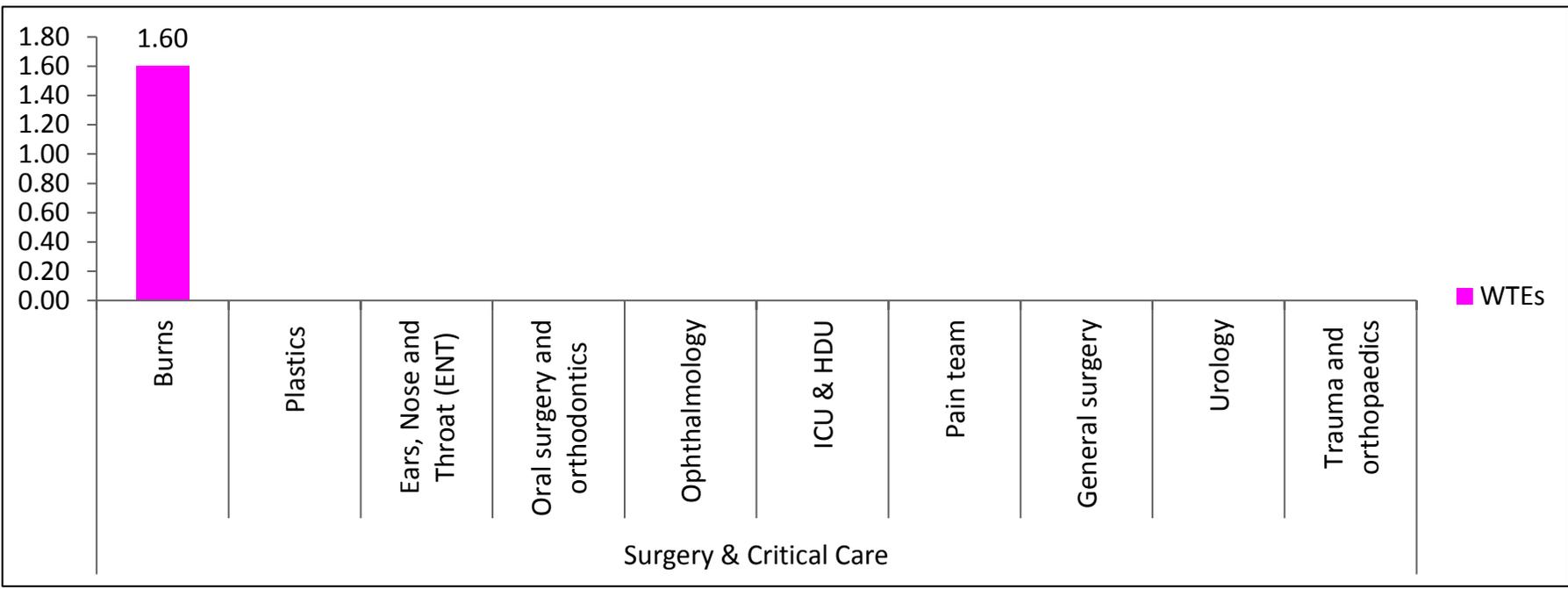
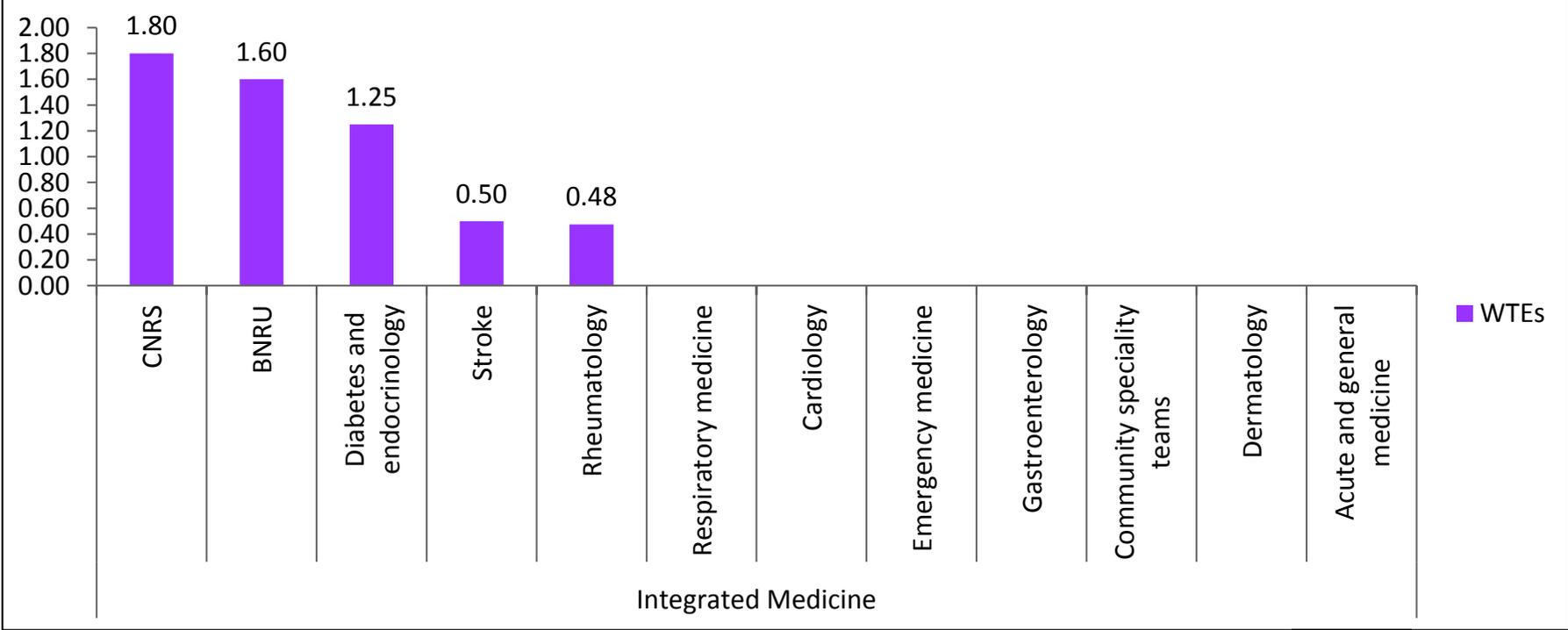


People
will be a great place to
our people have the
s and values to deli
excellence in care

Staff sickness absence

Were we are in BHT





- Positives of current structure/provision
 - Skilled, specialist psychologists
 - Embedded in multi-disciplinary teams
 - Provide a high quality, effective service
 - National and international profile
- Challenges
 - Only some BHT patients can access psychology to help them live with their health problem
 - Only some multi-disciplinary teams benefit from having psychology
 - Hidden in services → hidden profile in the Trust

The way forward

Mission

To achieve parity of esteem in BHT;
Valuing psychological health equally
with physical health

Vision

By 2024, the Psychological Service will have the capacity to see all BHT patients with physical health problems who require psychological interventions

BHT Strategic Priorities

Quality

We will offer high quality, safe and compassionate care in patients' homes, the community or one of our hospitals

- Clinically effective
- Community settings

People

We will be a great place to work where our people have the right skills and values to deliver excellence in care

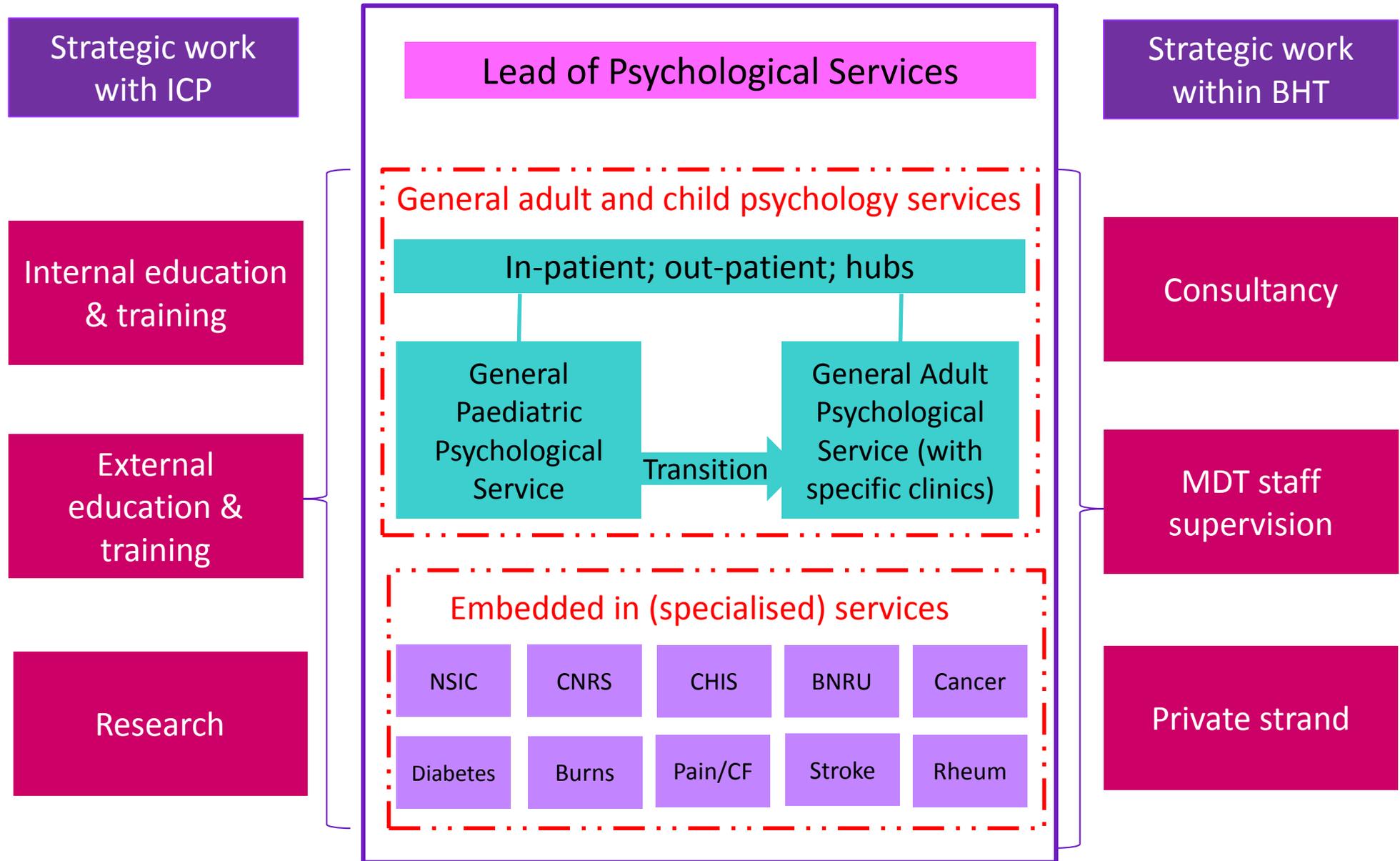
- Support HCPs to understand and use psychological principles in their work with patients
- Skill mixing

Money

We will be financially sustainable, will make the best use of our buildings and be at the forefront of innovation and technology

- Value for money
- Optimising resources

Possible future model





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Thank you

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Agenda item: 5
 Enclosure number: TB2019/68



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

5

Present:

<p>Voting Members:</p>	<p>Ms H Llewelyn-Davies Mr N Macdonald Dr D Amin Mr R Jaitly Mrs J Ricketts Mr G Johnston Dr T Kenny Mrs C Morrice Mr W Preston Mr R Roche</p>	<p>Chair Chief Executive Officer Non-Executive Director Non-Executive Director Divisional Director Non-Executive Director / Senior Independent Director Medical Director / Director of Infection Prevention and Control Chief Nurse Interim Director of Finance Non-Executive Director</p>
<p>Non-Voting Members:</p>	<p>Mrs B O’Kelly Prof D Sines Ms A Williams Mr D Williams</p>	<p>Director of Workforce and Organisational Development Associate Non-Executive Director Commercial Director Director of Strategy and Business Development</p>
<p>In Attendance:</p>	<p>Mrs S Manthorpe Mrs E Jones Ms J Sturgess</p>	<p>Director for Governance Senior Board Administrator (minutes) Lead Nurse for Tissue Viability (for agenda item 3)</p>

058/2019	<p>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.</p> <p>The winners able to be present were: George Wallis; Dorcia Allison; Alice Wilkins and Jumana Hussain; Jess Boulton; Sheena Conington; Geoff Darby; Administration Team for Sexual Health; Sharon Howard and Laura Witherden and Tenimol Binu.</p>
059/2019	<p>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. The Chair also welcomed Mr Barry Jenkins, the new Director of Finance who would be formerly joining the Trust in July.</p>
060/2019	<p>APOLOGIES: Apologies had been received from Mrs N Fox. Mrs J Ricketts was attending to represent Mrs Fox.</p>

061/2019	<p>DECLARATIONS OF INTEREST There were no further declarations of interest.</p>
062/2019	<p>PATIENT STORY The Chief Nurse introduced the patient story around tissue viability. Julie Sturgess lead nurse for tissue viability, introduced the video and highlighted the work of the team and the changes they had made to improve the service. Julie highlighted through the change in work practices they had improved service delivery to patients and were now able to provide supportive advice and give preventative information and training to colleagues working in the community. The importance of referring at the right time to right speciality was highlighted.</p> <p>The Medical Director praised Ms Sturgess for creating a different way of working for her team and asked for her congratulations to be passed on. The Director for Strategy recognised the importance of creating time for learning and for prevention and Professor Sines commented on the complex conditions of patients with lower limb problems and the importance of the correct referral.</p> <p>The Director of Workforce highlighted learning from best practice and suggested this learning should be spread to other areas of the Trust.</p> <p>The Chair passed on her thanks for sharing the patient's story.</p>
063/2019	<p>MINUTES OF THE MEETING HELD ON 27 March 2019 The minutes were accepted as an accurate record of the meeting.</p>
064/2019	<p>MATTERS ARISING AND ACTION MATRIX Updates were shown on the action matrix. There was no further comment.</p>
065/2019	<p>CHIEF EXECUTIVE OFFICER'S REPORT The Chief Executive Officer presented his report asking the Board to note the following; progress on the digital strategy and the full deployment of E-observations throughout the Trust for monitoring safety and driving improvements; noting the financial position and the agreed joint control total with the Clinical Commissioning Group (CCG) and the need to manage the risks.</p> <p>The work supporting developments with Bucks New University was highlighted which meant for the first time in a number of years the county would be training its own nurses.</p> <p>The Chair commented on the therapy and nurse led unit and how it is maximising on learning and what was being done differently. The Chief Nurse was asked to bring to Board at a future meeting real life examples of wider ways of learning.</p> <p>Mr Jaitly noted that within the Integrated Care System (ICS) joint report it would be useful to see a financial report in future. This was agreed to. Dr Amin queried the work around winter pressures and if there was more work to be done. The Chief Executive noted that last winter had been better managed however there had also been less pressure this year than last year. A joint CCG / BHT winter director had been appointed to manage pressures going forward.</p> <p>The Chair congratulated Mrs Fox on her new job and noted that Dan Gibbs would be joining the Trust as substantive Chief Operating Officer and Barry Jenkins would be joining as substantive Director of Finance.</p> <p>The Board NOTED The Chief Executive's report.</p>
066/2019	<p>QUESTIONS FROM THE PUBLIC</p> <ul style="list-style-type: none"> Alison Lewis, public patient partner noted that she welcomed the training around

	tissue viability.
067/2019	<p>INTEGRATED PERFORMANCE REPORT The Divisional Director provided the Board with an update on the integrated performance reports.</p> <p>Constitutional Standards</p> <ul style="list-style-type: none"> • A&E 4 hour standard had improved from 87.67% in March to 89.73% in April. The number of admissions had increased by 20% on the same time last year due to increasing use of observation / assessment wards which enabled the Trust to improve performance at a time of rising demand. • Cancer performance improved against the 62 day standard from 79.4% to 86.2%. • Referral To Treatment (RTT) open pathway performance decreased due to raising demand for the endoscopy service. <p>Quality</p> <ul style="list-style-type: none"> • There had been a reduction in falls • There had been a reduction in deep tissue damage. • There had been an increase in 30 day readmissions and the reason for this was being investigated. • There had been one case of MRSA which following investigation was considered to be unavoidable • The 25 day complaint target showed a continued improvement however there had been an increase in the number of complaints received and areas of poor performance were being targeted. <p>People</p> <ul style="list-style-type: none"> • Nurse turnover was rate was down, the lowest level for two years. 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%. • 23 registered nurses had joined the Trust in April and 17 existing staff gained their registration. • Temporary staffing spend was below the agency cap. <p>Money</p> <ul style="list-style-type: none"> • The Trust reported delivery of £1.1m deficit in Month 1 in line with the operating plan <p>Mr Jaitly requested more metrics on the community sites in future reports.</p> <p>Dr Amin queried the issues around clinical coding and the impact on the dips in finances which looked significant. The Director for Strategy noted and acknowledged these were significant. The issues were being investigated by the Quality Improvement Team and would be monitored through the Finance and Business Performance Committee.</p> <p>Dr Amin queried the Venous Thromboembolism (VTE) assessment levels. The Medical Director assured the Board the issue related to the changes made in the way the VTE risk assessment data was being captured. It was not related to patients not receiving the appropriate assessment and treatment.</p> <p>Dr Amin commented on the number of falls. The Chief Nurse explained that avoidable falls were being investigated and more information would be brought to the Quality and Clinical Governance Committee.</p> <p>Mr Johnston stressed that the finances needed to be improved and he urged haste in making savings early and safely.</p>

	<p>Mr Roche highlighted the success in attracting nurses which was very encouraging and the number of complaints versus accolades which showed that the Trust offered a fantastic service.</p> <p>The Board NOTED the Integrated Performance Report.</p>
<p>068/2019</p>	<p>INFECTION PREVENTION AND CONTROL REPORT</p> <p>The Medical Director presented the Board with the Infection Prevention data for March 2019 noting that there was a new target and criteria of <i>Clostridium difficile</i> for 2019/20 which is now 65. The Trust was on target with the new calculation.</p> <p>Mr Jaitly queried if it was possible for more up to date information to be brought to the Board on this issue. The Medical Director noted that the delay was around timing of information flows however she would investigate this and report back at the next meeting.</p> <p>Dr Amin questioned if trends were recognised early enough. The Medical Director explained there are regular reviews with actions immediately if required. The Chief Nurse commented there was regular challenge around line infections. Professor Sines noted the Quality and Clinical Governance Committee receives deep dive reports on infection.</p> <p>The Board NOTED the Infection Prevention Control report for March 2019.</p>
<p>069/2019</p>	<p>CORPORATE OBJECTIVES IMPLEMENTATION PLAN</p> <p>The Director of Strategy and Business Development presented the Corporate Objectives 2019-2021 Implementation Plan for approval. The plan focusses on 3 areas of transformation; improving culture; implementing new workforce models and tackling inequalities and variation.</p> <p>The BHT way sessions will be used to create a movement for change across the organisation to embed the objectives. The next BHT session in July will be focussing on tackling health inequalities across the community.</p> <p>Mr Jaitly noted that in approving these objectives, it was essential to note the importance of the Trust finances and ensure these were highlighted within the objectives</p> <p>Dr Amin queried why finance did not feature more highly in the corporate objectives. The Director of Strategy explained the Board had previously agreed that business as usual in relation to finances would be managed through the performance reporting. The objectives were about transforming the organisation and culture and this would hopefully have a positive affect the financial position. This did not mean that finances were not a priority for everyone in the Trust.</p> <p>The Medical Director commented on the changes sitting beneath the corporate objectives. These would create change through the training escalation framework and transformation, structural and cultural focus. This would enable the, the money to come through the transformation programme, if you get the money right you can get the quality right. Dr Amin noted that she wanted to understand more about the cultural change but that this could happen outside of the meeting. Mr Jaitly requested the financial situation was more developed and clearly explained in the plan.</p> <p>Professor Sines commented it was important to ensure there are clinical enablers and drivers within the financial plan which underpins the objectives. Professor Sines also asked if there was assurance the finances are there to deliver the digital strategy needed to drive the objectives.</p> <p>The Director of Strategy informed the Board the digital strategy would be coming to the Board in July however there was a significant challenge on capital in the next few years.</p>

	<p>There were risks and opportunities for joined up thinking for the patient's pathway.</p> <p>Mr Johnston commented on the need to have corporate objectives to culturally change the approach and to transform delivery of care going forward.</p> <p>The Director for Strategy agreed that the financial Key performance Indicators (KPI) needed to be emphasised and the wording strengthened so the Board had confidence the Trust was focussed on finances as well as quality. This change would happen in the final version of the objectives.</p> <p>The Chief Executive welcomed the Board's comments and urged the Board's sub-committees to receive assurance the objectives were moving forward.</p> <p>The Board APPROVED implementation plan subject to strengthening of the wording around finances.</p>
<p>070/2019</p>	<p>18/19 SUMMARY FINANCIAL POSITION</p> <p>The Interim Director of Finance presented the out-turn 18/19 financial performance which had been approved at the Audit Committee the day before (28 May 2019).</p> <p>Dr Amin questioned if the cause for being off plan was being analysed by the Finance and Business Performance Committee. The Interim Director of Finance noted the Committee was looking at lessons learnt from last year to improve for 2019/20.</p> <p>Mr Jaitly said that the Committee would look at the triggers and identify and deal with these earlier than it did last year. Dr Amin queried if the plan was realistic given that the cost improvement programme was not met last year. The Director of Workforce highlighted the plan had been agreed with NHS Improvement (NHSI) with a full identification of risks. The Executive Team would work with their teams to provide support in key areas and challenge in a timely way. The Chief Executive commented that the plan is achievable. It was explained that in previous years the CIPs by percentage had been higher than the current year.</p> <p>The Chief Nurse noted the Trust was doing things differently with a transformation plan around quality and culture with a focus on productivity and waste. There was support for the Finance team collectively and for working with partners differently without compromising on care and safety.</p> <p>The Interim Director of Finance noted the plan was a system wide plan to provide a solution for Buckinghamshire patients.</p> <p>The Board NOTED the 2018/19 out-turn financial performance, acknowledging there was a system wide challenge to deliver the plan.</p>
<p>071/2019</p>	<p>SEVEN DAY SERVICES</p> <p>The Medical Director presented the ten clinical standards, results and analysis from the survey taken in April 2019 for Seven Day Services which were reported in the Quality and Clinical Governance Committee.</p> <p>The Seven Day Services profile was being raised nationally and therefore the Medical Director would bring this to the Board twice a year. Internal audits had been undertaken to look at all 10 standards to gain better understanding of the services.</p> <p>The Chief Executive Officer queried the issues around inpatient patient safety. A deep dive around these issues would be undertaken and referred to the Quality and Clinical Governance Committee.</p> <p>Dr Amin questioned the number of audits and if more were expected. The Medical</p>

	<p>Director noted the direction of travel and that the IT strategy would assist with this, looking at areas which needed to be audited. Dr Amin queried if there was concern on the number of audits and the capacity of staff to undertake them. The Medical Director noted that this was the right area of work.</p> <p>Mr Jaitly commented on the impact on money and capacity and the importance of understanding the financial impact of 7 day services. The impact will be reported to Finance and Business Performance once the figures are clear.</p> <p>Professor Sines commented on the access to diagnostics and timely and consistent services. The Medical Director replied noting access was to all services and that it was timely. Professor Sines commented on the reliance on inter agency support including safeguarding. The Medical Director assured the Board there was good access with social services and good support from partners noting that mental health services would be accessed through A&E.</p> <p>Mrs Ricketts questioned if the workforce was available to deliver the services. The Medical Director explained this was not currently in place however; there was innovative practice taking place with the existing workforce. There was stretch for all the teams.</p> <p>The Board NOTED the findings of the April 2019 survey and SUPPORTED the recommendations in the report subject to the financials being included.</p>
<p>072/2019</p>	<p>QUALITY AND CLINICAL GOVERNANCE COMMITTEE CHAIR’S REPORT</p> <p>The Chair of the Quality and Clinical Governance Committee noted the priorities for the coming year included community hospitals and a new workforce model.</p> <p>Women and children’s services were considered to be excellent. However, there remained challenges in diagnostics for children’s services. It was stressed patient safety was prioritised.</p> <p>The national freedom to speak up guardian had visited the Trust and had been very impressed with women’s services and the openness and transparency of learning for front line staff about cultural change. Thanks were expressed to Tracey Underhill for organising the visit.</p> <p>The Committees Terms of Reference had been amended were presented for Board approval. Mr Jaitly asked for cross Committee referral processes to be highlighted in future versions of committees’ terms of reference.</p> <p>The Board NOTED the Quality and Clinical Governance Committee Chair’s report and APPROVED the Terms of Reference.</p>
<p>073/2019</p>	<p>FINANCE AND BUSINESS PERFORMANCE COMMITTEE CHAIR’S REPORT</p> <p>The Chair of the Finance and Business Performance Committee noted the Committee had met the previous day (28 May 2019) and discussed the cost improvement plan and the financial recovery board. It was noted the Trust needed to be realistic in facing issues and the key to delivering was to do things differently. The Committee noted the risk around estates, back log maintenance and IT infrastructure as well as the lack of Capex for the year. There Committee would be receiving a full report on managing risks for IT. The committee had looked at coding, community metrics and was looking for more analysis going forward.</p> <p>The Chief Nurse noted the need to make quality impact assessment part of the discussions and Professor Sines noted the need to be vigilant around safe staffing.</p> <p>The Board NOTED the Finance and Business Performance Committee Chair’s report.</p>

074/2019	<p>QUESTIONS FROM THE PUBLIC</p> <p>Julie Harris requested that 7 day services needed to be accessible and for transport to be available. The Medical Director noted that seven day services was for emergency services and not planned services, however her point was well made in relation to other services.</p> <p>Julie Harris thanked the Director of Strategy and Business Development for touring Wycombe Hospital in a wheelchair to experience accessibility issues.</p> <p>The Chair asked the Commercial Director for a report on accessibility of services to come to Board.</p> <p>A member of public queried the availability of GP services at the weekend and the impact this has. The Chief Executive Officer commented on the shortage of GP's nationally and that accessibility would reduce acuity access.</p>
075/2019	<p>AUDIT COMMITTEE CHAIRS REPORT</p> <p>The Audit Committee Chair informed the Board the Annual Governance Statement, Annual Report and Accounts had been approved by the Audit committee and signed on behalf of the Board by the Chief Executive Officer and Director of Finance. Thanks were given for the enormous amount of work undertaken by the Director for Governance, Interim Director of Finance and Justine Stratfold, Acting Financial Controller.</p> <p>It was noted the Quality Accounts would be submitted by 30 June and will be aligned with the Annual Report and Annual Governance Statement.</p> <p>The Board NOTED the Audit Committee Chair's Report.</p>
076/2019	<p>ORGANISATIONAL RISK PROFILE</p> <p>The Director for Governance presented the organisational risk profile which highlighted the top risks and how they were being managed.</p> <p>This was a new Board Assurance Framework (BAF) which incorporated the new corporate objectives and would be managed in a timely manner and monitored through the Board and sub committees. Each Executive Director was aware of their responsibilities and a new format for the BAF would be considered going forward. All risks are monitored in the Corporate Risk Register.</p> <p>The Board NOTED the Organisational Risk Profile.</p>
077/2019	<p>CORPORATE RISK REGISTER</p> <p>The Director for Governance presented the Board with the Corporate Risk Register (CRR) to give assurance the risk management process was complied.</p> <p>The CRR had been thoroughly reviewed at divisional level and at the Executive Management Committee and the actions were noted. Since publishing there had been changes to CRR 10 and CRR 63 around accessible information standards. There had also been changes in the risk level of the endoscopy service which was now a red risk (CRR 95)</p> <p>Professor Sines queried CRR 34 around deterioration and the suggestion for removal from the risk register and how this would be monitored going forward. The Medical Director explained that there was now an increased visibility of deteriorating patients and the Trust was maintaining vigilance. Professor Sines requested that something was added in the mitigation around sepsis as an important part of the quality journey. The Medical Director recommended the removal of CRR 34.</p> <p>The Board NOTED the risk register and AGREED to the proposal around CRR 34.</p>

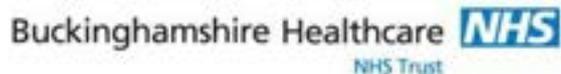
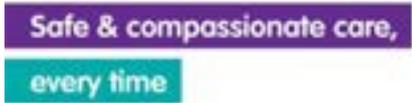
<p>078/2019</p>	<p>STP PLANNED GOVERNANCE</p> <p>The Director for Strategy and Business Development presented the Governance arrangements for the Buckinghamshire, Oxfordshire and Berkshire West (BOB) STP / ICS.</p> <p>The report had been prepared by PWC and set out the governance structure and work streams, including setting out accountabilities, roles and responsibilities.</p> <p>The report considered which work streams were best managed at a regional level. For example, acute collaboration and pathology services were highlighted in order to offer suggestions on how to manage these services better over time Capacity and capability across sites in the region were also being considered.</p> <p>Mr Jaitly asked for finances and financial implications to be included in future reports. The Director of Strategy and Business Development explained there would be a regular report to Board on the work of the STP and the financial control total would be part of the report and as well as the financial implications.</p> <p>Dr Amin asked for clarity on how the Trust would be working differently in the future across the STP and what would allow us to have value. The Director of Strategy and Business Development explained by working together across the STP the Trust would receive better value from services such as Pathology. Further work to deliver and design individual services was required.</p> <p>The Medical Director asked for clarity on dependency and timescales as sequencing was important.</p> <p>The Director of Workforce and Organisational Development commented that the system was already working and looking at solutions together. The governance structure would help in looking at ways of working to build solutions at scale.</p> <p>The Chief Nurse asked for communication around this to the public and staff and working with the local community.</p> <p>The Chair queried the role of Non-Executives in the STP and what would happen regarding the Boards and Non-Executives.</p> <p>The Chief Executive noted that there must be appropriate statutory oversight with a regular report to the Board and there was a wider challenge on engaging the Non-Executive Directors.</p> <p>Professor Sines queried the overall governance model and strategic workforce development.</p> <p>The Director of Workforce and Organisational Development noted the challenge of ensuring workforce was integral. The Local Workforce Action Board would look into this. They are a holistic group looking at all workforce issues.</p> <p>The Chair noted the challenges and that a regular STP report would be brought to Board, including information on financial performance of the partners.</p> <p>The Board SUPPORTED governance arrangements to improve better healthcare across the region.</p>
<p>079/2019</p>	<p>SELF-CERTIFICATION</p> <p>The Director for Governance presented the yearly report required by NHSI for approval for the NHS Provider licence self-certification.</p> <p>The Board APPROVED the self-certification.</p>

<p>080/2019</p>	<p>TRUST SEAL REPORT The Chief Executive Officer presented the Trust Seal Report.</p> <p>Mr Jaitly asked for more background to number 98. The Director for Governance would check the detail and report back to Mr Jaitly.</p> <p>The Board NOTED the report.</p>
<p>081/2019</p>	<p>PRIVATE BOARD SUMMARY REPORT The Board NOTED the summary of the private board held in March 2019.</p>
<p>082/2019</p>	<p>BOARD ATTENDANCE RECORD The Board NOTED the attendance record subject to the Quality Committee attendance being updated for the meeting on 7 May and for Tom Roche to be included as a non-executive director not an associate non-executive director.</p>
<p>083/2019</p>	<p>RISKS IDENTIFIED THROUGH BOARD DISCUSSION The Director for Governance set out the risks identified through Board discussion as follows:</p> <ul style="list-style-type: none"> • Coding levels • VTE capturing data and the risk associated with patient care • Finance risks and including identification of CIPs and how they can be incorporated into budget setting. • Digital strategy risks and the large investment required and mitigating that risk • System finance total and behaviours and solutions needed to rapidly put in place to meet those requirements. • Waiting list challenges and diagnostic challenges in children’s services • Backlog maintenance • Lending risk
<p>084/2019</p>	<p>ANY OTHER BUSINESS</p> <ul style="list-style-type: none"> • Mr Johnston mentioned the difficulties he had experienced with completing his statutory and mandatory training. The Director of Workforce would look into this. • The Chair announced he Trust Chaplaincy had won a Health Service Journal (HSJ) award and congratulations were expressed to them. They would be invited to present to the Board at a future date.
<p>085/2019</p>	<p>QUESTIONS FROM THE PUBLIC David Annetts from Pfizer, queried the Trust’s smoking cessation programme within the ICS and investment in this. The Medical Director noted historically the programme in the Trust had been supported by Public Health. This had now gone to a different provider and was now much more digital.</p> <p>Alison Lewis queried if the Disability Inequalities Group still existed. The Director of Workforce and Organisational Development noted this group had recently been restored and local charities were also involved.</p>
<p>086/2019</p>	<p>DATE OF NEXT MEETING Wednesday 30 July 2019, 9am, Florence Nightingale Hospice Charity, Aylesbury</p> <p>There being no further business the Chair recited the motion to bring the meeting in public to an end.</p>
	<p style="text-align: right;">Signed</p> <p style="text-align: right;">Trust Chair</p> <p style="text-align: right;">Dated.....</p>

ACTION MATRIX

Minute		Lead	Timescale	Update July 2019
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	On Agenda
043/2019	RTT trajectory to be reviewed by the Finance and Business Performance Committee.	Chief Operating Officer	31 May 2019	Included in the IPR report - closed
043/2019	QIP around outpatients to be brought to the Quality and Clinical Governance Committee.	Chief Nurse	September 2019	Quality Committee 3 September 2019
043/2019	Deep Dive into HCA / Nurse sickness rates to be brought to Strategic Workforce Committee	Director of Workforce and Organisational Development	August 2019	This will be brought to the August Workforce Committee.
065/2019	Examples of wider learning to be brought to Board	Chief Nurse	September 2019	Therapy led ward patient and staff story September Board
	Finances to be included in the ICS future reports	Chief Executive Officer	July 2019	Included in CEO report
067/2019	More information on the performance metrics for the community sites in future reports	Chief Operating Officer	September 2019	Not due
068/2019	Infection Prevention Control Report. More up to date information to be brought to Board if possible	Medical Director	July 2019	Discussed and confirmed no change to the data. Medical Director will provide a verbal update in addition to the paper at each meeting - Closed
069/2019	Corporate Objectives Implementation Plan – strengthen wording of finances	Director of Strategy and Business Development	July 2019	To be part of normal reporting processes – closed
071/2019	Deep dive in patient safety to go to Quality Committee – 7 day working	Chief Nurse	July 2019	Being scheduled - closed
072/2019	Board Sub Committee Terms of Reference Cross reference across the committees to be included in future versions of Terms of Reference	Director for Governance	May 2020	Not due
074/2019	Report on accessibility of services to come to a future Board	Commercial Director	July 2019	On Agenda
080/2019	Mr Jaitly asked for more background to number 98. The Director for Governance would check the detail and report back to Mr Jaitly.	Director for Governance	July 2019	Completed

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 Enclosure no: TB2019/069



TRUST PUBLIC BOARD 31 July 2019

Details of the Paper

Title	Patient Accessibility
Responsible Director	Commercial Director
Purpose of the paper	Following an observational exercise, undertaken at Wycombe Hospital on 2 nd May 2019 a number of areas of concerns were identified when navigating around the Hospital in a wheel chair. This paper provides the Board with an overview of the current accessibility experience within the Trust and identifies key actions for improvement.
Action / decision required (e.g., approve, support, endorse)	For Approval

6

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

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

ANNUAL OBJECTIVE

Which Strategic Objective/s does this paper link to?
 This relates to the Estates Strategy (which is an enabling strategy)

Please summarise the potential benefit or value arising from this paper:
 Addressing areas of improvement will improve patient experience

RISK

Are there any specific risks associated with this paper? If so, please summarise here.	<i>Non-Financial Risk:</i> Reputation
	<i>Financial Risk:</i> Risk of non-compliance with Equality Standards

LINK TO CARE QUALITY COMMISSION ESSENTIAL STANDARDS OF SAFETY AND QUALITY

Which CQC standard/s does this paper relate to?	Safe and effective <i>(if you need advice on completing this box please contact the Director for Governance)</i>
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Author of paper: General Manager Property Services
Presenter of Paper: Commercial Director
Other committees / groups where this paper / item has been considered: EMC
Date of Paper: 22 July 2019

Agenda item: 6

Enclosure no: TB2019/069

Disability awareness at Buckinghamshire Healthcare NHS Trust

In 2017/ 18 the national scores for disability were published as part of Model Hospital. Model Hospital is a digital information service designed to help NHS providers identify and realise opportunities to deliver the best patient care whilst improving productivity and efficiency. It provides the most up to date view of the Trust operation in line with its peers through comparing key performance metrics within a group of relevant “peer” Trusts.

In 2017/ 18 Buckinghamshire Healthcare NHS Trust was reported as lower (70.1%) than hospitals that are deemed to be similar (83.4%). These scores have been taken from the PLACE results (The Patient Led Assessment of the Care Environment)¹ from 2018/19. The table below provides an overview of key findings.

These scores are affected by our aged estate which is not required to be compliant against the 2014 DDA standards, and also the methodology of assessment which is a “snapshot” in a small number of locations. That said, a recent audit of an executive director in a wheelchair identified areas where we could do better.

To become outstanding as a Trust, it is necessary that when any changes are being considered, equality, disability compliance and awareness need to be part of all initial discussions relating to estates. This paper outlines areas that have been addressed since the audit and the model hospital benchmark data and next steps.

Compliance with legislation

Currently Buckinghamshire Hospitals have a mixture of Estates, some that is Trust owned and some that is owned by PFI partners. The estate in its entirety is over 20 years old and was built to HTMs at the current times. The Disability Act came into force in 2004. BHT is not liable to undertake alterations to existing infrastructure but is required to ensure that future alterations comply with current HTMs. Guidance asks the hospital to be “reasonable and practical” when making changes to the estate to reflect current legislation. In practice this means that we site walk and when issues are identified these are logged and we endeavour to address them.

The Patient Led Assessment of the Care Environment: What we have learnt from the 2018/ 19 PLACE results

1. **Signs (Dementia) – Orientation - Displaying the hospital name in the entrance to all wards. Consistent signage on toilet / bathroom doors displaying picture and text.**
2. **Dementia Clocks on wards: Link with dementia nurse. Set up Dementia Steering Group**
3. **Contrasting colours of floor and walls – follow dementia guidelines for department redecoration**
4. **Hot and Cold tap discs – Assessments noted missing discs. Ensure tap discs are visible.**
5. **Hearing loops in reception areas – review guidelines with audiology**

¹ The Patient Led Assessment of the care environment is a direct observation from a patient group about how BHT can improve their environment. It is a small snapshot of the entire estate and evaluates 4 of the Trust properties (inpatient wards) with parts of the hospitals evaluated each year on a rolling program. The results reflect up to 10 inpatient wards, ED, Out Patients, plus grounds and gardens in the 4 properties. There are a standard set of questions for area and cover the topics below with regards to disability and dementia. The questions asked are a straight forward yes or no answer; Access to the areas, Receptions and waiting areas, Directional signage, Flooring

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What has been done since the PLACE Audit?

Over the last 2 months, in partnership with our PFI provider at SMH Ward 10 is being currently being refurbished to make it compliant with the recommendations discussed previously in the document.

Estates have

- Laid new flooring that does not need to be polished and will not be reflective
- Laid a coloured strip between the bays and bathrooms to define the areas
- The toilet and bath room furniture is in contrasting colours
- Feature walls have been painted in the bays to reflect the same colour outside the bay
- New signage has been sourced that is dementia friendly
- Dementia clocks have been purchased by the wards
- All areas will be clearly identified and easily accessible

The area will set a standard that Property Services will seek to achieve when all changes are made in the future.

In addition, an observational exercise was undertaken at Wycombe Hospital on 2nd May 2019 and a number of areas of concerns were identified when navigating around the Hospital in a wheel chair. An update on the themes identified are provided below;

- The automatic door entrance system was not working. – this has been addressed and is now in working order
- There is no designated place for a patient in a wheelchair to sit other than in the corridor just past the reception desk. – there are areas within the cafés and public areas where patients and visitors can wait, we have also re arranged the chairs in the area for wheelchairs.
- The vending machines throughout the Trust are difficult for a wheelchair user to use. We have a mixture of vending machines that are and are not compliant. We are working with our service partners to address this with their suppliers. Both SMH and WH already have a number of compliant machines and we will work towards these being 100% by detailing this specifically in future contracts with our PFI partner.
- The fire extinguishers being on the wall next to where the leaflets are - restrict wheelchair users from getting close enough to the wall to reach to get some of the leaflets. –we have arranged for the leaflets to be moved to a more accessible height.
- A leaflet rack was placed too high on the wall and a hand sanitizer dispenser. – We will be writing guidelines to make sure any new areas or any communal areas have accessible leaflet racks and hand sanitisers at both DDA and standing heights
- Disabled toilet within Radiology department at Wycombe hospital. The flush for the toilet is on the wrong side of the seat. Users do not want to flush the toilet whilst on the seat but cannot reach the toilet flush from the other side of the toilet without stretching over the toilet (if able to do so) – the toilet was built to DOC M on washrooms and this area is compliant. The points have been noted and going forward it will be included in the guidelines for consideration.
- Red alarm cord should not be tied up and should be on the floor in case a wheelchair user falls out of their chair and is on the floor all plastic call cords MUST be released these should not be tied up anywhere – a message has been passed to all our service partners to make them aware that checking the emergency pull cords should be part of the daily checks and if they are tied up they should always be released.

There were a number of infrastructure challenges that were also identified

- Road way and dropped curbs – the team is looking at the area identified and all surrounding areas to put a business case to the board for funding
- Door furniture and types of doors – these will form part of our guidelines
- Reception desk heights need to be refurbished to be DDA compliant

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Next steps

Due to the complexity of the estate and the investment required to have parity across all buildings and multiple service providers, The Trust will compile a “best practice” guide so that anyone wishing to make changes within an area should consider the recommendations. These will include implementation of the key findings from the PLACE audit as well as guidance for:

- Patient access
 - o Hand rails in all corridors and leading to all bath rooms and toilets
 - o Seating areas along long corridors allowing people to rest
- Reception and waiting areas
 - o All areas to have ramp access with a slip resistant surface
 - o Appropriate height reception desks
 - o Provide a range of chairs including different heights, with and without arms and including bariatric
 - o All waiting areas are wheel chair accessible and patients in wheel chairs are able to sit alongside accompanying mobile escorts
 - o Hearing loops
 - o Accessible toilets big enough for a wheel chair user and carer possibly even a “changing places” toilet at one of our sites
- Lifts
 - o Easily signposted
 - o Large control buttons including brail
 - o Clear signage inside and outside of the lifts
 - o Audible announcements
- Flooring
 - o Flooring should be consistent in colour, matt, non-reflective
 - o Contrasting colour to the walls
- Way finding

The team are currently working with the communications team to address the issues with directional signage across the estate. It is an area of concern with no clear guidance currently. Not only is the directional signage challenging there is a culture of “temporary signage” being put up in places that are distracting to the public and patients.

 - o Signs should be easy to read and understand
 - o All signs should be at eye level
 - o There should be a hospital wide colour coding system
 - o Toilet and bay signs need to be seen from all angles
 - o Pictures and text should be used
- Bathrooms
 - o Toilet seats, flushes and rails should be a contrasting colour
 - o All toilet furniture should be of a familiar design
 - o Taps should be clearly marked hot and cold
- Car parking
 - o To provide assessable spaces not only for disabled patients but dementia, mothers and babies, carers and all vulnerable groups

Agenda Item: 7
Enclosure No: TB2019/070

TRUST BOARD MEETING IN PUBLIC
31 JULY 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, Oxfordshire and Berkshire West Integrated Care System (BOB ICS) Chief Executive Briefing, and the Buckinghamshire Integrated Care Provider (ICP) System Reports, are also appended to this report to provide an overview of our activities together with our system partners.

1. Learning

In May and June we recorded 400 and 409 births respectively in our care. I am disappointed that we saw an increase in our cases of *clostridium difficile* infection in May (seven); although this has improved in June at four cases. We have had no reports of MRSA in May and June, and no never events. I am disappointed that we recorded two falls causing severe harm in June. We recorded three Trust-attributed grade three/four pressure ulcers in May, and this area continues to be a particular area of focus. 89 patients passed away in our care in May and 55 in June.

We received 58 formal complaints in May and 63 in June. We continue to exceed the Trust target of 85% of cases responded to within 25 days, although we do recognise that these rates have dropped a little in the last few months due to the increased caseload. We received 1,275 accolades in April and 694 in May.

In May and June we received 69 and 67 excellence reports respectively. I was delighted to see this fine example of using one's initiative to invest in education and team development:

“Dr *** has initiated an intensive care journal club, this is attended by a multi-disciplinary team and has received widespread support. It is inspirational to trainees to see their senior colleagues taking time to invest in education and development. Because this is multi-disciplinary it has also helped to strengthen inter-discipline relationships.”

Recently our quality improvement (QI) team have been working closely with staff in our Emergency Department (ED) to look at the support we provide to high intensity users of this service: there is a cohort of patients who would benefit from a more coordinated process to provide an individualised care plan to better support their needs and help them navigate the health and social care system.

Data collated from 01 April 2017 to 31 March 2018 revealed that 96 adults attended ED ≥ 10 times in one year, totalling 1348 attendances; 68% were treated without admission and 25% of these patients presented primarily with mental health needs. The team sought to establish a Trust High Intensity User (HIU) project dedicated to supporting this cohort, akin to other EDs in the region. Launched in March 2019, it is focused on educating ED staff on the importance of using the right language and building trust and confidence at the ‘front door’ so that high intensity users are more inclined to engage with healthcare pathways and professionals. Notable outputs of the project so far include: redesign of the ED mental health training programme with input from Clinical Psychology; sourcing accurate information about the volume of patients affected by delays in receiving a Mental Health Act Assessment; engagement of ED staff with the regional HIU network to learn best practice; networking and regular communication between ED staff and Oxford Health regarding a developing urgent care pathway; inaugural monthly MDT meeting to develop individual bio-psycho-social care plans as part of a six-month pilot.

This project is about providing the right support for some of the most vulnerable people in our community through appropriate interaction, correct signposting and individual care plans, and although it is early days, I will share an update in a future report following the six-month pilot.

Quality and performance

In a previous report I made reference to the Care Quality Commission (CQC) routine inspection across the Trust in Q4 of 2018/19. I am extremely pleased and proud to acknowledge that the Trust has been rated Good overall, and Outstanding for Caring. We were also rated Good for Safe, Effective and Responsive, and Requires Improvement for Well-led. The improvement since our last inspection in 2016 when we were rated Requires Improvement overall, is down to the endless hard work and commitment shown by our staff. I hope they are as

proud as I am and have taken some time to celebrate. It was wonderful to visit many of our teams together with our Trust Chair and Chief Nurse on the day of the announcement, and I look forward to speaking with more members of staff during my biannual staff sessions over the coming weeks.

During their inspection, the CQC decided that our staffing levels in our community inpatient wards was not at the required level and we have been required to take immediate action to address this. After comprehensive and careful consideration, the initial phase of our action plan involved the closure of one of our community inpatient wards at Amersham Community Hospital, specifically Chartridge Ward, to ensure the staffing levels across our other wards could be maintained at the required level. The next phase of the plan is to work with our partner organisations and stakeholders across the county to design the most appropriate model of our community inpatient service, ensuring that it will be able to evolve with the population changes in Buckinghamshire and the predicted future demands on our services. I will share updates on this in my future reports.

Our A&E performance against the 4-hour standard improved from May to 89.05% in June. Regarding our cancer performance, we reported two patients waiting more than 104 days in April, and three in May; our performance against the 62 day standard was 83.3% in April, and 83.9% in May; slightly under the target of 85%.

Strategic view

Over the past two months, we have had a number of changes in the structures of our partnership organisations within Buckinghamshire as a result of the initiatives outlined in the NHS Long Term Plan. Twelve Primary Care Networks (PCNs) have also formed across the county, bringing together GP practices and integrated community teams, and each serving a population of 30,000–50,000 patients. The Buckinghamshire ICS has become the Buckinghamshire Integrated Care Partnership (ICP), reflecting alliances of 'place'-based alliances of NHS providers, commissioners, local authorities and third sector providers. Finally, congratulations to colleagues in the Buckinghamshire, Oxfordshire and Berkshire West Strategic Transformation Partnership (BOB STP), who have been successful in their application to become a Wave 3 Integrated Care System (ICS; see Appendix 3.1 and 3.2). I would also extend my congratulations to David Clayton-Smith who has been appointed BOB ICS Independent Chair. The BOB ICS will oversee planning and commissioning in the three 'place'-based populations of Buckinghamshire, Oxfordshire and Berkshire West. I have also appended to this report a briefing on the development of the BOB ICS Five Year Plan to deliver the priorities and requirements of the NHS Long Term Plan (Appendix 3.3 and 3.4).

Earlier in July we held our second BHT Way event for staff across the Trust, this time focused around our corporate objective of tackling variation and health inequalities. Working with our partners across the county, we have a lot to do to address some of the inequities that exist. One programme of work I would like to draw attention to is the Social Isolation Project in Buckinghamshire to support the physical and mental health of the 1 in 10 residents and >1 in 4 people over 65 in our county live alone. Phase 1 is underway and led by the public health team at Buckinghamshire County Council, identifying evidence-based best practice, engaging with partners and summarising available data and intelligence. Phase 2 will be codesigned with the Design Council and will be a 2-day workshop for 30 stakeholders, mapping local actions. I look forward to sharing updates on this important piece of work in future reports.

Money

The Trust is on plan year-to-date, reporting £1.7m deficit at the end of June. This position includes receipt of Performance Sustainability Fund, Financial Recovery Fund and Marginal Rate of Emergency Threshold monies, totalling £3.2m.

The financial environment in the NHS continues to be challenging, but the changing local landscape of working closer with our ICP and ICS partners can assist with delivery. This is being evidenced at an ICP level through the Q1 reported position whereby the Buckinghamshire ICP has agreed rephrased contractual plans enabling BHT to report delivery in line with plan. At an ICS level organisations are working together to deliver the national requirement to reduce capital plans by 20% in 2019/20.

The Q1 position highlights the need to focus attention on overspending in non-pay from clinical supplies and services and estate costs, and non-pay cost improvement plan (CIP) targets. With regard CIP delivery overall, values are being compensated through delivery of non-recurrent pay actions.

The Trust is managing its risk internally, but also as part of an ICP risk schedule, and reporting a collective ICP position to NHSE/I. The Trust have submitted the second phase of our Financial Recovery Plan (FRP) to

NHSE/I and we have completed our first formal monthly Undertakings meetings with them to discuss our position, risks, CIPs, FRP, and actions to improve our financial governance.

The Trust and Bucks CCG have established a Finance Committee in common to review and oversee the finances of the ICP as a whole. This Committee in common met in July to review the Month 2 positions, and forecast of likely Q1 out-turn, and will meet quarterly going forward.

People

I am pleased to report that our nurse vacancy rate reduced by 1% in May to 15.8%; in June our reported vacancy rate is 15.9%. This has been driven by improvements in recruitment and retention, as well as a number of existing staff gaining NMC registration. I do acknowledge that there are 11 areas with a nurse vacancy rate above 30%, although am assured that mitigating actions are in place to ensure safe care is maintained. Our staff turnover rate has significantly improved in the last few months, 13.4% in May. With regard to agency spend, this remains lower than previous quarters, a result of robust controls for nursing having been extended to other staff groups.

We were pleased to welcome Dr Henrietta Hughes to the Trust, the National Freedom to Speak Up Guardian, to discuss best practice from across the UK, and also to share some of the ways we are continually trying to improve our culture and ensure all staff feel able to speak up if the situation were to arise. Data from our 2018-19 staff survey show efforts are moving things in the right direction, with a 4% increase in staff feeling secure to raise concerns about unsafe clinical practice, as well as a 4% increase in staff feeling confident that the organisation will address their concerns. Henrietta was particularly impressed with the innovative quality improvement work that is taking place in the paediatric and maternity units.

I would also like to draw attention to the Equality, Diversity and Inclusion paper in the agenda of today's Trust Board in Public. I mentioned earlier our most recent BHT Way, and a significant focus within the Trust is driving equality, diversity and inclusion amongst our staff to ensure they feel valued and bring their whole selves to work.

I would like to take this opportunity to acknowledge that Carolyn Morrice, our Chief Nurse, has decided to take the next step in her career and is moving to the Chief Nurse post at Brighton and Sussex University Hospitals in October. I would like to thank her for her commitment to BHT and I'm sure I speak on behalf of the Board in wishing her well. While we recruit to a new permanent post, I am pleased to confirm that Jennifer Ricketts has been appointed as the Trust Interim Chief Nurse; may I formally offer my congratulations and welcome Jenny to the Board.

2. Outstanding practice

In June, our Trust Board were delighted to hear from our first cohort of medical trainees who presented their leadership projects. I am sure I speak on behalf of the Board, not only in thanking them for their hard work and for taking the time to present to us, but more importantly, in commending them on their innovative change proposals to transform outpatient care. It was fantastic to see and is an example of the talent and great ideas we have within the organisation to make positive steps forward for patient care, if we allow staff time to do so. This is why making it easier to get things done and releasing time for improvement projects are key areas of focus under our 2019-20 corporate objective around improving our culture.

I am delighted to highlight to the Board that the anaesthetic department has been successful in achieving Anaesthesia Clinical Services Accreditation (ACSA) Royal College of Anaesthetists scheme. This is an important milestone for our anaesthetists and reflects a lot of hard work by the staff involved.

In the first week of June we celebrated Volunteers' Week. Our volunteers are an exceptional group of people who dedicate their precious time to support the staff and patients at BHT, and are a vital part of our services, recognised by inviting them to join the celebrations of our CQC rating. It was fantastic to spend time with the team in Horatio's Garden (a wonderful space in the centre of Stoke Mandeville Hospital that can be enjoyed by all staff and patients on the site) and our A&E buddies in the Emergency Department. It was also humbling to sign a number of certificates to recognise the number of years of service to our Trust, one of 40 years. I would like to take this opportunity to say an enormous thank you on behalf of the Board to all our volunteers.

I would also like to mention that we have launched our 2019 Staff Awards, including a new category for quality improvement. This annual event showcases our amazing staff, their dedication and their ideas for advancing patient care, and it is always a delight to be involved with.

3. Proud to be BHT

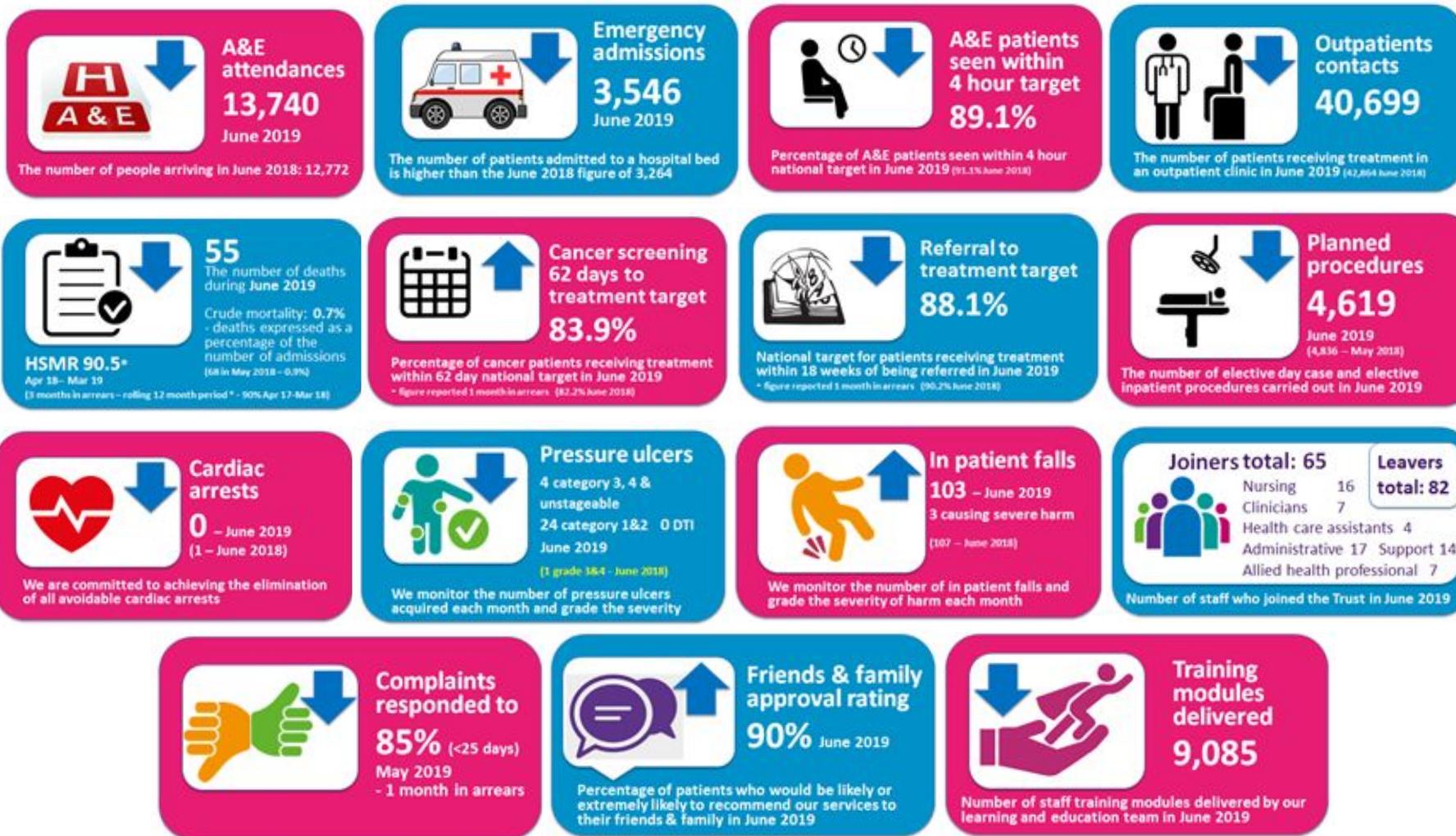
- A huge well done to Sue Glenister, our district nurse based at Aylesbury Adult Community Healthcare Team (ACHT), who has been awarded the Queens Nurse award for 2019. Congratulations also to our cohort of newly qualified Specialist Practitioner District Nurses. It is particularly heartwarming to see staff develop here at BHT.
- Congratulations to our fantastic Nutrition and Dietetic Team who have been crowned Regional Champions in the Health and Equalities Award category of the NHS Parliamentary Awards 2019, nominated by Rt Hon David Lidington CBE MP. The group delivered an innovative workshop to a group of South Asian ladies to raise awareness of the importance of a healthy diet and physical activity in reducing the risk of developing and managing Type 2 diabetes. As I write they are at the Houses of Parliament in London to attend an official ceremony to celebrate.
- I am delighted to share that staff at BHT have been shortlisted in two Nursing Times Workforce Awards: Nursing Manager of the Year; and Best International Recruitment Experience. Congratulations to the teams involved, and special thanks to James Stockbridge, Healthcare Assistant on Ward 12C, who took the time to write to me on his return from the shortlisting interview. Good luck for the 25 September 2019.

Neil Macdonald
Chief Executive

Appendices

- 1.0 Financial Recovery Board and Executive Management Committee
- 2.1 Bucks ICP Monthly System Report
- 2.2 Bucks ICP System Financial Position
- 3.1 BOB ICS Briefing
- 3.2 BOB ICS Wave 3 Application
- 3.3 BOB ICS LTP Briefing Cover
- 3.4 BOB ICS LTP Briefing Paper

Month in numbers July 2019 with June 2019 data



Please note: arrows show comparison with May 2019 data (figures going up or down) unless stated otherwise and are not intended as an indication of performance

Appendix 1.0 – Financial Recovery Board and Executive Management Committee

Financial Recovery Board

Financial Recovery Board (FRB) continues to meet on a weekly basis, attended by all Executive Directors and chaired by the CEO. The format of the meeting has been changed slightly, to include three elements to the agenda; whilst retaining its focus on financial recovery and close monitoring of Cost Improvement Plan (CIP) delivery, we have now added specific sections to cover overall financial performance (including review of risks to the forecast/delivery of control total) and the implementation of the Financial Governance Action Plan (see below).

We have CIP plans in place to deliver £16.3m (against the target of £15m). £5.5m of this is categorised as 'opportunity' (early stages of planning) but the majority are fully developed plans. Our financial risks continue to be monitored weekly, with more detailed discussion on CIPs and Commissioning for Quality and Innovation (CQUIN) schemes to understand these risks and actions to mitigate. The 'most-likely' risk assessment is (at the time of writing) £15.7m. Our biggest risks remain delivery of the savings programme (c£4m) and the receipt of Provider Sustainability Funding (PSF) and Financial Recovery Fund (FRF) (c£9m). Receipt of PSF and FRF is dependent upon meeting the financial plan. The work described above is expected to mitigate the current CIP risk. FRB also reviewed the Performance Framework, which escalates Division/corporate directorate performance where it is adverse to plan (quality, people and/or money metrics). This process will involve agreement of recovery actions where performance is off-track.

FRB continue to review completion of the Financial Governance Action Plan; which includes 60 recommendations for improvement in our financial governance processes, following reports conducted by Ameo, PwC and NHSI in Autumn 2018. All the recommendations are now included in a single tracker tool to monitor progress and record completion. This will also facilitate updates to Finance & Business Performance Committee and the NHSE/I Undertakings Meeting.

Executive Management Committee 17 May 2019 to 12 July 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 17 May 2019.

Quality

Patient/staff story
 Infection Prevention Control report
 Quality Accounts
 Head of Midwifery staffing report and Quarterly maternity safety report
 CQC Notice of Proposal
 Community inpatients report
 Operation Cataract Phase One report
 Seven day service
 Integrated Performance Report and exception reports
 Non-elective performance
 Endoscopy service
 Vascular service review
 Vascular stents alert
 Community benchmarking
 Clinical audit update, including national audit results
 CIP quality assurance process
 Safeguarding committee exception report
 Safeguarding adults and children annual report
 Cancer standards quarterly report
 Capacity governance reports Q3 & Q4
 National Audit for Care at the End of Life report
 Paediatric Decision Unit (PDU) options appraisal

Winter 2018/19 review

Maternity incentive scheme 2019
 National Spinal Injuries Centre response to NHS
 England Quality Surveillance Team
 Report on clinical accreditation
 Medicines optimisation

People

CARE value awards
 Bucks Health & Care Academy
 Guardian of Safe Working Hours annual report
 Guardian of Safe Working Hours quarterly report
 Freedom to Speak Up Guardian annual report
 Staff Survey
 HR contracts
 Medical appraisal and revalidation annual report
 Equality, diversity and inclusion
 'Board to ward' workforce compliance exception reports
 Buckinghamshire, Oxfordshire and Berkshire West
 Strategic Transformation Partnership people strategy
 Workforce strategy
 Temporary staffing
 Learning lessons to improve people practices

Money

2019/20 financial report and control total sign-off
 Process for waivers of Standing Financial Instructions
 Procurement investment case
 Buckinghamshire Healthcare Products Ltd (BHPL) Annual Report
 BHPL Shareholder Agreement
 Costing update
 Bid process and tender tracker
 BHT audit findings report 2018-19
 Monthly capital, cash and KPIs report
 Buckinghamshire Integrated Care System financial position
 Financial transformation
 Capital update
 Capital programme quarterly report
 BHT Undertakings Meeting

Strategy

A&E phase 2 business case
 Clinical psychology 2018-19
 Clinical strategy
 Integrated Care System and Integrated Care Partnership update
 ICT report
 Oxford University Hospitals strategy
 Chiltern Skin Clinic
 Combined heat plant
 Electricity procurement
 University hospital status application
 Endoscopy 5-year plan
 South 4 Pathology Partnership strategic outline case
 Property services quarterly performance report
 Car parking strategy
 66 High Street plans
 Corporate objectives implementation plan

Q1 reports for the following corporate objective programmes:

- Continue to improve our culture
 - Listening to the patient voice
 - An organisation that learns
 - Small change big difference
- Implement new workforce models
 - Make BHT a great place to work
 - Develop teams, talent and an inclusive workforce
 - Innovate with new models of care
- Tackle inequalities and variation
 - Embed use of accurate data across the Trust

Governance

EMC Terms of Reference and workplan
 Buckinghamshire, Oxfordshire and Berkshire West (BOB) Sustainability and Transformation Partnership (STP) governance
 Health & Safety Executive Letter actions update
 Care Quality Commission insight report
 Corporate Risk Register
 Board Assurance Framework
 Health & Safety
 Serious incident report and action tracker
 Health records management
 Performance framework
 Compliance with legislation
 Summary of internal audit work
 Lapsed policy list
 Lapsed patient information guidelines

The following policies have been approved:

- Charitable funds investment policy
- Management of charitable funds
- Outpatient prescribing policy
- Management of missing or lost health records policy
- Pregnancy loss policy
- Transgender policy for staff use
- Relocation expenses policy
- Exit policy
- Health records management policy
- Intrathecal chemotherapy policy
- IT computer usage policy
- Freedom of Information Act 2000 policy
- Policy for the management of persons requiring special considerations or security measures
- Policy for the prevention and management of occupational natural rubber latex allergy and glove use
- Discharge of adult inpatients and choice policy
- Policy for the management of skin exposure risks at work
- Trust media policy

Meeting minutes of the following:

- Quality & Patient Safety Group
- Divisional Operational Committee
- Health & Safety Committee
- Research & Innovation Committee
- Resilience Committee
- Capital Management Group
- Commercial Development Committee
- Risk & Compliance Monitoring Group
- Human Resources and Workforce Group



MEETING:	ICP PARTNERSHIP BOARD	AGENDA ITEM:	
DATE:	3 rd July 2019		
TITLE:	Monthly System Report		
AUTHOR:	Julie Hoare Noel Burkett		
LEAD DIRECTOR:	Julie Hoare MD Buckinghamshire Integrated Care Partnership		

Reason for presenting this paper:	
For Action	
For Approval	
For Decision	
For Assurance	✓
For Information	✓
For Ratification	

Summary of Purpose and Scope of Report:

The purpose of this paper is to provide an update on the development of the Buckinghamshire Integrated Care Partnership. It is broken down under a number of headings to provide a broad view of the progress made within the programme. It aims to provide a clear narrative which links the vision and strategy of the ICP, to the delivery of the work programme and progress against programme outcomes.

Authority to make a decision – process and/or commissioning (if relevant)

The partnership board is asked to:

- note progress
- provide comment, leadership and support to the evolving programme as a collective and on behalf of their constituent organisations
- approve the draft ICS Newsletter [appendix]

Conflicts of Interest: (please tick accordingly)

No conflict identified	✓
Conflict noted, conflicted party can participate in discussion and decision (see below)	
Conflict noted, conflicted party can participate in discussion but not decision (see below)	
Conflict noted, conflicted party can remain but not participate in discussion (see below)	
Conflicted party is excluded from discussion (see below)	
Governance assurance (see below)	

ICS Workstreams supported by this paper (please tick)

Capacity & Capability	✓
Communications & Engagement	✓
Service Improvement & Re-design	✓
Finance & Efficiency	✓
Governance & Leadership	✓

ICS Objectives supported by this paper (please tick)	
Joint Commissioning	✓
Integrated Provision	✓
Back Office	✓
Governance	✓

Governance requirements: (Please tick each box as is relevant to the paper)

Governance Element	Y	N	N/A	Comments/Summary
Patient & Public Involvement	✓			
Equality	✓			
Quality	✓			
Privacy	✓			
Financial	✓			
Risks	✓			
Statutory/Legal	✓			
Prior consideration Committees/Forums/ Groups	✓			
Membership Involvement	✓			

1. Introduction

It is two months since the previous work with some significant system changes happening during this time: the confirmation of BOB as an Integrated Care System with David Clayton as the independent chair, the subsequent change for Buckinghamshire to become an Integrated Care Partnership, the registration of the 12 primary care networks, BHT gained a good rating from CQC and the release of the long term plan framework.

This reports sets out the progress made in Buckinghamshire over this time and should be read alongside the system monthly financial report. The partnership board is asked to note the progress and

- o provide comment, leadership and support to the evolving programme as a collective and on behalf of their constituent organisations, in particular
 - o Challenges of the Clinical and Care forum
 - o Changes from ICS to ICP status
 - o Decision to refresh of the maturity matrix
 - o Decision to proceed to wait in publishing of our delivery plan
- o approve the draft ICP Newsletter (appendix)

2. System Performance

The partnership board has previously reviewed the quality and performance report for assurance. The table below depicts the ICS Roadmap performance indicators that were agreed for the system in 2017. Work is underway to develop a small set of indicators aligned to the ICP objectives that would best represent improvement for the Integrated Care Partnership across all work streams. This work will be available at the next Partnership board for consideration.

	Outcomes	EOY Trajectory	Current – May 2019	18/19 Performance
PERFORMANCE	Emergency admissions (65+) per 100,000 population	TBD	1902	1884
	Length of stay for emergency admissions	TBD	4.57	4.19
	Total delayed days per 100,000 18+ population	TBD	319	341
	Percentage of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services	75%	72% (current as of last reporting 18/19)	72%
	Percentage of older people (65 or over) who are discharged from hospital who receive reablement/ rehabilitation services	TBD	The data is not yet available and is reported nationally when available	3% Last year's performance ranked us 71 st nationally. The regional averages was 3.4%, against the national average of 2.9%
	Percentage of discharges following emergency admissions which occur at the weekend	TBD	24.5%	21.9%

3. Portfolio progress

Each work stream was requested to review their milestones to ensure only transformational work was included, this has now been completed. Noel Burkett is collating a revised work programme to focus on our system priorities. A review of the programme approach being used at delivery boards and its effectiveness is underway and will inform our approach and the alignment of agreed priorities to delivery boards going forward.

It is planned that this report going forward informs of the areas of progress and starts to report against the achievement of milestones in the form of a rag rating by each delivery board for if they are on course, successes and any exceptional items for escalation to the Partnership Board. Noel Burkett will be working with chairs and clinical leads going forward to ensure this is effectively in place.

Portfolio	Commentary
<p>Integrated Care Gill Quinton</p>	<p>Integrated Locality Development PCN Development - In terms of delivery we have held the first meeting with PCN accountable clinical directors and this focused on having some initial open and honest discussions so that collectively we are starting to get a clearer idea of what we are working to achieve, how we might work together to do so and what the main challenges are. A requirement of this group was to understand the Integrated Care Partnership (ICP) / PCNs and how these fit together as a system. As a consequence there is a further session on 9th July which will incorporate an hour long session with the partnership board. The plan is to establish a regular meeting with Accountable clinical directors (ACD's) and ensure a line of communication with the partnership board. Paper regarding utilisation of transformation resource, going to July Partnership Board</p> <p>Care Homes: Additional workshops have been held with members of the care homes steering group to establish baseline data, priorities and leads against the framework.</p> <p>Home First: As reported last month, progress being made across the programme. However limited service management capacity and project management support means that progress is slower than expected. Staff understanding of and receptiveness to change - as discussed at last Board - being logged as a programme issue to address. Programme Manager met with communications lead, Kim Parfitt and it is being raised and prioritised as appropriate within individual projects.</p>
<p>Mental Health Chris Wright</p>	<p>There have been some key developments within the Children & Young People's work stream of mental health transformation, Mental Health Support teams are now live in the 2 pilot areas and high level productivity exploration is taking place within core CAMHS services to inform the approach to meeting new 4 week waiting times.</p> <p>Work is underway in IAPT to balance the benefits of increasing access with the increase in waiting times; a paper has been drafted with key themes and recommendations.</p> <p>Implementation has commenced for individual placement and support workers to get those with Severe and enduring mental illness (SMI) into paid employment opportunities.</p> <p>Recruitment is underway to improve the urgent care pathway and a bid was submitted to NHSE for additional funding to accelerate the transition. Out of area placements continue to be a risk to quality and expense but the numbers are reducing vs FY19.</p> <p>BOB STP were awarded a modest sum of money for suicide prevention, this will be used to develop a standardised psychosocial assessment with guidance and to roll out additional self-help apps.</p>
<p>Access Care & Efficiency Debbie Richards</p>	<p>Elective Care: Revised System work plan is on track overall, but delivery is behind plan in some areas – risk/issues escalated were ophthalmology not yet delivering capacity through transformation leading to long waits for day cases & risk of 52 week breaches & clinical risk in retinal follow-up. An accelerated transformation plan has been requested to address the delays</p> <p>Medicines Management: Payment by results excluded budget requires finalisation with BHT. Anticoagulant re-procurement timetable is tight, PMO support identified and the business case is in development.</p> <p>Cancer: Focus on continued delivery of the CCG work stream (QIS) with practices increasing screening uptake and now preparing end of year reports. The year 2 programme is in development and has linked with learning disability service leads to look at joint working to tackle inequalities place for are in place for a community event in October 2019. Further to STP plans, we have now made contact with STP leaders to start to integrate plans and reduce duplication - delay in progressing a joined up approach.</p> <p>Maternity: Better births midwife continues to work on continuity of care models. To be presented at next maternity steering group. Saving babies lives 2 launched in March, a gap analysis is underway, Transformation money group requires clarity on what is for BOB spend and local spend</p>

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	<p>Long Term Conditions: Focused on working collaboratively with PwC to review & accelerate Respiratory & Cardiology Programmed</p>
<p>A&E Delivery Board Frances Woodroffe</p>	<p>Performance: continued strong performance in ambulance handovers, one of the best trusts in the South East. Improvements seen in the number of patients with a length of stay over 20 days (reduced from 82 in April at SMH to 73 in June). SDEC (same day emergency care) services continue to account for increasing proportion of NEL admissions, with 46% of all NEL admissions being discharged in less than 24 hours in June (national target 33%).</p> <p>Winter planning: Planning process for 19/20 commenced, meetings with individual system partners arranged to compile ICP plan and opportunities for improvement/investment for winter. Clarity on the process required for awarding funding to winter schemes is requested. ICS monies have been allocated to BOB for winter schemes, Bucks have proposed to fund the falls and frailty vehicle between November and March, 5 days a week, and support the role out of MiDoS across SCAS.</p> <p>NEL demand management programme: ICP programme established and schemes report progress monthly to Urgent Care Working Group (UCWG). Focus on avoiding attendance, avoiding admissions and enabling discharge, and programme aligned to national UEC priorities and standards for 19/20.</p>
<p>Clinical and Care Forum Robert Majilton</p>	<p>The Clinical Chair was appointed (Raj Bajwa), and it was agreed to rotate the chair on a quarterly basis, Tina Kenny will be the next chair person. The group has agreed a set of principles to work by:</p> <ul style="list-style-type: none"> • Act as a clinical leadership collective • Everyone will take responsibility for the success of the system as a whole, co-operating and supporting each other across historical boundaries • Leave organisational and personal drivers at the door • Strive to reach joint consensus prior to any further decisions which may be required at an organizational level • Challenge each other constructively when it is perceived that a member is not acting for the common good - 'challenge for the sake of the patient' • Use regular reflective practice focused on successes and failures, exploratory learning and making continuous improvement as a regular mechanism of the forum e.g. 'how did we do today?' • hear and understand the outcomes the population values • Nurture and promote emergent leaders with vision and the ability to articulate the vision • Adopt a coherent workforce development approach which has at its core a leadership talent pipeline • Exhibit a value-based approach to healthcare linked to quality improvement • will not be afraid to innovate and try new things <p>However there has been difficulty in establishing a momentum with this vital group, and there for an absence of the voice of senior clinical leaders driving the transformation agenda and attendance at the last meeting was very low. This will be considered at the next meeting, encouragement of members to attend is requested.</p>
<p>Digital Balvinder Heran</p>	<p>ICP ICT Strategy (digital, technology and information) with 5 year programme and operating model to come to August Board</p> <p>Financial review of all digital costs is being undertaken and for presentation to August Board - many projects funded through one off monies will need sustainable revenue budgets for on-going support, maintenance and development</p> <p>Leading ICT and digital work packages for move to new Council by 1st April 2020 and building the roadmap for harmonisation of ICT applications across Buckinghamshire</p> <p>Development of Business Case for in-sourcing GP IT, Corporate CCG Technology and Digital and Business Intelligence functions underway</p> <p>Building the 5 year rolling programme – technical, digital and business intelligence projects and the required resourcing (capital and on-going revenue)</p> <p>Building up central register of contracts across Bucks to ensure we maximise all procurement opportunities</p> <p>Supporting key programmes – LHCRE, Unitary</p> <p>Reviewing STP Digital presence – presentation to Chief Execs in August 2019</p>
<p>Workforce & OD Amir Khaki</p>	<p>System leadership module was delivered to over 60 participants (30+ clinicians) this month</p> <p>Between March 2018 to June 2019 the QI team delivered 6 QSIR Practitioner sessions (143 colleagues) & 7 QSIR Foundation sessions (199) across the footprint. It is important that we optimise this skill development across the system</p>

	<p>Further links with Care homes to deliver clinical training for nurses Bucks Health & Care Academy ToR were agreed by all partners and 10th July to confirm governance A new team member (Ann Patrick) was appointed to support OD activity and recruiting for the workforce position in July PCN development prospectus analysed and a simplified version of the maturity assessment tools being developed for supporting PCNs. BHT has agreed to move to appointment system wide directors roles going forward. Looking at an integrated MSK physio shared role trailblazer</p>
<p>Communications and Engagement Kim Parfitt</p>	<p>Staff Roadshows: During April 2019, the ICS Communication and engagement group held 12 drop in events across the county. The objectives were to engage with staff about ICS so they understand the benefits and feel part of the integrated system, ensure staff understand and are inspired about how they can get involved through their feedback, ideas and suggestion and launch of the new ICS Ideas Exchange. Without doubt, staff are clearly passionate about their role and can see the potential in a more joined up health and social care system. At all times, their focus was on improving outcomes for their patients or service users – more so then making their life easier. Currently the Project Management Office is reviewing all the suggestions that were made to identify which ones we will carry forward. We will be reporting back on this next month Digital Engagement: After winning funding from NHSE, we have now appointed Delib to deliver our new digital engagement tool for the Buckinghamshire system. Citizen Space https://www.delib.net/citizen_space. This will allow all consultations and engagement for the organisations in the Buckinghamshire ICP to be easily accessible to all residents in Buckinghamshire, ensuring a consistent approach across the system. Residents Panel: With funding from NHSE, we have appointed MES to recruit a 1500 strong resident’s panel for Buckinghamshire. This will be representative of our population and should be available to use from the Autumn. A review of the communications and engagement strategy is taking place to align with the 2019/20 delivery plan and other developments e.g. the long term plan, a draft will be presented at the August partnership board.</p>
<p>Estates Ali Williams</p>	<p>A&E Project phase 2: Tenders returned and in line with budget. FBC completed and will go to NHSI and DoH for approval next week. Project should be completed by December 2019 but may delay due to expected sign off process at DoH. FBC is potentially at risk of non-approval given DoH is requesting STPs reduce capital funds by 20%. Buckingham OBC - model for health and care centres and potential for new site at Leys Hill: One Public Estate has provided a grant for this work – contractors have been appointed and stakeholder work is starting New Builds for Berryfields and Meadowcroft Surgeries, Aylesbury and Millbarn and Simpson Medical Centres in Beaconsfield: Outline business cases (OBC) submitted for both these schemes have now been approved by NHS England and planning applications are lodged with the relevant planning authorities. The OBCs support the colocation of the two practice teams in each scheme and bring primary and community care together into local facilities that are aligned to the ICP model of care. Both schemes will deliver improved access to care for patients and transform the way care is delivered, through the implementation of digital technology and working in collaboration with other services to meet the health and social care needs of patients. The schemes will also improve local resilience and create capacity to manage future population growth. Stoke Mandeville feasibility study: One Public Estate have provided a grant for this work – tenders have completed and contractor appointment is imminent S106 Developer Contributions: The CCG is seeking legal advice to vary legacy (PCT) Section 106 Agreements where developer commitments to either allocate or gift land (sometimes with additional contributions in the form of money or shell and core structures) for GP buildings in areas of housing growth where the proposed provision does not fit with the CCG’s current strategic objectives. The advice we are seeking will enable more effective negotiations in securing Deeds of Variation to these agreements to enable financial contributions from the developers concerned to be put towards more appropriate health infrastructure developments, such as extensions to other viable GP practice buildings or in respect of large, new and viable practice buildings via the “pooling” of old legacy S106 Agreement commitments and proposed S106 Agreements. BHT has recently submitted a number of S106 applications to both Aylesbury Vale for 6000 houses and Wycombe District councils for 2000 houses. Wye Valley Surgery: Following completion of the building works on the Wycombe Hospital site, Wye Valley surgery has now relocated to their new premises on 17th June 2019.</p>

4. System Assurance

A system assurance meeting took place on the 22nd of May, chaired by Fiona Wise. A productive meeting was held, key points to notes and action from the meeting were:

- Constructive dialogue with in terms of understanding the direction and steps being taken by the system
- Good understanding of financial challenges facing system; revised planning submission that now meets the financial control totals acknowledged
- Robust discussion around various consultancy packages in place; ensure supports part of coherent plan v. series of ad hoc requests
- Discussion and clear articulation around potential performance and clinical impacts associated with ICPs digital plans – recognized potential barrier in assessing sufficient capital funds
- Discussion by ICP to shape its future structure and commissioning intentions; opportunities to capitalize on 'at scale' approach and need to link with STP

Key Actions from assurance meeting:

- Ensure a robust and clear tracking of financial position through the year in place; reduce volatility seen in forecasting in 2018/19
- Finance DoF discussion to take place in regard to recovery plan timelines – agreed deadlines need to be realistic; Chief Finance Officers to jointly agree expectations
- Discussion between NHS E/ South East Director of Digital Transformation and ICP CIO to explore improving access to capital funding for digital programmes
- ICP plan in place to have a real and immediate focus on improving overall financial and associated operational performance; ensuring a set of plans and trajectories to delivery improvements with clearly identified action owners
- ICP to have an compelling narrative as to how the system is tackling its performance challenges and how it will engage with staff and public as part of this

Preparation has commenced, with the schedule set out below for noting, and any other items for inclusion to be raised by the partnership board members :

Next Assurance Meeting: Wednesday 7th August 2019

- **Lead [named below] First draft of slides Due:** Friday 19th July
- **Final Chief Exec Review of Slide Deck:** Thursday 25th July
- **Slide Pack due to be submitted to NHSE:** Thursday 1st August

Next Assurance current agenda discussion:

- Q1 Financial Position [*Lead: Gary Heneage & Wayne Preston*]
- Q1 Performance [*Lead: Frances Burdock & David Williams*]
- Transformation to ICP [*Lead: Julie Hoare*]
- Long Term Plan [*Lead: David Williams/ Robert Majilton/ Julie Hoare*]

A submission was also made to NHSE/I of our delivery against the MOU, no feedback has been received as yet.

5. Progression to ICP

With the move to becoming an ICP and that realignment of commissioning functions Lou Patten is leading the work to optimise this opportunity to ensure functions continue to improve and be effective and support the best outcome for Buckinghamshire and gain the benefit of opportunities to work at scale with Oxfordshire and at BOB level. A consultation with affected staff will be taken forward over the summer period, with a view to realignment following as quickly as possible.

A self-assessment against the maturity matrix was previously undertaken, although we have moved to becoming an ICP, this maturity matrix continues to be an effective tool to inform our development. The Partnership board is asked to agree if we should repeat the self-assessment and when this would best be completed to contribute to our road map plans to becoming an Integrated Care Partnership.

As noted in a previous report we have now progressed and commissioned Peopletoo to explore options for the next phase of service integration across the system, identifying any risks and dependencies associated with the option. Peopletoo and partners Libera have a wealth of experience in developing integrated health and social care models, and as well as examples of best practice, will bring hands on knowledge and experience of what is and isn't working elsewhere. This will enable us to embark on a more ambitious programme of integrated working. The leaders Maggie Kenney or Kirsty Jordan from Peopletoo will be contacting people to arrange to meet.

We are aiming to present a first draft of the outputs from this work to the Partnership Board on October..

The Provider Collaborative met and plans to set out and agree its terms of reference and the critical role it can play in supporting the system on its journey to an Integrated Care Partnership.

At the last Partnership board which was a CEO session, it was recommended that a system senior leader's event be organised in September. This will bring together those people who have a vital role in developing our partnership culture, demonstrating it in the way they lead and delivering tangible changes that improve the outcomes for the people of Buckinghamshire and the sustainability of the system. A suitable date for everyone is proving challenging to elusive, however will need finalising this week to ensure attendance.

The Long term plan framework (annexe b) was released and the response will be coordinated overall at BOB ICS level. A system meeting is taking place on the 10th July to plan meeting the requirements and building on the plans already in place. There will be opportunities to work at scale on strategic plans, with a more local approach where there are implications to our work programme. In particular we will need to set out our financial, activity and workforce changes, this overlaps with our Buckinghamshire plans to develop a financial recovery plan and so very timely. A base is being developed to identify the expertise and capacity required by the system to complete this component of our future planning. It is recognised that the plan focuses on the health system, we will need to align very carefully with future planning for social care and the council as they are integral to our place based, population management approach.

We have as yet to publish the 2019/20 delivery plan for the public, guidance is sort from the partnership board whether this should proceed, or whether it should be delayed so it can be incorporated in a single approach to communication and engagement with the long term plan.

6. Other items

Presentations have been given to both the **Health and Well Being Board and the Health and Social Care Scrutiny Committee** updating of the progress of the now Integrated Care Partnership. Both were well received with positive feedback. In particular they were pleased to hear that we are focusing our work, streamlining the approach, strengthening links with community and voluntary sector, joining up working and rolling out a system approach and look forward to confirmation in a years' time that integrated teams around PCN's and shared pathways around respiratory and cardio vascular disease are in place.

They wanted to better understand the interface of scrutiny with the BOB ICS, recognising that the changes are in an early stage. A review of the Getting Bucks Involved group was requested to ensure our approach of population engagement is as effective and productive as possible. They also echoed the concern voiced by Suzanne Westhead as to the national lack of clarity of the Better Care Fund. Finally they asked to ensure we maintained effective links with local authority officers and elected members in the ongoing work at locality / network level.

We were unsuccessful in being a pilot site for developing closer working relationships with the community and voluntary sector. A submission has recently been made to "Skills for Care" integration by Fed Bucks and BCC, which required a local authority lead for support in mobilising an innovative approach using virtual training for PCN's and Health Tech at the university .

As a development in our approach to our **newsletter** (see appendix), its collation and timing has been rescheduled so that a draft can be presented at each partnership board for agreement, and should any additional items be identified at the partnership board they can be included before it is circulated.

7. Appendix

ICS Draft Newsletter – for Partnership Board approval



Latest news from across the Integrated Care Partnership in Buckinghamshire

Buckinghamshire, Oxfordshire, Berkshire West (BOB), Integrated Care System

It has been announced by NHS England/Improvement (NHSE/I) that Buckinghamshire, Oxfordshire and Berkshire West (BOB) now becomes an Integrated Care System.

It was recognised by NHSE/I that the progress made by Buckinghamshire and Berkshire West as early pioneers of integrated care has shown the difference it can make to the care and health of local communities when NHS providers, commissioners, local authorities and other sector partners work together.

For us in Buckinghamshire, this signals the move to becoming an Integrated Care Partnership (ICP) providing us with the opportunity to focus on delivering local services for local people whilst getting the benefits of working at scale and sharing expertise and resources across the BOB ICS.

Our 12 Primary Care Networks will be the building blocks of more localised health and care in communities, bringing together primary and community services, such as GPs, pharmacists and mental health.

Martin Tett, Leader of Buckinghamshire County Council and Chairman of the Health and Wellbeing Board said “I am delighted that NHS England has recognised the work we are doing in Buckinghamshire and the difference it is making to our residents. Together with our partners, we can continue to focus on the health and care needs of each community within Buckinghamshire.”

Lou Patten, Chief Executive Officer of Buckinghamshire Clinical Commissioning Group said “It is important we continue our work in Buckinghamshire through our Integrated Care Partnership. Delivering larger projects across Buckinghamshire, Oxfordshire and Berkshire West, allows us to focus on local services in our county.”

Independent Chair appointed to BOB ICS

David Clayton-Smith has been appointed to the role of Independent Chair of the Buckinghamshire Oxfordshire and Berkshire West Integrated Care System (BOB ICS).



David is currently the Independent Chair of the Epsom and St Helier Improving Healthcare Together 2020-30 Board and the Chair of the Kent, Surrey and Sussex Academic Health Sciences Network (AHSN).

He has extensive experience in Board level roles within the NHS, having formerly been Chair of the East Sussex Healthcare NHS Trust (2016 and 2019), Chair of NHS Surrey for three years from 2010 and Chair of NHS Sussex between 2012 and 2013.

David is also a board member and Treasurer of Fairtrade International. He is director and co-founder of Andrum Consulting which specialises in supporting entrepreneurial businesses.

Throughout his career, David has held board-level positions in major blue-chip businesses, latterly as Commercial Director of Halfords and Marketing Director for Boots the Chemist.

The appointment to the role of Independent Chair follows an extensive recruitment process to find someone with the necessary leadership skills and experience to be a key ambassador for the ICS. As Independent Chair, David will work with Fiona Wise, ICS Executive Lead and Chief Executives from across the BOB ICS patch to support and promote partnership working, while making sure there is the appropriate level of

independent oversight and assurance of ICS decisions and delivery of strategic priorities.

Speaking about his appointment David said:

“I am committed to ensuring that partnership working continues to be a strong theme throughout the work of the ICS. I am looking forward to the opportunity to play my part in helping to achieve the BOB ICS ambition and vision for the communities we serve.”

Great news following the latest CQC inspection - Buckinghamshire Healthcare NHS Trust rated as 'Good overall and 'Outstanding' for our care

The latest CQC inspection took place in February and March this year and included both acute and community services. In their report, the CQC recognised improvements made at the Trust since its last inspection in 2016, when it was rated 'requires improvement'. It was especially pleasing that the our care has been rated 'Outstanding'.

The publication of the report is a significant milestone in the Trust's quality improvement journey. The 'Good' overall rating is testament to the hard work of its staff, partners, volunteers and supporters and is an endorsement of the work and improvements we continue to make on a daily basis.

The CQC provides a rating against 5 key questions for every service and provider:

5 Key Questions	2016 Rating	2019 Rating
Are services safe?	Requires improvement	GOOD
Are services effective?	Requires improvement	GOOD
Are services caring?	GOOD	OUTSTANDING ☆
Are services responsive?	Requires improvement	GOOD
Are services well-led?	Requires improvement	Requires improvement

Overall rating for the Trust GOOD

Services receiving outstanding ratings included end of life care, emergency department, outpatient service and adult community health services.

Some comments from inspectors in the report:

- Without exception, staff were caring, considerate and passionate about getting it

right first time for patients.

- Patients were empowered and supported to manage their own health, care and wellbeing and to maximise their independence.
- There were comprehensive systems to keep people safe.

The Trust is working to rectify some of the inspectors concerns regarding the number of interim roles on the executive team and we have made permanent appointments for several positions with new colleagues joining us over the next few months. We are also looking at our options for ensuring sustainable safe staffing in community inpatient wards

David Williams, Director of Strategy and Interim Chief Operating Officer said: “We could not have achieved this without your support and the strong Integrated Care Partnership we are successfully building together. We look forward to continuing to work closely with you in developing health and social care services for the people of Buckinghamshire so they can have happy and healthy lives.”

BHT Chief Executive Neil Macdonald said: “This is wonderful news and is testament to the hard work of everyone in the Trust, our volunteers, partners and supporters. It is fantastic that we have been recognised as ‘Outstanding’ for caring.”

“Today marks another key milestone for us. The news that our progress has been recognised will give everyone at BHT a real boost and our patients greater confidence that the improvements we’re making on a daily basis are making a real difference to those for whom we care.”

You can view the full report here <https://www.cqc.org.uk/provider/RXQ>

Networking promotes better patient experience and counts towards your own CPD



Buckinghamshire Bridges is a group of primary and secondary healthcare professionals working together to “build bridges” between both sectors to provide a better patient service and experience within Buckinghamshire. With the integrated care partnership currently developing, this is a fantastic opportunity to build strong relationships that will only ever lead to better patient care in the long run!

The group usually meets every month, alternating between Wycombe and Stoke Mandeville hospital sites. The sessions open from 7.30pm with presentations starting around 8pm so that you have time to network with fellow GPs and healthcare professionals from the Buckinghamshire Healthcare Trust. Food will be provided on the night and will be sponsored by a Pharma Sponsorship. There is free parking. Don't forget the meetings count towards your CPD - Internal CPD points are available per session attended, with certificates given out on the night.

We would like to invite you to our next Buckinghamshire Bridges meeting on **Thursday 11 July 2019** in **Training Room 1, Post Graduate Centre, Stoke Mandeville Hospital**.

We have two presentations taking place on the night which last approx. 30 minutes each. We will be hearing from:

- Lamprini Kirkineska, General/Acute Medicine Physician - Delayed treatment of patient with sepsis – improving patient referral procedure from primary care to hospital
- Ben Collins, Deputy Divisional Director, Thame and Marlow Community Hubs.

There is no need to book as we like to keep these meetings informal. We look forward to meeting you on 11 July.

Please do spread the word to your colleagues, the more people we have attending the sessions, the better.

We are always interested in hearing from anyone who would like present at one of our Buckinghamshire Bridges events. So if you or your colleagues have something to share or a topic you would like to bring to discuss, please do let me know.

If you would like to go on the invite list for these monthly meetings, please contact Dee Irvin on 01494 734853 or dee.irvin@nhs.net

Living with and beyond cancer - report findings



A review of cancer services in Buckinghamshire has published its findings, with the psychological, physical, emotional and practical impacts of a cancer diagnosis and the related treatments highlighted as the main concerns for people affected by cancer.

The findings, which will inform future strategy, also demonstrated the importance of co-ordinating services across Buckinghamshire to enable patients to live well.

To read more about the Living with and Beyond Cancer findings, undertaken by NHS Buckinghamshire Clinical Commissioning Group and Macmillan Cancer Support, and to see the full report, please [click here](#).

Read the latest update from the Thames Valley and Surrey Local Health and Care Records Partnership



[Click here to read the latest update](#)

Virtual reality treatment to be offered to NHS patients in Buckinghamshire and Oxfordshire

NHS talking therapy services Healthy Minds in Buckinghamshire is among the first in the country to offer state-of-the-art virtual reality therapy to treat the phobia.

Fear of heights is a significant problem for one in five people at some point in their lives, and most never receive treatment. Now Healthy Minds, are to offer VR to people with a fear of heights as part of an NHS pilot.

In the VR-enabled treatment programme, patients are gradually exposed to powerful virtual reality scenarios that trigger their symptoms. Because these situations do not have any of the perceived real-life dangers, patients have the confidence to try things they would normally avoid, enabling them to overcome their fears and negative thoughts. In fact, users report finding therapy easy to engage with and even fun to use.

One of the most innovative features of this treatment is the virtual therapist. A friendly computer-generated avatar, voiced by a real person, who carefully guides the patient through the therapeutic work, helping them practise techniques to overcome their difficulties. An NHS therapist will be available in the room during treatment sessions with Healthy Minds.

Retired paramedic Richard was able to look over the balconies of Oxford's Westgate Shopping Centre after completing VR therapy, something he would never have been able to do before.

He said: "I lived with a debilitating fear of heights for all of my life and had to organise my life so that I completely avoided all situations that exposed me to heights and altitude as I would experience intolerable anxiety. Since having the VR-enabled therapy I can now go to my local shopping centre and I am able to freely walk around and go to all floors and even look out over the balcony. This is something that would be simply impossible for me to do before having this treatment."

[Read the full article.](#)

Find out more about [Healthy Minds, Buckinghamshire.](#)

Two members of Bucks CCG Diabetes Team visit No 10.



Two members of Bucks Diabetes Team were invited to meet the Prime Minister at No 10 on 24 June.

Kathy Hoffman and Gill Dunn proudly represented the great work taking place in Buckinghamshire.

Kathy and Gill were surprised and delighted to receive an invite to No 10. This accolade goes to everyone in the CCG, primary care, community and secondary care, TV Clinical Network and all who have and continue to support work that is improving the care for people living with diabetes.

Launch of Primary Care Networks

This week sees the launch of Primary Care Networks in Buckinghamshire and nationwide – a new kind of collaboration between groups of GP practices and other community-based health and care services, which aims to benefit both patients and surgeries alike.

Across the country many GP practices are coping with unprecedented pressures due to increased workload, increased demand, an aging workforce and a shortage of GPs. At the same time, many patients today have illnesses that are being treated in hospital when care provided in the community would have better outcomes.

This is because community services such as general practice, social care, mental health

and voluntary community groups are not working together as effectively as they could. Forming Primary Care Networks (PCNs) seeks to address both these issues.

A PCN is a number of practices working together, typically with a total of between 30 – 50,000 registered patients. Each network is formed of practices located near one another and together they will get significant investment for new staff in the coming years. They will effectively become a team within a team. The new staff members to be recruited, as funding is allocated in the coming years, will include clinical pharmacists, paramedics, physiotherapists, physician's associates and social prescribers.

PCNs are also expected to provide some new services and will need to involve local community health and care services, including voluntary sector groups and patient representatives, in the design, planning and perhaps delivery of these services.

Buckinghamshire has 12 Primary Care Networks (PCNs), covering the population of the entire county and including all 50 of its practices.

Next edition:

The next edition of the ICP newsletter will be published on **Thursday 1 August**.

If you would like to submit articles, or have suggestions for the ICP newsletter, please email them to ccgcomms@buckscc.gov.uk by **Monday 22 July**.

Your community, Your care : Developing Buckinghamshire together

NHS Buckinghamshire Clinical Commissioning Group, Buckinghamshire Healthcare NHS Trust, South Central Ambulance Service NHS Foundation Trust, Oxford Health NHS Foundation Trust, Buckinghamshire County Council, FedBucks

Buckinghamshire's Integrated Care System is part of the Buckinghamshire, Oxfordshire & Berkshire West Sustainability & Transformation Partnership

System Financial Position

Bucks ICS - Month 2

2019/20

Dashboard – Month 2

Performance against key financial targets is summarised in the table below – for BHT and CCG

Key Target	Ytd	Forecast	Rationale
Efficiencies	Amber	Amber	CCG YTD £0.8m off with F/cast £3.2m off. Trust are developing mitigation plans to cover slippage risk.
Income	Amber	Amber	ICS income risk share at M2 of £1.6m
Expenditure	Amber	Amber	Material variances in Non pay , CHC and IS
Net Risks	N/A	Red	£15m unmitigated risk across the ICS

Consolidated Position – All ICS Partners

Excluding CSF/PSF/FRF	Plan - YTD	Act - YTD	Var - YTD
CCG	(2.50)	(2.49)	0.01
Trust	(3.50)	(3.50)	0.00
BCC	(24.00)	(18.00)	6.00
Oxford Health	(1.10)	(2.20)	(1.10)
SCAS	0.00	0.30	0.30
Sub Total	(31.10)	(25.89)	(5.21)

Explanation of variances:

BHT - Overspend on non pay (£1.3m) : Drugs £0.4m, Clinical supplies (£0.8m) and premises/plant pressures (£1.2m) mitigated by additional contract income & risk share.

CCG – emerging pressures in CHC and over-performance:
Planned/Unplanned care – mainly in Independent Sector

OH -operational pressures in particular Residential Care, OATS, Oxfordshire CAMHS services and staff recruitment difficulties resulting in high use of agency staff in MH inpatient areas and Community Hospitals

BCC - the underspend relates to year to date and is due to budget profiling which is being revised

Financial Position M2 – BHT/CCG only

Month 2 ICS - Year to date			
Excluding CSF/PSF	Plan	Act	Var
CCG	(2.50)	(2.49)	0.01
Trust	(2.80)	(2.80)	0.00
Sub Total	(5.30)	(5.29)	0.01

Month 2 ICS - FOT			
Excluding CSF/PSF/FRF	Plan	Act	Var
CCG	(15.00)	(15.00)	0.00
Trust	(14.40)	(14.40)	0.00
Sub Total	(29.40)	(29.40)	0.00

- The above excludes the receipt of any CSF, PSF and FRF but includes the receipt of MRET in the Trust position as a result of the Trust signing up to the control total.

System Efficiencies Update - CCG

Month 2 Delivery		YTD Target	YTD Actual	Variance	Total delivery	Forecast Variance
CCG - Efficiency savings 2019/20	Gross Efficiency Plan £k	£k	£k	£k	£k	£k
Savings delivered already						
Re-allocate funding sources	8,318					
- Improved Access (£6/ head)	3,383	564	564	0	3,383	0
Reduce non acute contracts						
- OOC reserve	500	83	83	0	500	0
- Overperformance reserve	1,519	253	253	0	1,519	0
- NCAs	0	0	0	0	0	0
- Frimley Transaction costs/IR	500	83	83	0	500	0
- Frimley IR	483	81	81	0	483	0
- reduce acute growth to agreed activity levels	1,933	322	322	0	1,933	0
Reduce targeted investments	2,099					
- Hold investment	673	112	112	0	673	0
- Market Rent	306	51	51	0	306	0
- Cancer MOU	604	101	101	0	604	0
- MH - physical health check (remove £485k of £685k)	485	81	81	0	485	0
- Remove YOS billed by BHT	31	31	31	0	31	0
Target Investments	1,000	167	167	0	1,000	0
System efficiencies - Now identified						
- Targetting growth		0	393	393	2,358	2,358
- Contract negotiation		0	333	333	2,000	2,000
Total Savings delivered already	11,417	1,929	2,654	725	15,775	4,358
Savings partly delivered /yet to deliver						
CHC	3,100	517	0	(517)	2,325	(775)
Medicines Management	3,800	633	633	(0)	2,850	(950)
Running costs	1,000	167	167	0	1,000	0
Reduce non-NHS contracts by 3%	199	33	0	(33)	0	(199)
Reduce targeted investments	645			0		
- S75 Smoking Cessation from BCC	145	24	0	(24)	0	(145)
- Hold Investments - R/Costs	500	83	0	(83)	0	(500)
Total Savings partly delivered /yet to deliver	8,744	1,457	800	(657)	6,175	(2,569)
Gap of unidentified / gap from the risk assessment						
System efficiencies - Unidentified	5,021	837	0	(837)	0	(5,021)
Total Efficiency Delivery	25,182	4,223	3,454	(769)	21,950	(3,232)

- Forecast gap of £3,232k
- CHC is reported as not yet achieving YTD, however, actions are on track and savings expected over the course of the year
- Shortfall included on risk schedule

Systems Efficiencies Update - BHT

No	Improvement Programme Workstreams	Executive Director Lead	Opportunity (£'000)	Plans in Progress (£'000)	Fully Developed (£'000)	Risk Adjusted Value (£'000)	Plan identified (£'000)	Final Target (as at 3.5.19) (£'000)	Gap to be identified (£'000)
1	Workforce Productivity	Bridget O'Kelly	4,448	-	1,500	1,945	5,948	1,500	4,448
2	Joining corporate services across our health system (back office)	Wayne Preston	500	-	800	850	1,300	800	500
3	Developing our commercial partnerships	Ali Williams	489	49	397	578	935	1,000	-65
4	Best Value in pathology and Radiology	Tina Kenny	120	-	102	114	222	500	-278
5	Divisional CIPs*	Natalie Fox		8	2,422	2,426	2,430	5,500	-3,070
6	Optimise our buildings	Ali Williams		107	830	884	937	1,000	-63
7	Improving Patient Flow	Natalie Fox		-	1,000	1,000	1,000	1,000	0
8	Effective Outpatients	Natalie Fox		90	910	955	1,000	1,000	0
9	Best Prescribing	Tina Kenny		205	569	672	774	750	24
10	Getting the best value from non-pay	Wayne Preston		66	908	941	974	1,200	-226
11	Optimise our Theatre time	Carolyn Morrice		-	772	772	772	750	22
12	Going Digital	David Williams		-	-	-	0	0	0
		Total	5,557	525	10,210	11,136	16,293	15,000	1,293

Annual Target (£m)	YTD Target	YTD Position	YTD Variance
15.0	1.3	1.4	0.1

At M2 there is an over delivery of £0.1m

- The Annual Financial Plan is to deliver a breakeven position. The Plan assumes the full delivery of £15m recurrent productivity and efficiency savings.
- Full Divisional Mitigation plans are required to eliminate the risk in slippage on the YTD divisional positions. These plans are being worked on and completed within the next two weeks.

System Forward Quarterly Forecast

- BHT and the CCG are expecting to hit Quarter 1 Control Total
- CCG and BHT agreed mechanism for Qrt1 - estimated risk share shortfall of £2.5m
- The CSF/PSF available at Qtr 1 is £3.2m
- Finance Committee in Common (CCG & BHT) on 5 July

Forward Run-rate / FOT

- Both BHT and CCG forecasting on plan at this stage
- There are net risks of £15.6m. Of the gross risks, £10.6m relates to CIP/QIPP delivery
- PWC now finished work re savings. Focus on respiratory, cardiology and Children's hub. Further opportunities identified by PWC which are under review.
- Organisational FRPs submitted to regulators on/before 30 June

System Risks and Opportunities

System - Net Risk Position	Plan			Month 2 Risk		
	BCCG £m	BHT £m	System £m	BCCG £m	BHT £m	System £m
1. Risks within the plan on 4 April						
Unidentified QIPP/CIP	5.0	3.4	8.4	2.5	3.4	5.9
NCSO pressures not budgeted	1.0		1.0	1.0		1.0
Baseline pressures	1.7		1.7			-
QIPP/CIP risk (following risk assessment)	2.4	3.7	6.1	1.0	3.7	4.7
CHC - over performance risk	2.0		2.0	2.0		2.0
PC delegated budget risk	1.0		1.0			-
ICS Planned Income above contracted level		10.0	10.0		6.9	6.9
System Risks within the plan on 4 April	13.1	17.1	30.2	6.5	14.0	20.5
Risks post 4 April Submission						
RICS depreciation		1.6	1.6		1.6	1.6
Acute over-performance				3.2		3.2
Divisional Cost Pressures		5.0	5.0		6.0	6.0
Non compliant specialities - RTT	1.4	0.4	1.8	1.0	0.4	1.4
System Risks post 4 April submission	1.4	7.0	8.4	4.2	8.0	12.2
System - Total Risks	14.5	24.1	38.6	10.7	22.0	32.7
Mitigations:						
Control Total adjustment (used to bridge system gap)		5.0	5.0		5.0	5.0
Contingency	3.8	2.1	5.9	3.8	2.1	5.9
PC delegated budget now balanced	1.0		1.0			-
Other mitigations	1.7		1.7	0.4		0.4
Hold divisions to deliver within plan		5.0	5.0		0.4	0.4
Additional Efficiencies delivered		6.1	6.1		2.5	2.5
Mitigations: awaiting external confirmation						
Additional £5m of savings (although this is a risk too)	1.9	3.1	5.0	1.8	-	1.8
OOC Contract savings via blended rate	2.0		2.0			-
External Funding		0.4	0.4	0.7	0.4	1.1
RICS depreciation - highlighted to NHS I as sitting outside of the plan		1.6	1.6			-
System - Total Mitigations	10.3	23.3	33.6	6.7	10.4	17.1
System - Net risk	4.2	0.8	5.0	4.0	11.6	15.6

System risk showing a net risk of £15.6m

Main risks are:

- Unidentified QIPP/CIP
- ICS Planned income above contracted level
- Divisional overspends

Main mitigations are:

Use of Contingency

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Briefing Papers: June 2019

Purpose

The purpose of this briefing is to provide Chief Executives with key papers and updates to use as appropriate within their own organisations and with Boards.

	Item	Paper
1	<p>Wave 3 ICS Application</p> <p>Buckinghamshire, Oxfordshire and Berkshire West was announced as a third wave Integrated Care System on 18 June by Simon Stevens. This marks a significant milestone in partnership working and for the collective leadership demonstrated across the BOB patch. Next steps will be the agreement of a Memorandum of Understanding with NHS England/NHS Improvement.</p>	 <p>20190531 BOB ICS Application Form vFinal</p>
2	<p>Acute Collaboration</p> <p>An Acute Collaboration Workstream has been set up, following agreement at the April meeting of the Chief Executive's Group, covering two distinct areas; an elective programme and a support services programme. Belinda Boulton from Oxford University Hospitals NHS Foundation Trust has been appointed as Programme Director. Neil Macdonald (Buckinghamshire Healthcare NHS Trust) is the Chief Executive Sponsor and Andy Statham (Royal Berkshire Hospital NHS Foundation Trust) is the workstream Senior Responsible Officer for the Elective Care workstream.</p>	 <p>Acute Collaboration Vfinal.pdf</p>
3	<p>Stakeholder Management MoU</p> <p>A Stakeholder Management MoU for 2019/20 has been agreed to take into account the revised ICS governance arrangements.</p>	 <p>Stakeholder engagement MoU v1.</p>
4	<p>Five Year People Strategy</p> <p>The strategy has been developed by the HR Directors of the six main providers. The Chief Executive Sponsor is Will Hancock, of South Central Ambulance Trust. 2019/20 priorities include talent management, equality diversity and inclusion, bully and harassment, workforce planning and STP-wide recruitment. Work will also include further development of the longer-term plans, ensuring that the specific needs of each system are addressed and aligning the strategy with other key areas of work such as primary care.</p>	 <p>Update on People Strategy_5 June 2019</p>

	Please note, an updated version of this presentation is being developed.	
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Application form in support of being considered for maturing ICS status

The NHS Long Term Plan, published in January 2019, sets out commitment for national coverage of Integrated Care Systems (ICSs) by April 2021. An ICS brings together local organisations to redesign care and improve population health, creating shared leadership and action. They are a pragmatic and practical way of delivering the ‘triple integration’ of primary and specialist care, physical and mental health services, and health with social care.

Becoming an ICS is complex and not all systems will be immediately ready to become an ICS. Instead systems will become ICSs in waves. To be formally named an ICS it is expected a system will be able to demonstrate progress against the attributes of a maturing ICS which align with the key requirements for ICSs reported in the NHS Long Term Plan, and is the minimum level of maturity for all systems to reach by April 2021.

Domains	Attributes of a maturing ICS
(1) System leadership, partnerships and change capability	<ul style="list-style-type: none"> • Collaborative and inclusive multi-professional system leadership and governance; including local government and the voluntary sector. • Clear shared vision and objectives, with steady progress made visible to stakeholders and staff. • Dedicated capacity and supporting infrastructure being developed to help drive change at system, place and neighbourhood levels (through PCNs). • Effective ongoing involvement of voluntary and community partners, service users and the public in decision-making at system, place and neighbourhood levels. • A culture of learning and sharing with system leaders solving problems together and drawing in the experience of others.
(2) System architecture and strong financial management and planning	<ul style="list-style-type: none"> • System is working with regional teams to take on increased responsibility for oversight. • Plans to streamline commissioning are underway. • System has credible plans for meeting system control total and, where not already achieved, for moving towards system financial balance. • System wide plans for workforce, estates and digital infrastructure being implemented. • System is managing resources collectively and signed up to the ICS financial framework.
(3) Integrated care models	<ul style="list-style-type: none"> • PCNs implementing new or redesigning care models with partners to meet population need – that is enabling integrated provision of health and care within neighbourhoods. • Integrated care teams operating at neighbourhood and place bringing together PCNs, mental health, social care and hospital services as per the triple integration set out in the LTP. • Starting to implement plans to: <ul style="list-style-type: none"> ○ address unwarranted clinical variation; ○ deliver the 5 service changes in the LTP; ○ tackle the prevention agenda and address health inequalities. • PHM capability being implemented including segmenting and stratifying population using local and national data to understand needs of key groups and resource use.
(4) Track record of delivery	<ul style="list-style-type: none"> • Evidence of tangible progress towards delivering national priorities especially the 5 service changes set out in the LTP.



	<ul style="list-style-type: none"> • Consistently improving delivery of constitutional standards with credible system plans to address risks. • Robust system operating plan and system financial management in place, with a collective commitment to shared financial risk management. • Robust approach in place to support challenged organisations and address systematic issues.
(5) Coherent and defined population	<ul style="list-style-type: none"> • A meaningful geographic footprint that respects patient flows. • Where possible contiguous with local authority boundaries; where not practicable has clear arrangements for working across local authority boundaries. • Covers an existing STP of sufficient scale (-1m pop or more).

STPs that would like to be formally recognised as an ICS should complete the form below, bearing in mind the five criteria listed in the table above. If you have any questions about the form or application process, please contact your [\[Regional Director of Strategy and Transformation\]](#).



ICS Application Form

Please complete the contact details for the following individuals:

Role	Name	Contact email	Contact telephone no.
STP leader	Fiona Wise	f.wise@nhs.net	07831454298
Senior responsible lead for application	Fiona Wise – as above		
Operational programme lead for application	Gaurav Puri	Gaurav.puri@nhs.net	07957692796

What population size does your proposed ICS cover based on the GP registered list? (In 000s)
1, 800, 000 people (1.8m)

STP name:
Buckinghamshire, Oxfordshire and Berkshire West (BOB)

Please demonstrate support from your STP leader by providing their electronic signature:

Signature: 
 Name: Fiona Wise
 Date: 31.5.19

Please list the organisations involved in your ICS:

Local Authorities:

- Buckinghamshire County Council
- Oxfordshire County Council
- Reading Borough Council
- Wokingham Borough Council
- West Berkshire Council

Academic Health Science Network:

- Oxford Academic Health Science Network

NHS Clinical Commissioning Groups:

- NHS Buckinghamshire CCG
- NHS Oxfordshire CCG
- NHS Berkshire West CCG

NHS Healthcare providers:

- Buckinghamshire Healthcare NHS Trust
- Oxford Health NHS Foundation Trust
- South Central Ambulance Service
- Oxford University Hospitals NHS Foundation Trust
- Royal Berkshire Hospital
- Berkshire Healthcare Foundation Trust
- Buckinghamshire GP Federations:
 - Medicas
 - Fedbucks





- Oxford GP Federations:
 - OxFed
 - PML
 - SEOx
 - Abingdon
- Berkshire West GP Federations:
 - Wokingham GP Alliance
 - Reading Primary Care Alliance
 - Newbury GP Alliance
 - North and West Reading GP Alliance

Healthwatch:

- Healthwatch Buckinghamshire
- Healthwatch Oxfordshire
- Healthwatch Reading
- Healthwatch West Berkshire
- Healthwatch Wokingham

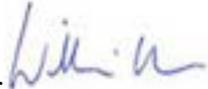
Health Regulator and oversight bodies:

- NHS England and NHS Improvement
- Health Education England
- Public Health England
- Care Quality Commission

This document sets our formal expression of interest, as a system, in becoming an Integrated Care System. It summarises key strengths of our places – building on two ICS forerunners, Buckinghamshire and Berkshire West, and progress in Oxford over the past 12 – 18 months – and the intensive leadership development journey we undertook as part of the aspirant programme; which helped us develop a shared vision and roadmap to progress our system maturity. It also kick-started our work on agreeing and developing our system 5-year strategy, re-thinking commissioning and identifying areas – where as a system – we can add most value, such as working through the implications of population and economic growth and strengthening acute collaboration.

Please demonstrate support from your partner organisations by providing their electronic signature:

Signature: 
 Name: Fiona Wise
 Organisation: BOB ICS Exec Chair
 Date: 31.5.19

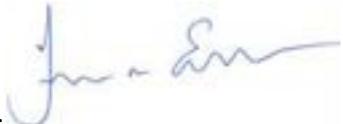
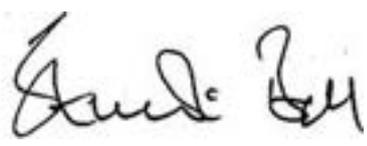
Signature: 
 Name: Will Hancock
 Organisation: South Central Ambulance
 Service NHS Foundation Trust
 Date: 31.5.19

Signature: 
 Name: Cathy Winfield
 Organisation: NHS Berks West CCG
 Date: 31.5.19

Signature: 
 Name: Yvonne Rees
 Organisation: Oxfordshire County Council and
 Cherwell District Council
 Date: 31.5.19





<p>Signature:  Name: Gary Ford Organisation: Oxford Academic Health Science Network Date: 31.5.19</p>	<p>Signature:  Name: Bruno Holthof Organisation: Oxford University Hospitals NHS Foundation Trust Date: 31.5.19</p>
<p>Signature:  Name: Neil Macdonald Organisation: Buckinghamshire Healthcare NHS Trust Date: 31.5.19</p>	<p>Signature:  Name: Lou Patten Organisation: NHS Oxford & Bucks CCGs Date: 31.5.19</p>
<p>Signature:  Name: Julian Emms Organisation: Berkshire Healthcare NHS Foundation Trust Date: 31.5.19</p>	<p>Signature:  Name: Nick Carter Organisation: West Berks Council Date: 31.5.19</p>
<p>Signature:  Name: Gill Quinton Organisation: Bucks County Council Date: 31.5.19</p>	<p>Signature:  Name: Steve McManus Organisation: Royal Berkshire NHS Foundation Trust Date: 31.5.19</p>
<p>Signature:  Name: Stuart Bell Organisation: Oxford Health NHS Foundation Trust Date: 31.5.19</p>	

Your response to the below five questions can be no longer than 3 pages in total.

Q1. How will you ensure strong system leadership with effective collective decision making and governance? You



should describe the extent to which this is already in operation, including the relationships in place that will enable effective system working and drive change at system, place and neighbourhood levels. Refer to **Domain 1 "System leadership, partnerships and change capability"**, when answering the question.

As a group of system leaders, we are driven by finding out what works on a local level and responding to what people need. We are making sure that big decisions are being made together. Over the past months we have developed and agreed a set of principles for how we operate. These focus our collective energy on delivering services that achieve the best possible outcomes and value for the 1.8 million population we serve, ensuring we:

- Facilitate activities to occur as locally as they can; as close to the patient with service delivery at a scale which delivers optimum outcomes and efficiency
- Reduce unwarranted variation in outcomes and value
- Avoid wasted effort but reducing duplication in the system, where it exists
- Drive consistency of intent, approach and outcome
- Align decisions with our long term population health goals and the national Long Term plan (LTP)
- Deliver services in a way that is well understood by our population and staff

It is worth noting that some of our providers are strong contributors to other systems – such as Oxford University Health (OUH) – which is a centre of clinical excellence providing high quality specialist care in areas like cardiology, cancer and neurological rehabilitation; and Berkshire Healthcare who support high quality research in dementia.

Building on these, we are in the process of refreshing our strategy (in response to the LTP) which builds on a clear, person-centred vision for health and care services across the BOB system. This is set across the following pillars of work:

- Prevention and addressing the pockets our health inequality across our geography
- Integrating care – with a focus on developing primary and emergency care in response to our population health needs
- Improving the quality of care and outcomes, with key workstreams on maternity, mental health, cancer and acute care collaboration
- Growing and supporting our workforce and their skills
- Digital transformation – building on our current Local Health and Care Record (LHCRE) programme
- Efficiency and productivity – including developing a methodology to spot and share best practice across the system
- Making meaningful engagement and partnership building / work central to all our work

**Refer to annex 1 for an overview of this.*

Given our scale and composition, we have developed ways of working that harness our collective strengths and experiences and build on the lessons learnt from our two first wave ICSs that have been set up at a localised scale – Berkshire West and Buckinghamshire. It is at this level where the partnerships of NHS providers, commissioners, local authorities and other sector partners come together to improve health and care in their area. Leaders across the organisations that make up Oxfordshire have also agreed to establish their integrated care delivery in this way and are making rapid progress through our shared learning and experience; and are building on a positive system response to the CQC which has transformed local ways of working.

Integrated working at place has enabled us to establish a jointly commissioned outcomes-based contract for mental health in Oxfordshire, that includes voluntary organisations within the provider collaboration; set up a single joint commissioning team across the Local Authority and the CCG in Buckinghamshire; and in Berkshire West we have taken further steps to design and embed place-based functions. Several joint appointments are now being made between commissioning and provider partners (e.g. single Director of Long Term Conditions / ICP Delivery, shared Director of Communications etc). Further work is planned to create a single Berkshire West Transformation function which will provide expertise and delivery capacity for the implementation of their change programme.

As a system we have had some key successes over the past year, for example: (1) we have a very robust approach to working with our Estates Directors and our estates strategy was rated as 'Good'. In bidding for capital, we were able to successfully prioritise and were unilaterally agreed that services for those with mental health and learning difficulties were priority areas for capital investment in our system; (2) we have established an acute collaborative work stream with a focus on elective care pathways and support functions such as pharmacy. The elective work



stream focuses on several specialities; which will allow us to better respond to constitutional standards – for example, a joint dermatology service between Royal Berkshire Hospital Trust (RBHT) and Oxford University Hospital Trust (OUHT). RBHT are also taking on waiting list work for patients on the OUHT lists.

We adopt a ‘do once and share’ approach across the system and our infrastructure is made up of, 45 Primary Care Networks (PCNs) which form the core building blocks of our system, both as providers of integrated multi-professional working around local populations, but equally through their alignment with secondary and community care, and Local Authorities; altogether making up our three Integrated Care Partnerships (as illustrated below), with clear oversight from our Health and Wellbeing Boards.



We have found that effective and meaningful involvement of voluntary and community partners, service users and the public in decision-making occurs mainly within place. For example, Berkshire West has strong track record of working with local community partners as evidenced by an outstanding 360-degree survey score for 2018/19 which the ICP will look to build on and share best practice from in future years with the system. There is also work in collaboration with Local Authorities to create a new strategy for working with the voluntary sector that seeks to reduce the number and complexity of commercial contracts held between public sector organisations and important delivery partners from the third sector. This process of consolidation will ensure that more effort can be focused on delivering high-quality services rather than the bidding for, and management of, a multitude of smaller value contracts. We have also learnt valuable lessons from recent experiences in Oxfordshire on this and have developed an evidence-based framework to planning for the design and delivery of all health and care services, engaging the public and key stakeholders at an early stage to fully understand their views.

Refer to annex 2 for how these ways of working are supported and reinforced through our refreshed system governance, which we have developed in response to an independent review which enabled us, as an executive team, to reflect and discuss what was working and what wasn't working well and put forward ideas for how to address these issues and improve. We are in the process of appointing an Independent Chair to support our endeavours and challenge us when necessary (*note: interviews were held on 24 May and we hope to announce the appointment shortly*).

Q2. What progress has been made towards putting in place appropriate commissioning, oversight and infrastructure arrangements, as well as to manage financial resources collectively for the system's population? Refer to Domain 2 "System architecture and strong financial management and planning", when answering the question.

Streamlining commissioning – Supported by the system, the CCGs are developing a clear view of what commissioning functions will look like in the future; and they have undertaken a piece of work with staff across the three CCGs, looking at specific commissioning functions and where they could sit in the future landscape – with some functions being done at the system level and others in place; building on our experience of integrating care and interfaces / opportunities with Local Authority colleagues. There will be a limited number of decisions that commissioners will need to continue to make locally but independently, for example in relation to procurement and contract awards. We plan to utilise the integrated health and care commissioning functions of our Local Authority and CCGs to do this.

Where appropriate, our governance is clear; CCGs delegate their commissioning functions to a lead CCG, coordinated



by the STP, as we already do for areas such as NHS 111 and ambulance services. It will be the collective responsibility of the ICPs and the ICS to ensure where possible we standardise our work across BOB, on our 'do once and share' ethos that reduces overlap and enhances productivity. For example, we have a successful BOB wide workstream for Primary Care that coordinates clearly scoped areas of primary care commissioning. This split of commissioning functions will develop over the next year, as our ICPs and the ICS become more mature and we establish clarity through delegation and eventually legislation.

Alongside this, Berkshire West work is progressing work to create a single approach to Commissioning between the three Local Government organisations and the local NHS partners. This approach will reduce the complexity of delivery organisations having to contract with multiple purchasers and create a set of common service specifications and harmonisation of payment rates.

We are also working with other systems in the South East and the regional team to determine where collaboration and/ or doing things differently will generate improved outcomes and value. Within our systems we have specialist centres who can excel at this, such as Oxford Health who pioneered new models of care for forensic psychiatry.

Oversight arrangements – Whilst building on lessons of testing different approaches to system-led oversight over the course of 2018/19 we have an agreed position with our new joint regional team about how we will progress our system oversight arrangements; with the system being the point of contact for the region and the convener to resolve issues as they arise. Over the coming year we will establish the foundations, resource and infrastructure to become a self-assuring system from 2020/21.

System financial management – We have agreed our 2019/20 control totals and submitted a plan to deliver this. The planned receipt of PSF and CSF results in a surplus of £44.7m. There is a £71.9m improvement in the underlying position from 2018/19 actuals to the 2019/20 plan position which needs to be sustained moving into 2020/21. The underlying position for 2019/20 is a £60.7m deficit; work will be completed over the summer on a long term plan to address this. Efficiency plans have been developed utilising national benchmarking tools including NHS RightCare, Getting it Right First Time, the 10 point efficiency plan in the Long Term Plan, Bronze Diagnostic report and the NHS Continuing Healthcare Strategic Improvement Programme. Priority areas of focus and schemes have been identified for implementation. There is a planned increase in both CCG (£15.9m, 0.6%) and provider (£27.1m) efficiency savings respectively. We are planning to develop a system financial framework to support our system approach; this is an area where it would be helpful to have support and expertise from NHS England and NHS Improvement.

System wide plans for workforce – We have gone beyond a workforce plan and produced a far more comprehensive 'People Strategy'. This work has been led by excellent weekly collaboration from HR Directors, who are also now working very effectively together in a framework stretching from 'sharing/mutual support' right through shared projects and joint ventures to strategic partners. There is a highly engaged and integrated team at HEE working effectively as part of the system to support our local priorities as well as national programmes. Wider participation has been achieved through workshops and a well-attended and diverse LWAB. This work is linked to our ICS strategy and Primary Care Development.

Q3. What is the health system aiming to achieve? Refer to Domain 3 "Integrated care models", when answering the question.

Building on our progress in transforming health and social care in 2018/19 and in response to the LTP, our main areas of focus are: (1) prevention and reducing health inequalities; (2) out of hospital care; the integration of primary and community services through multi-disciplinary teams and effective working with social care; (3) further developing our NHS 111 Clinical Assessment Service to include GP Out of Hours during 2019 and ambulatory care / same day emergency care; (4) personalised care – increasing individuals' control of their health and be in receipt of tailored care and support. We will also have a focus on further developing personal health budgets, social prescribing and informed decision making; (5) strengthening our digital capability through an interoperability programme across our key providers, as part of the Global Digital Exemplar Programme and the Thames Valley LHCRE programme will allow further advances to be made in the sharing of clinical information.

Further work is required in respect of the development of digitally enabled outpatient care as of our 2019/20 work programme with the emphasis in several areas including:

- Redesigning services to reduce the number of outpatient activity
- Replacing outdated service delivery by using digital-first



- Shifting outpatient appointments closer to home and develop and strengthen integration between primary and community care

All service models will consider both physical and mental health (parity of esteem) and will be approached through a population health lens. A key priority for the Buckinghamshire, Oxfordshire and Berkshire West ICPs is to support emerging PCNs via stronger federations which already exist across Buckinghamshire and Berkshire West; as these are key to the sustainability and delivery of out of hospital service delivery. There are significant numbers of PCNs and we recognise the importance of establishing a coordinated approach that ensures all voices are heard within each ICP. ICS overview will be the responsibility of the ICS Primary Care Group, who already meet and share best practice. At present, PCNs have different levels of maturity; each ICP intends to provide the appropriate support to achieve the baseline service requirements for their patients and to empower those innovative networks who wish to develop at a faster pace, to flourish. Now that we have established the construct of our PCNs, we will make sure to have population health information at PCN profiles, to support segmentation and stratification of patients / need at a more local level. These profiles will also include variations in unwarranted clinical variation in terms of planned care referrals and non-elective activity.

As the integrated, collective system for a number of 'anchor institutions' across a wide population area, which is expected to see rapid economic and population growth, BOB will be working with partners to support and promote the exciting agenda across the Oxford-Milton Keynes-Cambridge corridor and ensure it is well placed to support the resulting health and care needs for that population now and in the future.

To deliver all the above, it will be vital to engage widely across our system; building on our strong networks in place whilst continuing to develop collaborative working arrangements and use of resources across constituent organisations. We are committed to full and early co-production between the NHS and local government and to strong clinical leadership.

**Q4. How would becoming an ICS enable you to improve financial and operational performance?
Refer to Domain 4 "Track record of delivery" and refer to your findings from the system bronze diagnostic process, when answering the question.**

Viewed as an STP, supported by the bronze diagnostic pack, we have:

- Better than average performance on operational standards
- Challenges regarding historic investment in mental health
- Higher numbers of elective admissions and variations in demand for acute care
- Challenges around workforce and cost of living
- Recurrent financial deficits across our places

Becoming an ICS will allow the system to work through these by:

- Strengthening acute collaboration, especially through elective capacity management and system-based procurement / distribution
- Single workforce strategy, including local authority partners with a focus on the whole system care
- Sharing of best practice, especially in the development of community integration models and the development of PCNs
- Strategic financial planning, including capital and digital

Early success against these have been shown through a coherent digital and estates strategy and strong progress on a system-wide clinical strategy.

The system has collectively developed and signed off its 2019/20 operating plan. We have determined which outcomes and actions are best driven at place and system, which has resulted in a set of collective priority areas for system action. We have agreed that the system has a design and delivery role in respect of: (1) population and economic growth, (2) acute collaboration on planned care and strategic planning, (3) resource allocation and system design; a design role with local delivery for workforce, capital and estates; and for all other priorities the system will either hold to account or coordinate the sharing of good practice (as per annex 1).

A Delivery Oversight Group is being established reporting to system Chief Executives Group. Its purpose is to provide scrutiny and assurance of delivery at both workstream and place-based level and to manage risks. Key objectives for





2019/20 are to:

- Develop oversight role at system level and process for receiving assurance from Place / workstream level
- Develop in year performance monitoring and interface with NHSE/I assurance processes
- Set up processes to share good practice across the system
- Agree methodology to support STP to develop and implement system improvement opportunities

A Financial Oversight Group, chaired by the system finance lead, is being established reporting to the Chief Executive's Group. The purpose of this group is to provide collective financial leadership to support the improvement of our financial position and performance, to explore and develop pooled budgets across health and social care, and to design and implement the system financial management framework including risk management arrangements.

Key objectives for 2019/20 are to:

- Establish financial management arrangements for monitoring and delivery of the 2019/20 plan
- Design the ICS financial framework by September 2019 for implementation from 1 April 2020
- Develop and implement risk management arrangements with clear escalation routes and peer support to address issues that arise

The initial phase of this work has been to develop these arrangements at Place level where there is clear evidence of effective partnership working and shared financial risk management. This has already started to develop into cross-Place arrangements. The next phase of work will be to take the agreed best practice for adoption across the system.

Both these groups will be in place by July 2019.

Q5. Which system or geographical area do you propose as an ICS? If there are any footprint boundary issues with the area you are proposing, please flag. Refer to Domain 5 "Coherent and defined population", when answering the question.

We do not intend to shift our boundaries at this stage. However, as a system we routinely think through the most appropriate scale for any activity or transformation we undertake. Given our composition and centres of excellent in research and specific clinical specialities, such as cancer treatment; we will in many cases be working across different systems. For example, we work very closely with Milton Keynes (part of the BLMK ICS), Swindon (part of the Bath, Swindon and Wiltshire STP) and Frimley ICS on pathology, radiotherapy and digital.





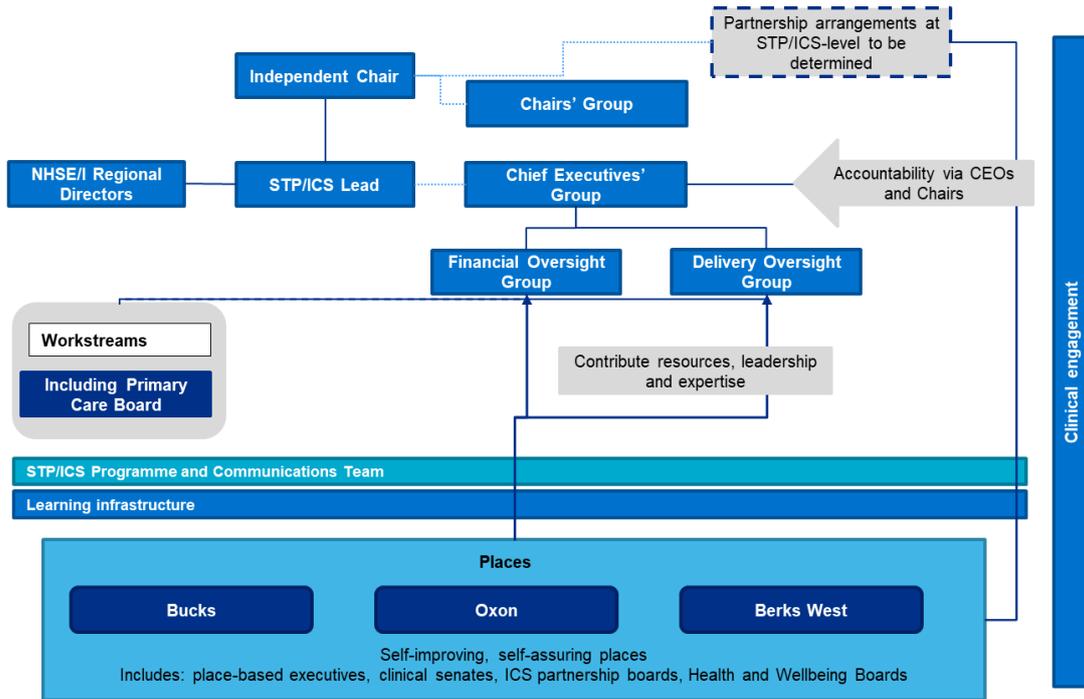
Annex 1 – Overview of system priority work areas and role

ICS role	Description	Priority	ICS oversight running through all strategic priorities Partnerships & Engagement, including patient and public involvement
System design & delivery	Design approach to a problem at ICS level. Deliver solution at ICS level	<div style="display: flex; justify-content: space-around;"> <div style="background-color: #90EE90; border: 1px solid black; border-radius: 10px; padding: 5px;">Population & economic growth</div> <div style="background-color: #FFC0CB; border: 1px solid black; border-radius: 10px; padding: 5px;">Acute collaboration</div> <div style="background-color: #FFC0CB; border: 1px solid black; border-radius: 10px; padding: 5px;">Strategic planning, system design & resource allocation</div> </div>	
System design & place/org delivery	Design approach to a problem at ICS level but leave places/ organisations to deliver	<div style="display: flex; justify-content: space-around;"> <div style="background-color: #FFC0CB; border: 1px solid black; border-radius: 10px; padding: 5px;">Workforce</div> <div style="background-color: #FFC0CB; border: 1px solid black; border-radius: 10px; padding: 5px;">Capital & estates</div> </div>	
Set or confirm ambition and hold to account	Agree ICS ambition (or confirm ICS signs up to nationally set ambition) and hold places to account for/support delivery	<div style="display: flex; flex-wrap: wrap; justify-content: space-around;"> <div style="background-color: #FFC0CB; border: 1px solid black; border-radius: 10px; padding: 5px; width: 30%;">Primary care inc. Primary Care Networks (PCNs)</div> <div style="background-color: #FFFF00; border: 1px solid black; border-radius: 10px; padding: 5px; width: 30%;">Financial balance & efficiency</div> <div style="background-color: #FFC0CB; border: 1px solid black; border-radius: 10px; padding: 5px; width: 30%;">Mental health</div> <div style="background-color: #FFC0CB; border: 1px solid black; border-radius: 10px; padding: 5px; width: 30%;">Urgent & emergency care</div> <div style="background-color: #FFC0CB; border: 1px solid black; border-radius: 10px; padding: 5px; width: 30%;">Cancer</div> <div style="background-color: #FFC0CB; border: 1px solid black; border-radius: 10px; padding: 5px; width: 30%;">Maternity</div> </div>	
Coordinate, share good practice, encourage collaboration	Bring places/ organisations together as a community of practice to share approaches and solutions	<div style="display: flex; flex-wrap: wrap; justify-content: space-around;"> <div style="background-color: #66B3FF; border: 1px solid black; border-radius: 10px; padding: 5px; width: 30%;">Research & Innovation</div> <div style="background-color: #66B3FF; border: 1px solid black; border-radius: 10px; padding: 5px; width: 30%;">Children & young people</div> <div style="background-color: #66B3FF; border: 1px solid black; border-radius: 10px; padding: 5px; width: 30%;">Personalised care</div> <div style="background-color: #66B3FF; border: 1px solid black; border-radius: 10px; padding: 5px; width: 30%;">Digital</div> <div style="background-color: #66B3FF; border: 1px solid black; border-radius: 10px; padding: 5px; width: 30%;">Prevention & reducing inequalities</div> <div style="background-color: #66B3FF; border: 1px solid black; border-radius: 10px; padding: 5px; width: 30%;">Population health</div> </div>	

	ICS Workstream
	A core function led by Fiona Wise, Shadow ICS Executive Lead
	Delivered by the Financial Oversight Group
	Delivered in place



Annex 2 – Refreshed system governance arrangements



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.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Briefing Paper: 17 July 2019

Purpose

The purpose of this briefing is to provide Chief Executives with an updated position on the development of the BOB ICS five year plan, to use as appropriate within their own organisations, with their Boards and key stakeholders.

	Item	Paper
1	<p>Developing the BOB ICS Five Year Plan</p> <p>The next phase of work to develop the BOB ICS five year plan is underway. The plan will describe how all partners will work together locally and together at scale, when appropriate, to ensure current and future health and care needs are met. It will describe how the ICS will deliver its agreed priorities and the requirements of NHS Long Term Plan Implementation Framework, published at the end of June.</p>	 Briefing_BOB ICS Delivery Oversight Gr

7



17 July 2019

Briefing

Developing the BOB ICS Five Year Plan

Leaders from the health and care organisations within the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (BOB ICS) are working together to plan for and respond to local health and care needs over the next five years.

The five year, one system plan will set out how all partners will work together locally and together at scale, when appropriate, to ensure current and future health and care needs are met. It will describe how the ICS will deliver its agreed priorities and the requirements of NHS Long Term Plan Implementation Framework.

The details NHS England and NHS Improvement’s requirements are set out in the NHS Long Term Plan Implementation Framework, published at the end of June 2019

<https://www.longtermplan.nhs.uk/publication/implementation-framework/>

The timescale for developing and publishing the BOB ICS plan is as follows:

By 27 September 2019	Submission of BOB ICS draft plan to NHSE/NHSI South East Regional Team for review
By 15 November 2019	ICS plan agreed with ICS leadership and NHSE/NHSI South East Regional team, in consultation with National Programme Directors
End of November	Plan to be published

The detail of the BOB ICS Five Year Plan will be developed by members of the BOB ICS Delivery Oversight Group. This is a core group within the ICS, which reports to the BOB ICS Chief Executives’ Group. The Delivery Oversight Group is chaired by Fiona Wise, BOB ICS Executive Lead with its membership made up of:

- Senior strategy leads from member ICS organisations (NHS Trusts, ICPs and CCGs)
- BOB ICS workstream leads, such as mental health, cancer, urgent & emergency care
- Representatives from Health Education England, Oxford Academic Health Science Network and the Thames Valley Cancer Alliance

There are 13 weeks between the publication of the Implementation Framework and the submission of the draft plan. This time period includes taking the draft plan through the NHS Trust and CCG Boards within the BOB ICS area.

Briefing: | Delivery Oversight Group Meeting Held on 10 July 2019 (final)

7

Engagement to Develop the BOB ICS Five Year Plan

Engagement can be described in terms of the following activities:

1) Work to date

- Ensuring patient experience strategies and insight informed thinking about common strengths, challenges and gaps
- Testing proposed priorities with a range of stakeholders, including the five Healthwatch organisations in March
- Working with the five Healthwatch organisations on a Healthwatch Long Term Plan survey (1250 respondents) and 10 focus groups and giving this feedback to local leads and workstreams to consider
- Enabling workstreams to access a complete review of all insight gathered through Healthwatch and place-based activities from 2015 to 2019

2) Work to support the development of the five year plan (July to November)

- Integrated Care Partnerships to work with the local government colleagues and elected members to gather their thoughts and views as the BOB ICS plan develops
- Patient and public groups are to be kept informed, through local communications channels, of the development of the five year plan and that the views they have given on a wide range of issues over the past five years is being fully considered (and to ensure that any future engagement does not duplicate previous questions)
- Integrated Care Partnerships to reflect and act upon the responses to the recent Healthwatch survey and focus groups
- Representatives of the five Healthwatch organisations will be involved with the Delivery Oversight Group so that they can input to and comment on the plan as it develops

3) Work to ensure patient, public and stakeholder involvement is embedded throughout all parts of the ICS (ongoing)

- Appointment of an Independent Chair to spearhead the development of partnership work
- Enabling and supporting workstreams to have effective involvement of voluntary and community sector partners, the public and service users
- Establishing a framework describing how involvement in decision making is embedded across all parts of the ICS.

Governance

We are currently working through the timeline to develop our plan and ensure full engagement across BOB and will write out again shortly about this.

Agenda item: 8
 Enclosure no: TB2019/071

Safe & compassionate care,
 every time



Buckinghamshire Healthcare
 NHS Trust

TRUST BOARD WEDNESDAY 31ST JULY 2019

Details of the Paper

Title	Integrated Performance Report (IPR)
Responsible Director	David Williams, 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

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

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

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, exceptions and action to be taken going forward.

RISK

Are there any specific risks associated with this paper? If so, please summarise here.	<i>Non-Financial Risk:</i> Delays in patient pathways
	<i>Financial Risk:</i>

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 <i>(if you need advice on completing this box please contact the Director for Governance)</i>
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Author of paper: David Williams, Interim Chief Operating Officer

Presenter of Paper: David Williams, Interim Chief Operating Officer

**Other committees / groups where this paper / item has been considered:
 EMC, F&BPC, Quality Committee**

Date of Paper: 22.07.2019

8



Buckinghamshire Healthcare
NHS Trust

Integrated Board report

June 2019

Safe & compassionate care,

every time

Executive summary

This summary outlines the operational performance of the Trust for the month of May 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 86.58% in May to 89.05% in June. The daily average attendance for June was 458 which was a decrease from 459 in May. The best day performance was 95.05%. Attendances across Urgent & Emergency Care at BHT were higher than planned, 13,740 compared to 13,411.

Cancer performance for May improved with 83.9% of patients treated within 62 days compared to 83.3% in April. This was above expected % of 82.9% but not compliant with 85% target. 104 day breaches increased from 1.5 in April to 2.5 in May. Cancer referrals continue to increase.

Waiting list size remains high and audit of processes has been confirmed for 22 and 23 July 2019.

RTT Open Pathways performance decreased from 88.6% to 88.1% and number of patients the waiting list higher than planned, actual 29972 compared to plan of 29624. Patient breaching 18 weeks has increased from 3357 to 3489. Additional Ophthalmology activity commissioned by the CCG will support this speciality over the next few months.

Diagnostic waiting times continue to improve with Endoscopy utilising an insourcing service at weekends. This is vital to improvement of earlier diagnosing of cancer and appropriate treatment.

Quality

Of the four cases of CDiff, two were considered avoidable, and re-education on best practice to suspect and manage the infection to the clinical areas affected has been carried out.

Despite the increasing number of complaints received during the months of May and June the complaints team have continued to meet the trust target of 85% and have introduced a new style of reporting to assist the divisions in reviewing and actioning their complaints information including themes and trends.

The Patient Experience team are underway with implementing the Patient Experience Improvement Framework with NHS I/E who last month supported a trust wide workshop which included advice and support around improvements that could be made.

Quality Improvement methodology continues to be embedded across the trust and Steering group has been formed to plan World Quality Day in November 2019.

Harm free care has improved to 93.2%, however falls avoidance continue to be an area of focus, and reinforced within this years CQUIN schemes with some new initiatives on prevention. Pressure Ulcer avoidance (3 ulcers with deep tissue damage as per this report) again continues to be an area of work, including new processes for debriefing and learning to prevent occurrences.

Finance

The trust is on plan YTD delivering a £1.7m deficit position. This position includes the receipt of non-recurrent Performance Sustainability Fund (PSF), Financial Recovery Fund (FRF) and Marginal Rate of Emergency Threshold (MRET) monies totalling £3.2m. Also included is benefit of £2.5m non-recurrent ICP income risk phasing from Buckinghamshire CCG.

The YTD month 3 normalised position excluding receipt of PSF, FRF and MRET is a £4.9m deficit, and without the ICP income phasing would be £7.4m.

Cash balances at the end of the Month were in line with those planned, with no additional loan draw down in month, but £1.6m draw down is planned in July.

Workforce

Nursing recruitment and retention continues to be a focus; despite a higher number of nurse leavers in July, recruitment activity and the registration of existing members of staff resulted in only a small increase in the nurse vacancy rate; this rate remains better than our forecast.

74% of staff have completed their appraisals, against a target of 90%, with 55% having completed the publication process; the Education team will publicise the process for publication, which is a final sign off process from the manager. This is a significant improvement from the same time last year.

The robust approach to temporary staffing management continues; year to date total spend is c£1m less than the same period last year

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. The following four pages show Key Performance Indicators (KPI's) for the Floodlight based on SPC charts that show how performance has changed from month to month. These are then followed by two pages that show charts for either those KPI's where performance is shown on a weekly basis rather than on a monthly basis or 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



Above Control Limit – shows significant improvement



Below Control Limit – shows significant deterioration

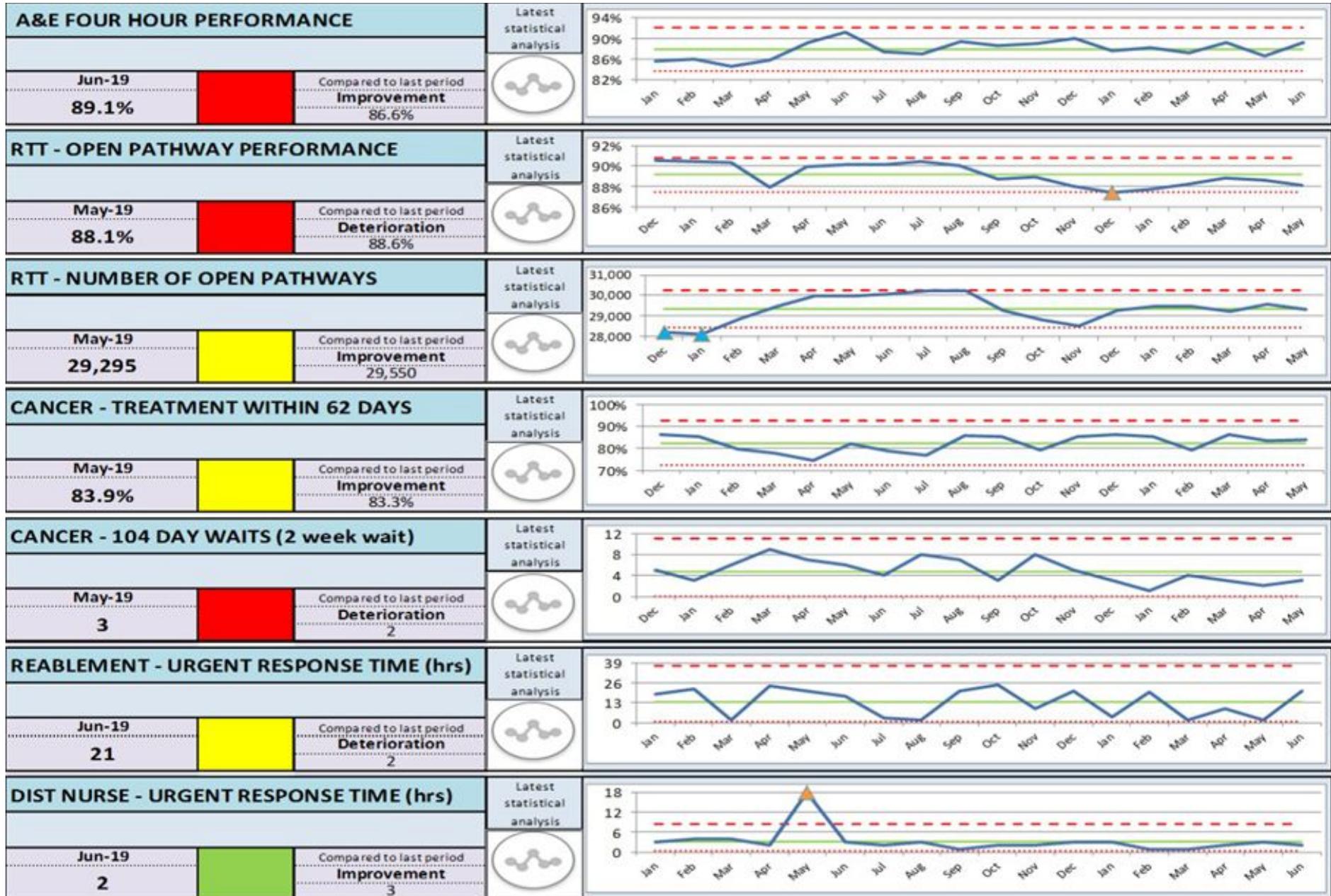


Below Control Limit – shows significant improvement

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

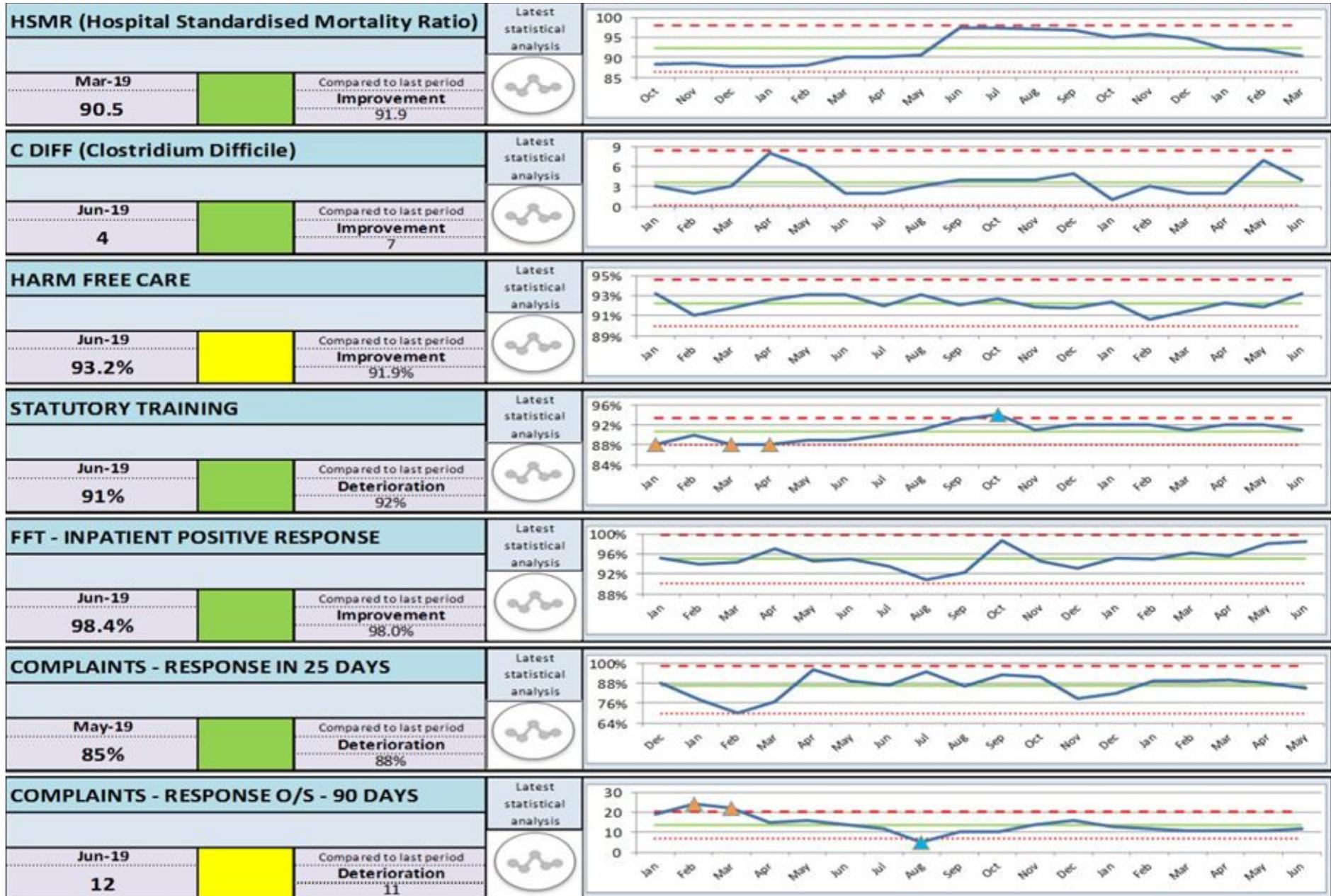
Trust operational Floodlight report – SPC chart section

QUALITY



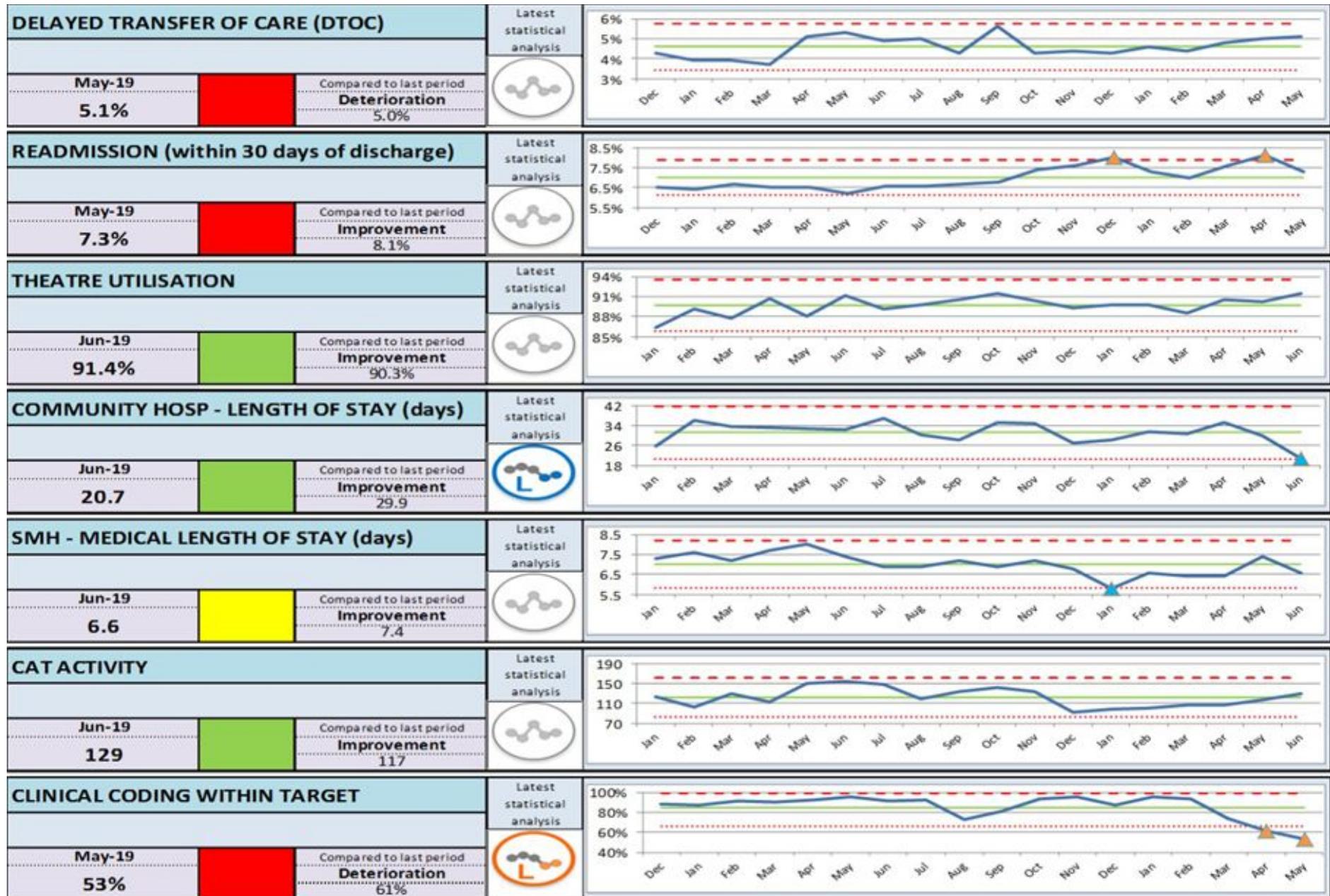
Trust operational Floodlight report – SPC chart section

QUALITY



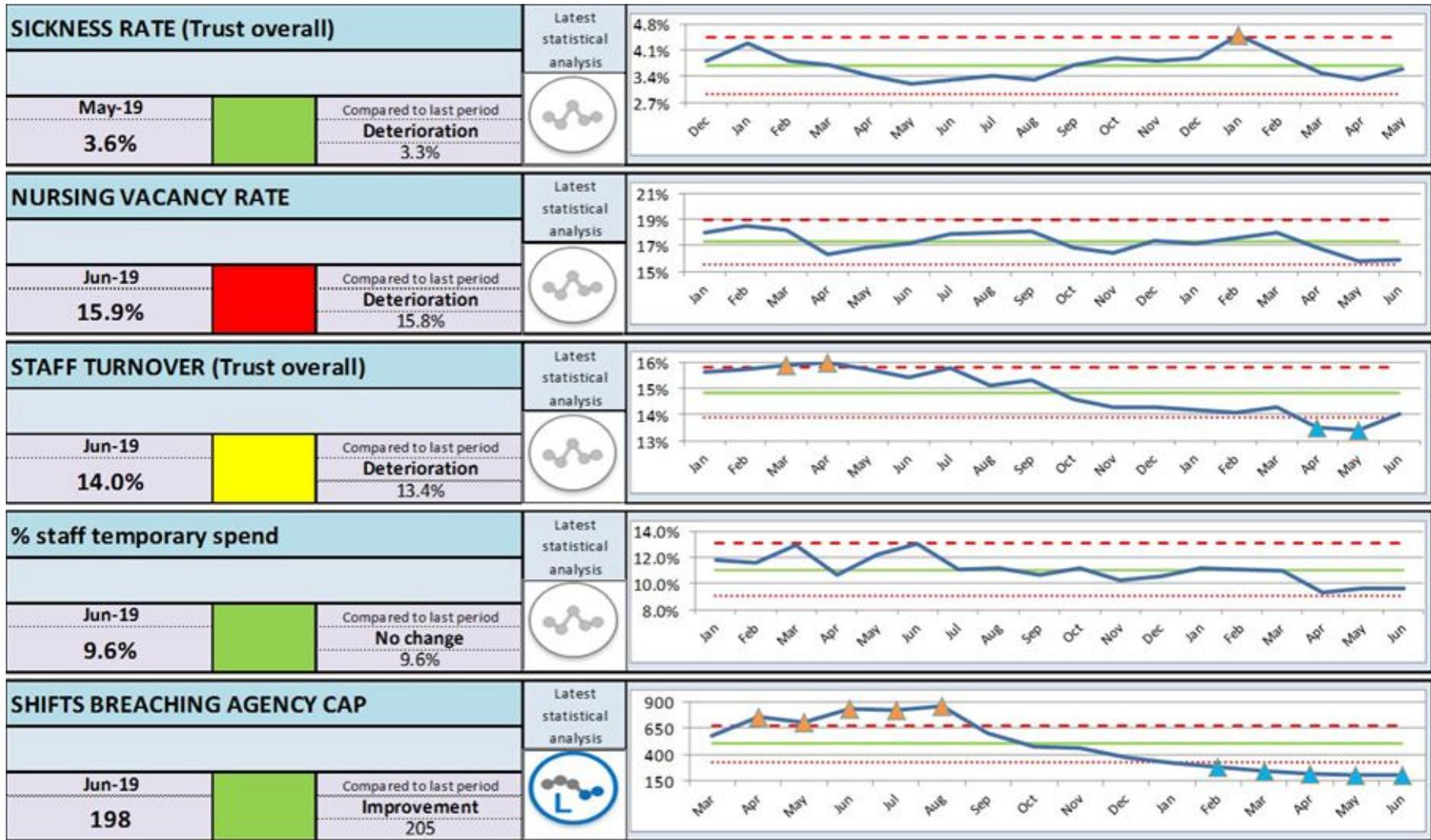
Trust operational Floodlight report – SPC chart section

EFFICIENCY



Trust operational Floodlight report – SPC chart section

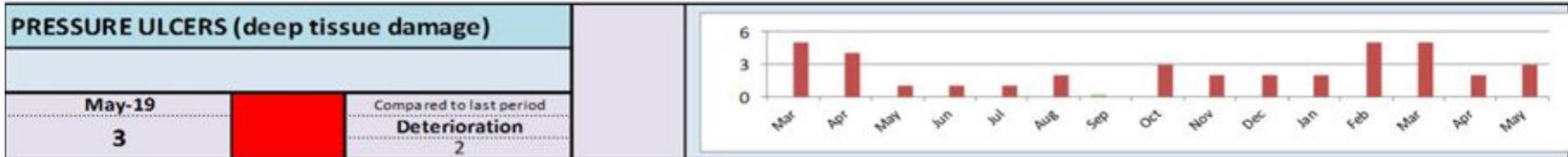
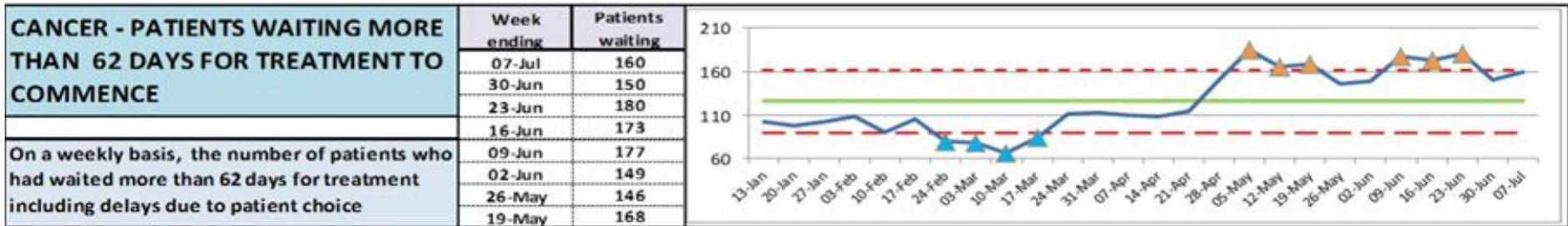
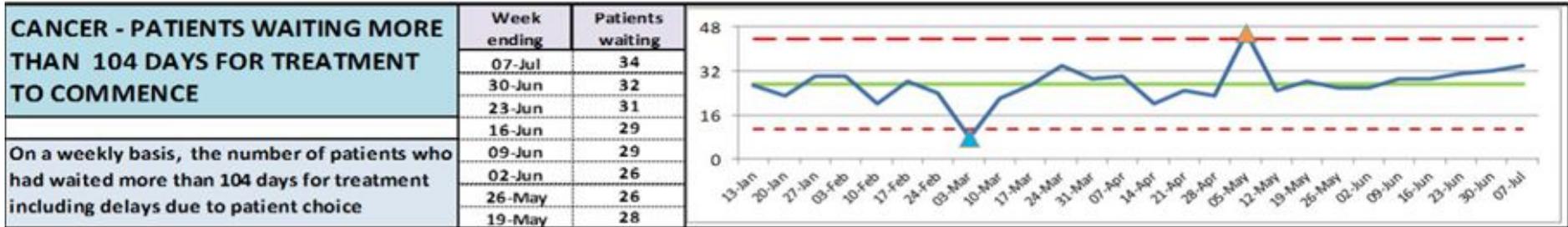
PEOPLE



Trust operational Floodlight report – other charts



Trust operational Floodlight report – other charts



	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

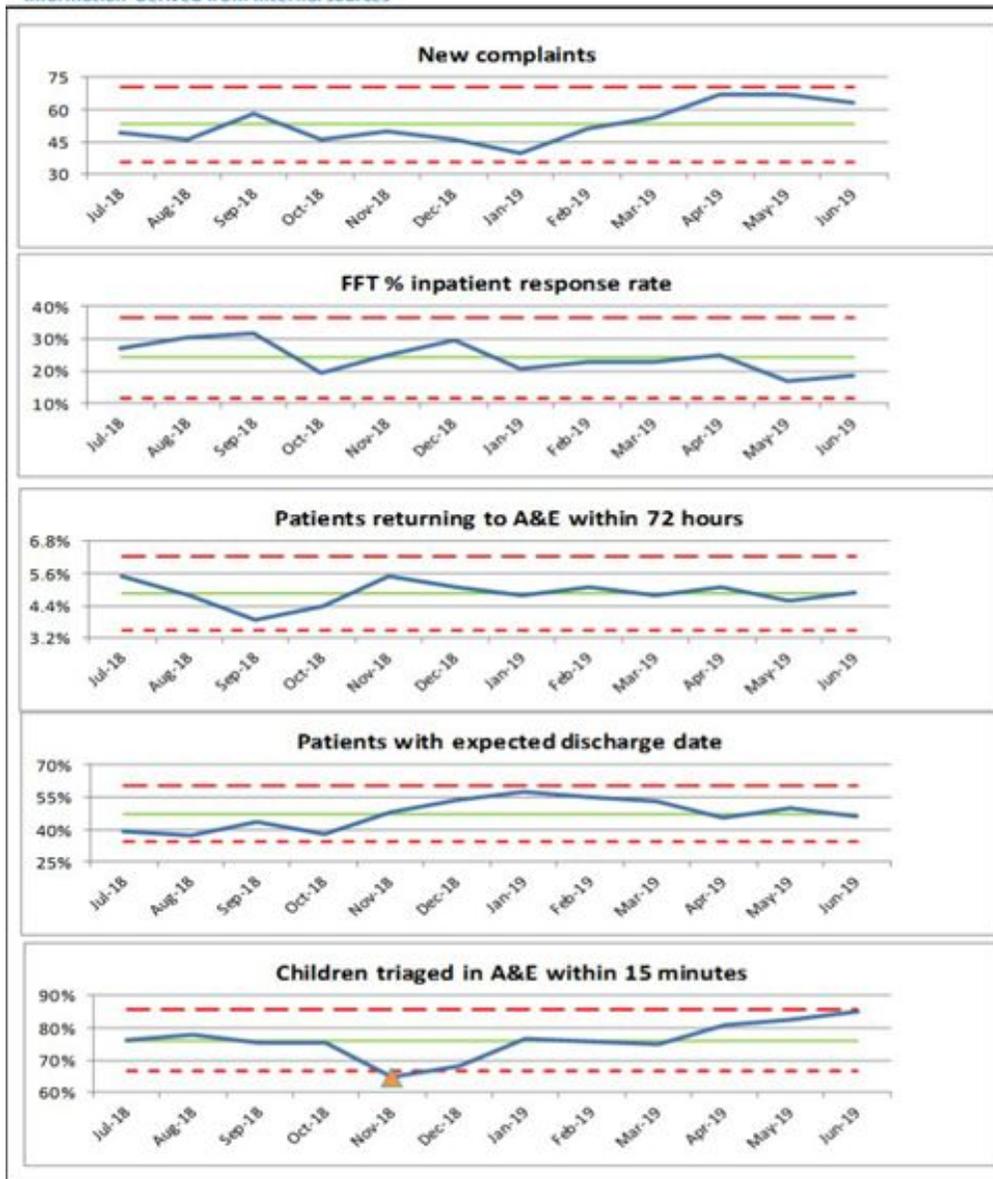


Quality: patient experience

PATIENT EXPERIENCE - LEADING INDICATORS (SPC)

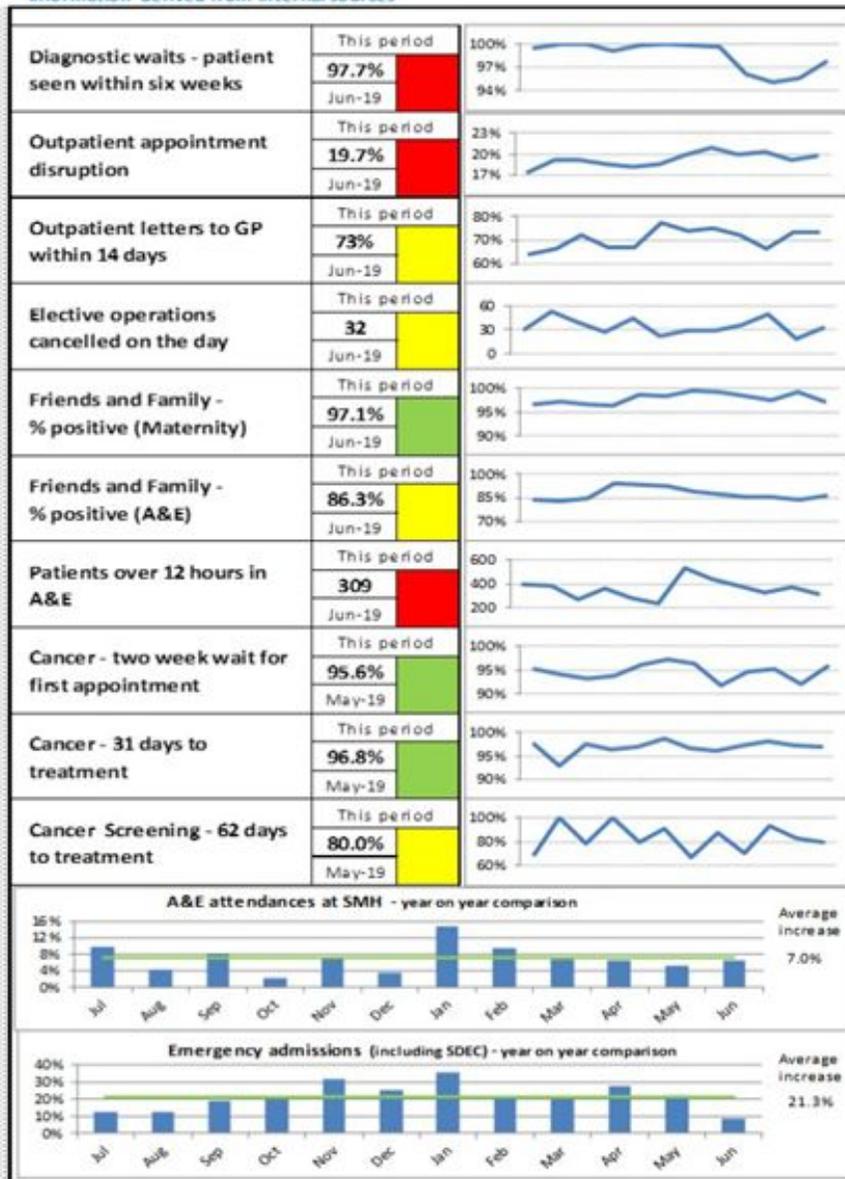
Lead - Quality Committee

Information derived from internal sources



PATIENT EXPERIENCE - TREND INDICATORS

Information derived from internal sources



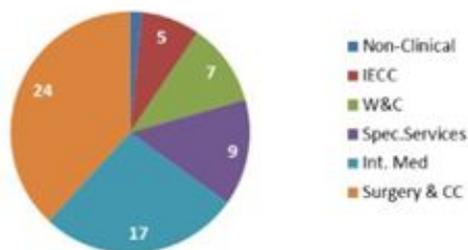
Quality: patient experience

Accolades

Division	Apr-2019	May-2019	Grand Total
Corporate/Non-Clinical Support Services	2	4	6
IECC	478	141	619
Integrated Medicine	103	89	193
Specialist Services	389	234	623
Surgery	109	107	220
Women & Children	194	119	314
(blank)			
Grand Total	1275	694	1975

Complaints

63 Trust Complaints received in June 2019



Top 6 Specialties for complaints in June

General Surgery	9
Trauma and Orthopaedics	6
National Spinal Injuries Centre	5
Dermatology	4
Ophthalmology	4
Acute & General medicine	4

Complaints received: The number of new complaints received in June was 63 and remains a high number when compared to the last three months.

By Specialty: June's complaints by specialty shows a higher than average amount for general surgery. Themes have ranged from procedure pain, clinical decisions, cancellations, screening and post operative care. The five spinal cases shown within specialist services had no trend in location apart from two cases relating to discharge and nursing care. A newly devised patient experience report including a more detailed breakdown of complaints information will support divisions at a local level to analyse and plan actions for improvement.

Themes Trustwide: Delays and cancellations were the most common themes identified in June followed by treatment/procure concerns. Behaviour and attitude of staff was the third most frequently coded theme and a trust wide communications training programme has been launched to help improve this.

Speed of response: The trust target of 85% of 25 day responses was achieved in May 2019

Key Achievements – June

- Held Patient Experience Improvement Framework workshop involving over 30 staff, patients and volunteers, led by NHSI/E Head of Patient Experience
- Secured charitable funding to expand pilot of Envoy FFT platform to whole organisation
- Sage and Thyme communications training promoted to staff, 30 so far trained
- Trust Patient experience group contributed to review of minor eye injuries pathway, and SCBD campaign
- Held first 'Listening to the patient voice' training session for staff
- Held first meeting of 'Listening to the patient voice' working groups involving, patient experience, PALS and complaints, clinical audit, communications and chaplaincy
- Attendance at divisional meetings to discuss patient experience with new divisional PE reports that breaks down both patient experience data and complaints at a divisional level

Key Priorities – July

- Deliver the plan for FFT Envoy expansion across the whole organisation including OP IP and day case services.
- Hold staff workshop on Picker 2018 A&E survey results
- Deliver listening event for neonatal unit parents
- Deliver two events with Bucks Vision to involve patients in cataract and glaucoma pathway reviews
- Train further group of patient assessors for Perfect Ward

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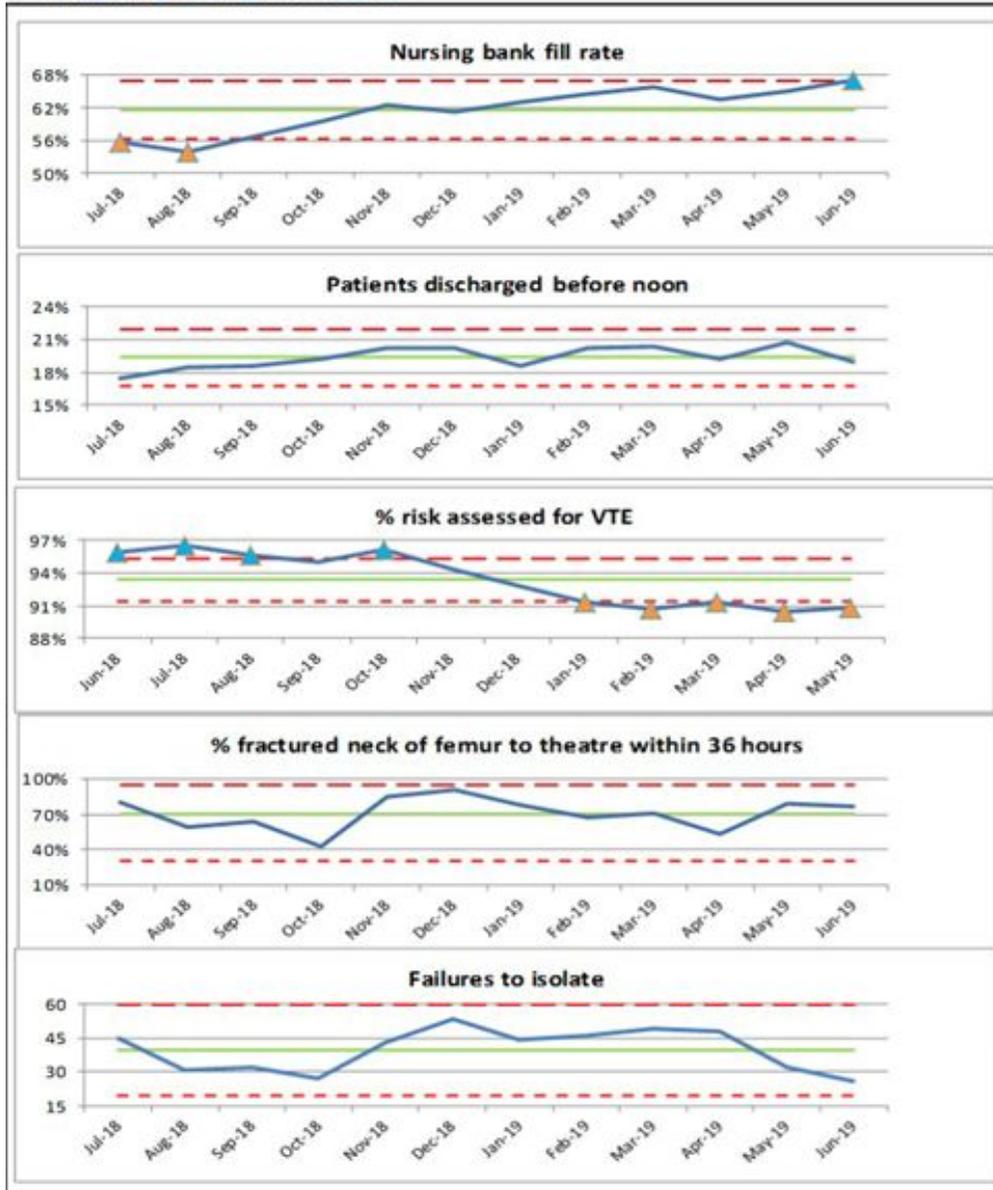
every time

Quality: patient safety

PATIENT SAFETY- LEADING INDICATORS (SPC)

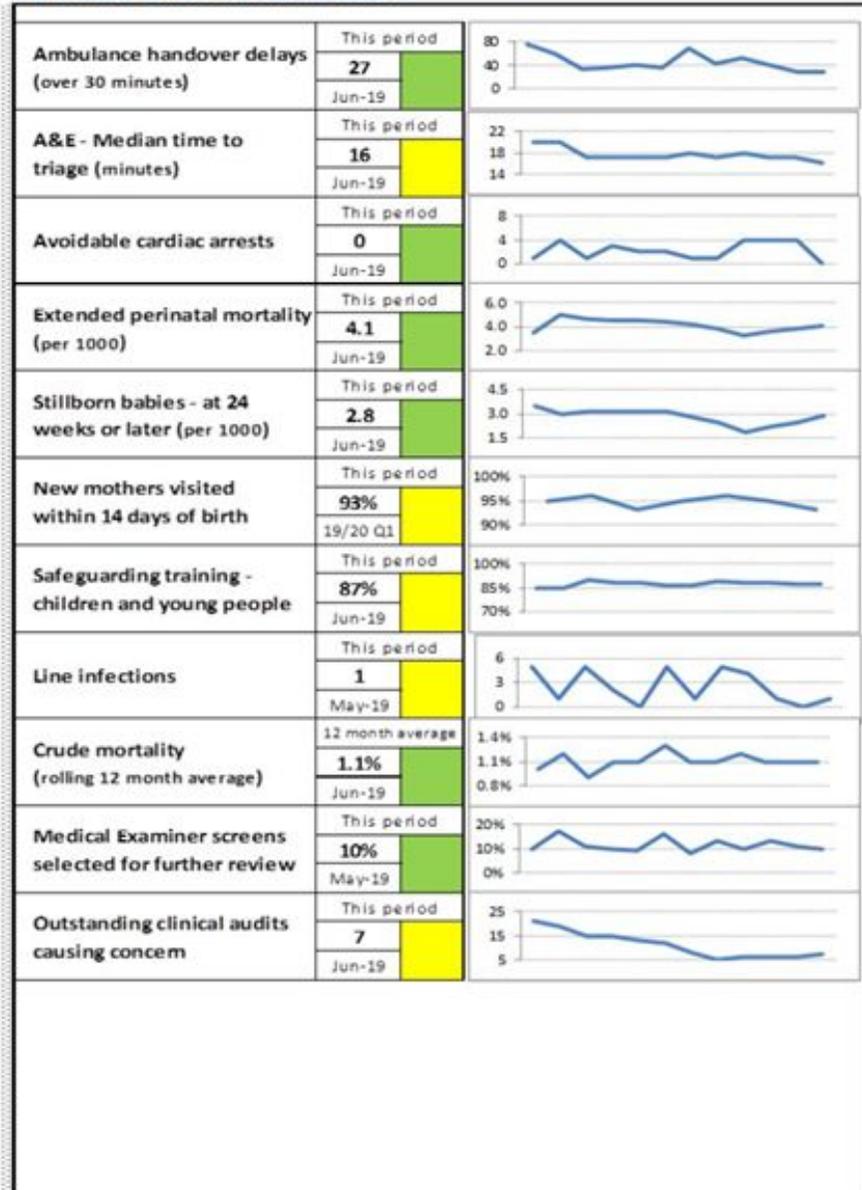
Lead - Quality Committee

Information derived from internal sources



PATIENT SAFETY - TREND INDICATORS

Information derived from internal sources

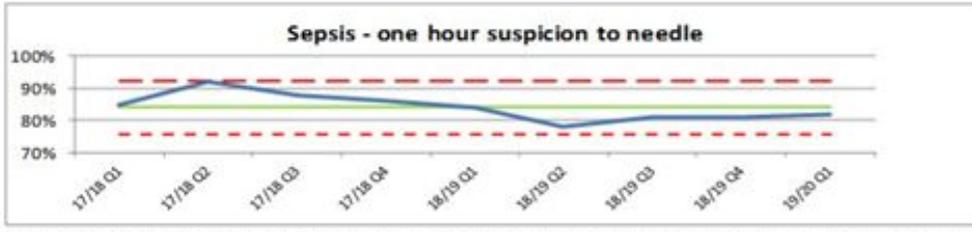
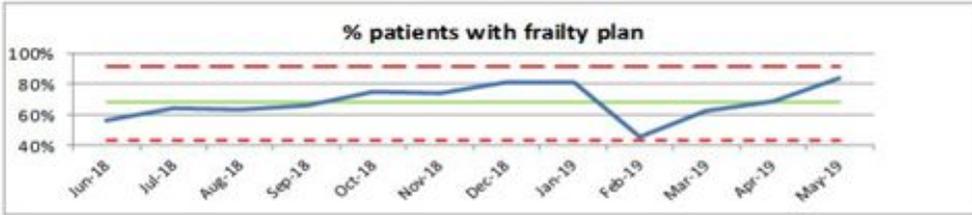


Quality: patient safety

PATIENT SAFETY- LEADING INDICATORS (SPC)

Lead - Quality Committee

Information derived from internal sources



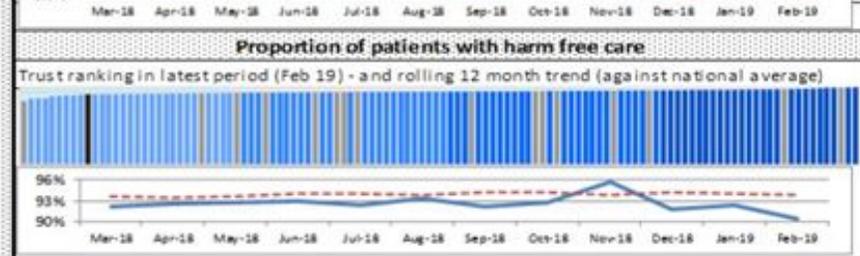
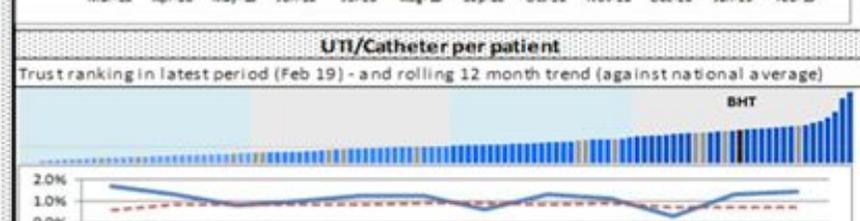
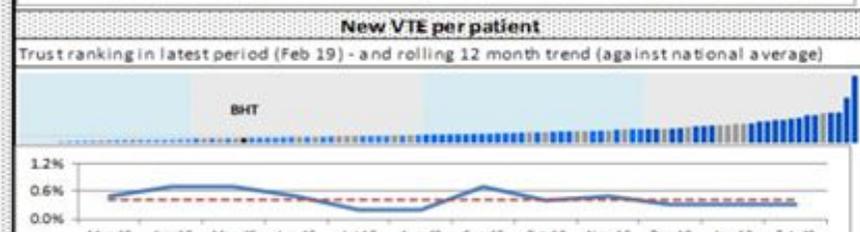
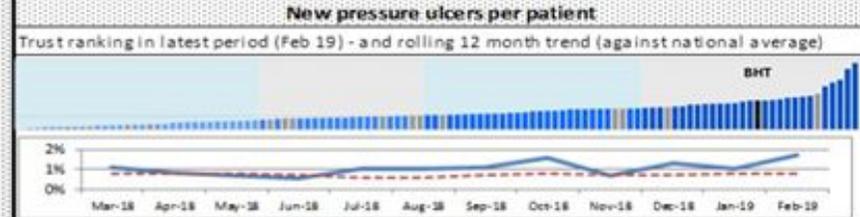
Safety incident reporting

Information source is latest CQC insight



PATIENT SAFETY - TREND INDICATORS

Information source is NHSI Model Hospital - for benchmarking nationally



Quality: Key Issues and Learning

Key lessons learned and actions from serious incident reports this month

NHS Improvement issued a Patient Safety Alert '*Wrong selection of orthopaedic fracture fixation plates.*' For all NHS organisations where orthopaedic surgery is undertaken to repair fractures.

Rationale for the alert, due for completion by May 2019.

Throughout the NHS, a number of incidents were reported recently where *reconstruction plates* were used instead of *dynamic compression plates*, due to mis-selection, resulting in further surgery. The confusion arose due to recent design changes whereby plates looked similar, and partly due to the current theatre instrument tray system used in some trusts.

Actions for Trusts

Trusts were required to identify all clinically relevant patients who have had a plate fitted since Feb 01, 2008, and to undertake a retrospective review of patient xrays. If the wrong plate was used – seen on xray - these cases were required to be reported as a Never Event with an action plan. The theatre instrument tray process also required review, with reconstruction plates purchased as separate sterile packs, stored separately. The key messages were for dissemination to relevant staff across the trust, and changes of practice to be reflected in Local Safety Standard Procedures.

BHT's compliance with this alert was completed through :

A retrospective audit within the Dept. of Trauma and Orthopaedics, BHT was undertaken. This involved analysis and cross referencing of clinical records, theatre registers and manufacturers records.

From 01.02.18 – 28.02.19 **1624 cases were identified**, and using exclusion criteria , **narrowed down to 82 cases** where long-bone diaphyseal fractures had been fixed using a plate technique. The audit findings were reported to Executive s and will be shared with relevant staff.

Audit outcome : No reconstruction plates were used in trauma cases in the trust in this timeframe and it was identified that the instrument tray used in this organisation is not a risk factor .

Mortality review and alerts

•Mortality review and alerts

- Total compliance with ME screens **100%**
- 86%** no care problems identified
- 14%** selected for SJR
- SJR compliance up to **89% overall**
- 32%** of all compliments led to excellence reporting
- 89%** patients had DNACPR
- 83%** patient had TEP
- 96%** of applicable calls achieved by medical examiner to bereaved relatives
- 96%** compliance with medical examiner discussion with certifying doctor
- A purposeful sample of ME cases re-screened to provide quality assurance
- Expression of interest made to present at 2nd National RCP mortality conference
- Regional MEs appointed by National Medical Examiner
- 3rd LeDer Annual Report - recommendations and BHT actions monitored and driven through mortality reduction group

Quality Improvements

Recent Key Achievements and key priorities:

- Building capability across BHT continues.
- Meeting with audit/clinical effectiveness and patient experience teams to discuss future collaborative working to drive improvements and learning
- Attended PEG meeting to present QI & Waste Spotting
- Steering group formed to plan World Quality Day in November 2019
- Intranet pages for QI now in place
- QI team supporting a number of projects and interventions achieved include:
 - High Intensity Users: MDT meeting supported by ED consultant from JRI; care plans discussed for patients
 - Coding recommendations report completed and meeting of key stakeholders run
 - FallSafe project - new notes trollies in place on HASU to enable stay in the bay working, supported by the ward staff

Safe & compassionate care,

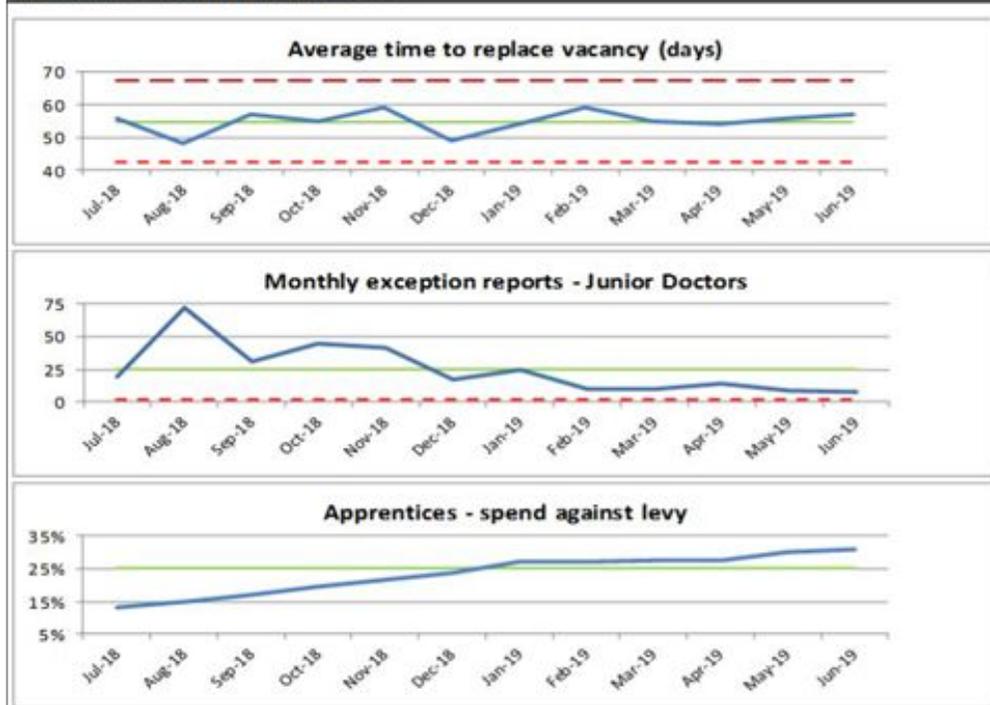
every time

Workforce indicators

WORKFORCE - LEADING INDICATORS (SPC)

Lead - Workforce Committee

Information derived from internal sources



WORKFORCE - TREND INDICATORS

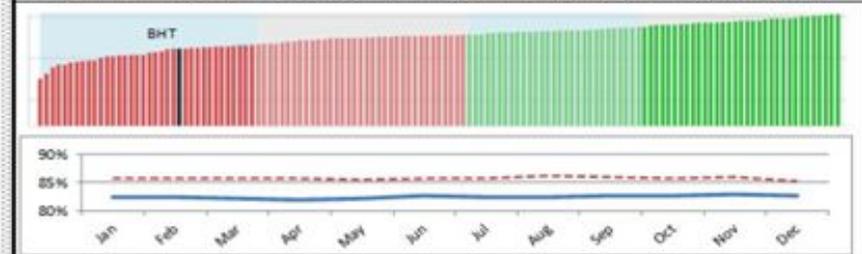
Information derived from internal sources



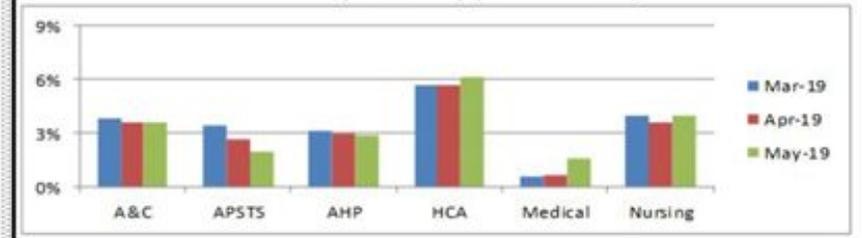
Information source is NHSI Model Hospital - for benchmarking nationally

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

Appraisals

At the end of June, 55% of staff had completed and published their appraisal and a further 19% who have completed their appraisals but not published them.

Our trust target for completed appraisals is 90%, so with the current activity levels and the support programme in place we are confident that by the end of next month our completed appraisals will be 90%.

Spend on agency staffing

Our grip and control processes to manage temporary staffing continue to successfully control our agency costs. This is achieved through working collaboratively with Heads of Nursing and other service leads to ensure patient care standards are maintained. The data shows an average reduction of c£300k per month compared with last year, a cumulative cost avoidance of c£1m in the first quarter of the year

Apprenticeship

As part of our people plan to develop staff, we are supporting 198 colleagues on clinical and non-clinical apprenticeship programmes. This is an increase of nearly 15% compared to last year.

In particular we are planning 79 clinical apprentices with 62 in nursing.

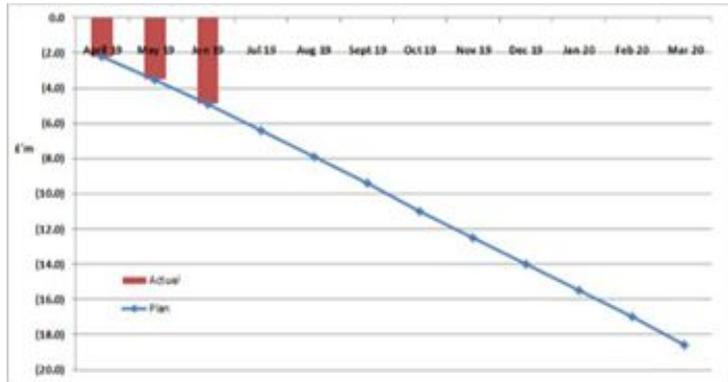
We continue to spend our levy in line with our planned expenditure to ensure we do not lose any of our levy or run short.

Income Mth	DAS MONTHLY INCOME	Cumulative Total DAS Income with Top Up	Sum of Monthly Expenditure	Sum of Cumulative Expenditure	Sum of total DAS spent (%)
M1	80,194	2,066,473	62,829	560,371	27.12
M2	86,611	2,161,510	62,327	622,697	28.81
M3	83,034	2,252,622	68,811	691,509	30.70



Finance: income and expenditure

Retained surplus / (deficit), before PSF/FRF/MRET



Key Highlights

- The trust is on plan YTD delivering a £1.7m deficit position.
- The YTD position includes the receipt of Performance Sustainability Fund (PSF), Financial Recovery Fund (FRF) and Marginal Rate of Emergency Threshold (MRET) monies totalling £3.2m, in line with plan.
- The YTD month 3 normalised position excluding receipt of PSF, FRF and MRET is a £4.9m deficit, in line with plan.
- The year-to-date position includes pro rata element of £5m improved contract value agreed with Bucks CCG, and £2.5m non-recurrent ICS income phasing from Bucks CCG.
- Delivery of Efficiency Plans are broadly on plan, but do include a number of non-recurrent items to balance under delivery on recurrent plans.
- There is a national exercise to reduce capital at ICS/STP level by 20%.

Trust I&E Performance (£M)

(£m)	Plan	Actuals	Variance	Annual Plan	Forecast
Contract Income	100.3	101.3	1.0	400.9	400.9
Other income	7.9	8.6	0.7	32.2	32.2
Total income	108.2	109.9	1.7	433.1	433.1
Pay	(67.9)	(67.9)	0.0	(267.7)	(267.7)
Non-pay	(38.4)	(40.2)	(1.8)	(156.8)	(156.8)
Total operating expenditure	(106.3)	(108.1)	(1.8)	(424.5)	(424.5)
EBITDA	1.9	1.8	(0.1)	8.6	8.6
Non Operating Expenditure	(6.8)	(6.7)	0.1	(27.2)	(27.2)
Retained Surplus/(Deficit) before PSF, FRF and MRET	(4.9)	(4.9)	(0.0)	(18.6)	(18.6)
Performance Sustainability Fund (PSF)	0.9	0.9	0.0	5.8	5.8
Financial Recovery Fund (FRF)	1.3	1.3	0.0	8.6	8.6
Marginal Rate of Emergency Threshold	1.0	1.0	0.0	4.2	4.2
Retained Surplus/(Deficit) Including PSF, FRF and MRET	(1.7)	(1.7)	(0.0)	0.0	0.0
Non Recurrent I&E	3.2	3.2	0.0	18.6	18.6
Normalised I&E Surplus / (Deficit)	(4.9)	(4.9)	(0.0)	(18.6)	(18.6)

Divisional I&E Performance (£M)

Division / (£m)	YTD Variance	Forecast	Forecast variance	Last 3 Month Run Rate		
				M01	M02	M03
Integrated Medicine	(0.4)	(76.5)	0.0	(7.0)	(6.5)	(6.3)
Integrated Elderly Care	0.4	(35.0)	0.0	(3.0)	(2.8)	(2.7)
Surgery And Critical Care	(0.7)	(86.9)	0.0	(7.7)	(7.7)	(7.5)
Women and Children	0.5	(45.9)	0.0	(4.0)	(3.7)	(3.6)
Specialist Services	(0.4)	(69.0)	0.0	(6.3)	(6.1)	(5.9)
Total Clinical Divisions	(0.6)	(313.9)	0.0	(28.1)	(26.7)	(26.1)
Chief Executive	0.3	(4.7)	0.0	(0.4)	(0.3)	(0.3)
Chief Operating Off-Management	0.0	(1.4)	0.0	(0.1)	(0.1)	(0.1)
Corporate Services	(0.4)	1.0	0.0	0.0	0.2	(0.4)
Commercial Director Mgmt	0.1	0.1	0.0	0.0	0.0	0.1
Finance Dept.	0.1	(4.7)	0.0	(0.3)	(0.4)	(0.4)
Information Technology	0.5	(7.6)	0.0	(0.5)	(0.5)	(0.4)
Performance and Delivery	0.0	(3.6)	0.0	(0.3)	(0.3)	(0.3)
Property Services	(0.5)	(46.5)	0.0	(4.2)	(4.0)	(4.1)
Human Resources	0.1	1.8	0.0	0.2	0.2	0.1
Medical Director	0.1	(0.3)	0.0	(0.0)	0.0	0.0
Nursing Director	0.0	(15.9)	0.0	(1.4)	(1.3)	(1.4)
Pdc And Depreciation	(0.1)	(18.4)	0.0	(1.6)	(1.6)	(1.5)
Bht-Bhpl Sla	0.0	0.0	0.0	0.0	0.0	0.0
Strategy And Business Dev.	(0.0)	(0.7)	0.0	(0.0)	(0.0)	(0.0)
Total Corporate	0.1	(100.9)	0.0	(8.7)	(8.1)	(8.6)
Contract Income	(2.6)	411.9	0.0	32.4	32.9	32.5
ICS Risk Allocation Contract Income	3.6	7.5	0.0	2.1	0.5	1.0
Provisions	(0.7)	(4.7)	0.0	0.0	0.0	0.0
Donated Asset Reporting Adj	0.1	0.0	0.0	0.1	0.1	(0.1)
Retained Surplus / (Deficit) before PSF, FRF and MRET	0.0	(0.0)	0.0	(2.2)	(1.3)	(1.3)
Performance Sustainability Fund (PSF)	0.0	0.0	0.0	0.3	0.3	0.3
Financial Recovery Fund (FRF)	0.0	0.0	0.0	0.4	0.4	0.4
MRET	0.0	0.0	0.0	0.3	0.3	0.3
Retained Surplus / (Deficit) Including PSF, FRF and MRET	0.0	(0.0)	0.0	(1.1)	(0.3)	(0.3)

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Finance: cash & Accounts Payable / Receivable

Cash Position

	June '19	July '19	Aug '19	Sept '19	Oct '19	Nov '19	Dec '19	Jan '20	Feb '20	Mar '20	Apr '20	May '20
OPENING BALANCE	4.7	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0
INFLOW												
Receipts	34.4	39.3	38.2	38.2	38.2	38.2	38.2	38.2	38.2	38.2	38.7	38.7
Revenue Support Loan		1.6	1.0	1.5								
	34.4	40.9	39.2	39.7	38.2	38.2	38.2	38.2	38.2	38.2	38.7	38.7
OUTFLOW												
Pay	(23.2)	(22.3)	(22.3)	(22.3)	(22.3)	(22.3)	(22.3)	(22.3)	(22.3)	(22.3)	(22.7)	(22.7)
Non Pay	(13.0)	(17.4)	(15.1)	(13.0)	(13.9)	(14.2)	(14.1)	(13.9)	(13.9)	(9.9)	(15.0)	(14.8)
Capital Expenditure	(0.9)	(1.2)	(1.8)	(0.2)	(1.8)	(1.5)	(1.5)	(1.5)	(1.5)	(1.5)	(1.0)	(1.2)
Loans, Interest and PDC				(4.2)	(0.2)	(0.2)	(0.3)	(0.5)	(0.5)	(4.5)		
	(37.1)	(40.9)	(39.2)	(39.7)	(38.2)	(38.2)	(38.2)	(38.2)	(38.2)	(38.2)	(38.7)	(38.7)
NET INFLOW / (OUTFLOW)	(2.7)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(0.0)	0.0
CLOSING BALANCE	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0

Cash – Key Highlights

- The Trust is drawing down £1.6m in support of the in year deficit and in advance of incentive payments (PSF, FRF) in July. This will need to be repaid once funding flows to the organisation or when the Trust begins to deliver a surplus.
- Based on the operating plan income and expenditure trajectory, together with continued arrears of PSF and FRF the Trust will need to draw down £1m in August to support operations.
- Income was lower in month due to a repayment of credit notes to Bucks CCG. This had an equivalent impact on cash expenditure in month by reducing ability to pay creditors.
- Non pay cash outflow will increase in July as there will be additional cash receipt from the arrears of a VAT claim.
- Approval is requested to take out a loan of £1m required for August and £1.5m September respectively.

Accounts Payable & Accounts Receivable

(£m)	Current	30-60 days	60-90 days	90-120 days	>120 days	Total
NHS	2.4	0.8	0.7	4.9	4.0	12.8
Non-NHS	1.8	0.4	0.4	1.0	2.0	5.6
% of total	13%	4%	4%	27%	22%	100%

Accounts Payable

Table 13 - Accounts Payable

(£m)	Current	30-60 days	60-90 days	90-120 days	>120 days	Total
NHS	1.3	0.0	0.0	0.0	0.2	1.5
Non-NHS	2.3	0.9	0.0	0.3	0.2	3.7
% of total	69%	17%	0%	6%	8%	100%

Better Payment Practice Code

Table 14 - Better Payment Practice Code

	Count Total	Count Pass	% Pass	Total (£m)	Pass (£m)	% Pass
NHS	1,287	484	38%	9	6	67%
Non-NHS	23,865	17,668	74%	70	62	89%
Total	25,152	18,152	72%	79	68	86%

Accounts Payable & Accounts Receivable – Key Highlights

- Accounts Receivable** - Debt has increased in month 3 from £14.3m to £18.4m. Largely driven by outstanding invoices raised in June 2019 for Health Education England £1.1m, Wessex Spec Comm Hub £0.3m, The Shelburne Hospital £0.5m and Buck County Council £0.6m.
- Accounts Payable** - Both NHS and Non-NHS invoices payables have increased from £1.1m to £5.2m. This is driven by the return to paying invoices only when due. Recently, all invoices approved for payment have been paid in an effort to restore relationships with suppliers whilst the backlog was brought up to date.
- Better Payment Practice Code** - BPPC performance remains poor year to date but is reflective of the work that has been undertaken within the accounts payable team to bring accounts up to date and process the backlog. The volumes processed are a lot higher than the same time last year. 25k vs 21k but most of the difference relates to older invoices which has had an adverse affect on this metric.

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Finance: business performance

USE OF RESOURCES - TREND INDICATORS

Lead - Finance and Business Performance Committee

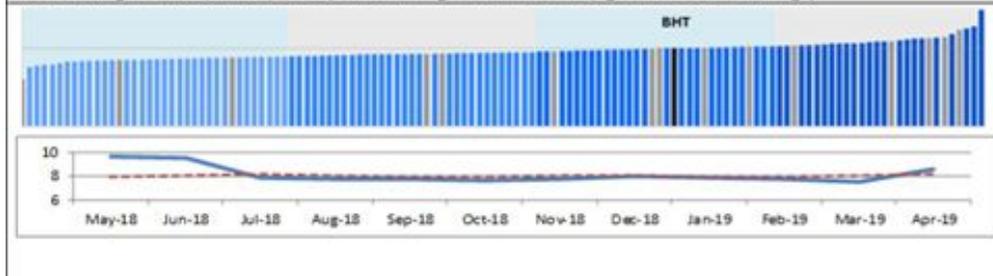
Information source is NHSI Model Hospital - for benchmarking nationally



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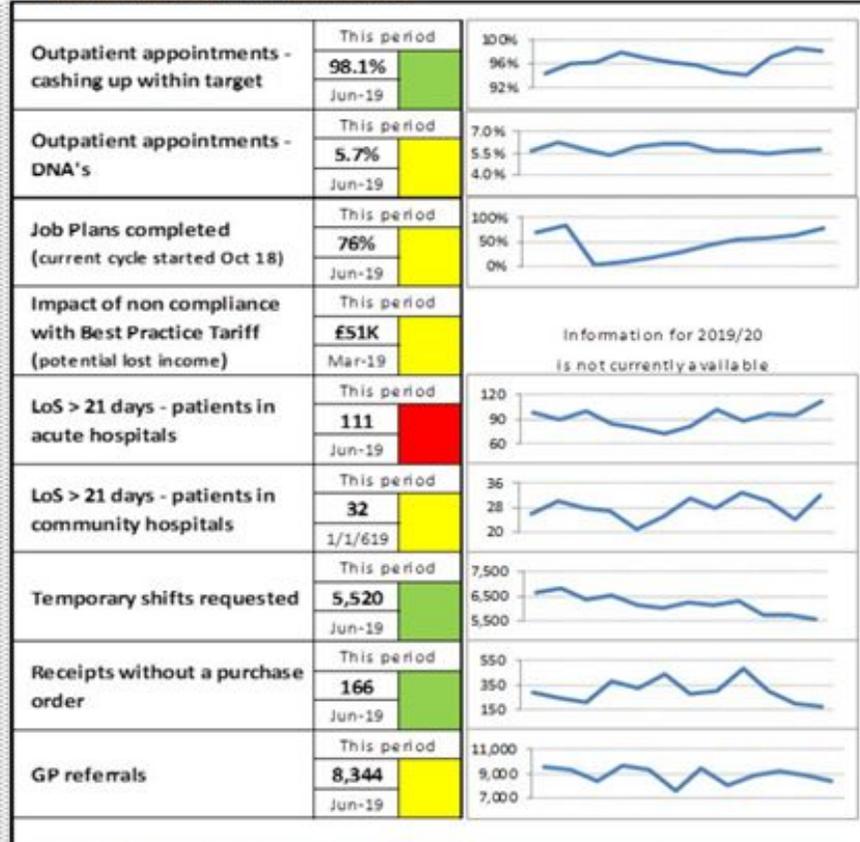
NURSING CARE HOURS PER PATIENT DAY

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



USE OF RESOURCES - TREND INDICATORS

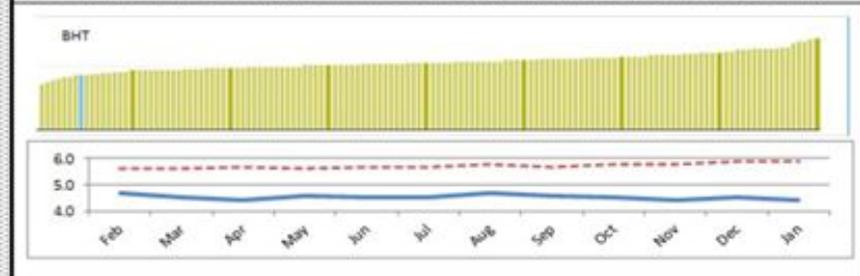
Information derived from internal sources



Information source is CHKS

AVERAGE DIAGNOSES PER CODED EPISODE (Depth of coding)

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



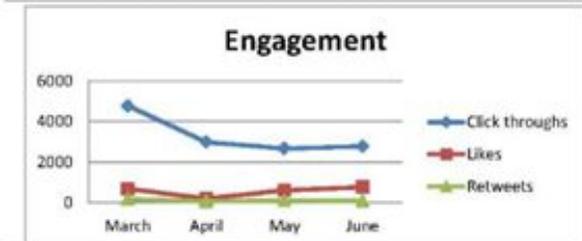
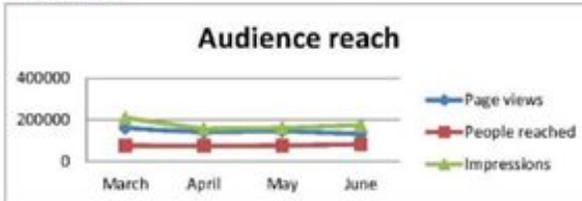
Communications and engagement

INTERNAL

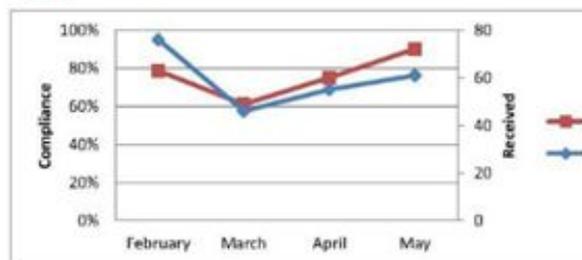
	This month	Last month
CEO brief video clicks	56	31



DIGITAL

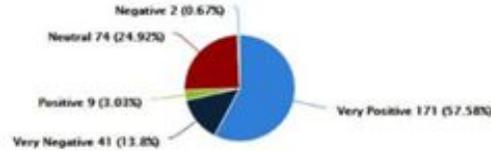


FOI

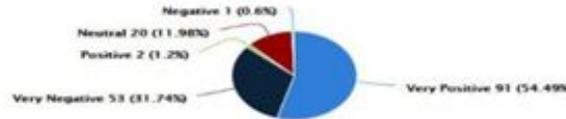


MEDIA Sentiment

This month



Last month



Key stories

- Mix 96 / BFP / Bucks Herald:**
- Bucks hospitals rated 'good' in latest inspection
 - Joy as hospital trust improves



Bucks Free Press / Mix 96:

- A ward at Amersham hospital to close temporarily because of worries over safe staffing levels. 22 beds will be out-of-use, from 1st July, until more nurses can be recruited.

BFP:

- Cancer hub to aid patients in town - a new cancer hub has been launched in Amersham giving patients in the area the opportunity to receive some of their treatment at the new community hub.

PUBLIC ENGAGEMENT



Key activity

Public engagement events

- Community hubs stakeholder group meetings
- EDS2 patient grading meetings

Internal

- TLC campaign continues as part of Small Change Big Difference
- NHS Parliamentary award, Dietetics team announced as regional winners for Health Equalities award
- First meeting of Communications advisory panel

External

- Equality, Diversity and Human Rights Week - Celebrated Local Radio Day and SMH Radio FM status with several BHT staff live interviews
- Supporting HSJ award entries
- supported publication of quality account
- CQC announcement day support, including selfie board campaign, pull up banners & updating posters
- Comms support re chartridge ward closure

PERFORMANCE AGAINST KPIs - Quarterly

	Baseline	Target	QTD
20% increase in digital engagement*	14,774	17,728	16,797

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



Performance exception report																	
Month: May 2019	Executive Director:	David Williams, Acting COO															
	Completed by:	Jenny Ricketts, Divisional Director for Surgery															
Indicator/Performance standard	Referral to Treatment Time (18 weeks). Greater than 92% of the total elective waiting list to be waiting less than 18 weeks for treatment.																
Variation from plan	2019																
	Monthly waiting list plan	29,624	29,972														
	Monthly waiting list actual	29,550	29,295														
	Waiting list growth/shortfall actual (March 19 - 29,225)	+ 325	+70														
	Incompletes >18 weeks	3,357	3,489														
	Monthly RTT plan	88.7%	88.4%														
	Monthly RTT actual	88.6%	88.1%														
	52 week breaches	0	0														
Reason for variation	<p>BHT 18 week performance ranked 56th out of 129 trusts nationally in May 2019. Despite continuing to treat patients over 18 weeks, there was a noticeable drop in performance attributed to an increase in the backlog of long waiters.</p> <p>Deterioration in compliance by key specialities below:</p> <table border="1"> <thead> <tr> <th></th> <th>April</th> <th>May</th> </tr> </thead> <tbody> <tr> <td>Ophthalmology</td> <td>77.1%</td> <td>75.1%</td> </tr> <tr> <td>Paed Ophthalmology</td> <td>93.7%</td> <td>89.2%</td> </tr> <tr> <td>Pain</td> <td>84.6%</td> <td>82.1%</td> </tr> <tr> <td>T and O</td> <td>75.3%</td> <td>74.8%</td> </tr> </tbody> </table> <p>There has been a decline in the quality of validation in May due to new, inexperienced team members. As a consequence, validation performance was sub optimal in month.</p> <p>We continue to priorities our 2ww cancer patients and urgent referrals appropriately. However, June focus will include our long waiting patients.</p> <ul style="list-style-type: none"> • There have been no 52 week breaches throughout 19/20 to date • May diagnostic DM01 submission remains non-compliant (4.41%) as predicted due to insufficient endoscopy capacity. This is however better than predicted performance due to continued weekend insourcing. • Ophthalmology continues to see a rise in cataracts demand post cessation of Operation Cataract Phase 1 (Vanguard). £300k of additional funding has recently been agreed with the CCGs. Plan for additional activity to be agreed. 			April	May	Ophthalmology	77.1%	75.1%	Paed Ophthalmology	93.7%	89.2%	Pain	84.6%	82.1%	T and O	75.3%	74.8%
		April	May														
Ophthalmology	77.1%	75.1%															
Paed Ophthalmology	93.7%	89.2%															
Pain	84.6%	82.1%															
T and O	75.3%	74.8%															
Impact (People/Safety/Money)	Patients continue to wait in excess of 18 weeks for treatment																
Key actions to be taken to address variation	Date:	Description:															
	Aug 2019	Working up 'Operation Arthroplasty' plan to target long waits for hip and knee surgery															
	Jun 2019	Additional support and training to be given to the validation team to improve performance															
	Jun 2019	Insourcing endoscopy procedures for 250 patients in month															
	Jun 2019	Ophthalmology Demand and Capacity exercise commenced in April as part of the Effective Outpatient project.															

	Jun 2019	Operation cataract phase two and phase three plans being worked up to sustainably manage waiting times for patients											
	Jun 2019	Validation of ASIs and duplicate patients in medical specialties as waiting list is growing and affecting overall compliance											
Forecast date to return to plan/trajectory for recovery	Annual waiting list size is anticipated to grow due to the rise in demand over plan for Ophthalmology. This has been submitted to NHS(I). However, this may change now with agreement of the new activity plan and additional funding.												
	Referral to Treatment	Mo nth 1	Mo nth 2	Mo nth 3	Mo nth 4	Mo nth 5	Mo nth 6	Mo nth 7	Mo nth 8	Mo nth 9	Mo nth 10	Mo nth 11	Mo nth 12
	Incomplete pathways <=18 wks	26, 28 5	26, 22 5	26, 25 8	26, 35 0	26, 43 9	26, 43 2	26, 57 8	26, 59 9	26, 59 8	26, 64 4	26, 71 4	26, 74 8
	incomplete RTT pathways Total	29, 62 4	29, 67 2	29, 63 9	29, 72 5	29, 94 2	29, 84 5	29, 99 8	30, 28 6	30, 48 4	30, 52 3	30, 63 2	30, 68 9
	Performance % (92% standard)	88.7%	88.4%	88.6%	88.6%	88.3%	88.6%	88.6%	87.8%	87.3%	87.3%	87.2%	87.2%
	incomplete RTT pathways >52 weeks	0	0	0	0	0	0	0	0	0	0	0	0
Monitoring	Trust PTL meetings (weekly), APMG (weekly), SDU Business Meetings (monthly) Surgery Divisional Board												

Performance Exception Report												
Month: June 2019	Executive Director:	David Williams										
	Completed by:	Lorraine Pitblado										
Indicator/ Performance standard	Trusts Accident & Emergency 4hr Standard - 95% of patients to be seen, admitted or discharged within four hours.											
Variation from plan	June Plan	92% Total patients expected 13,411										
	June Actual	89.05% Total patients attended 13,740										
	<p>Attendances were 329 more than planned and the 4 hour standard was 2.95% less than trajectory.</p> <ul style="list-style-type: none"> The daily average of patients for the month was 458 which was a decrease from 459 in May. The best days performance 06/06/2019 was of 95.05%. The daily average seen through GP steaming was 37 patients which was a decrease from 42 in May. 											
Reason for variation	<p>Highlights for the month of June 2019:</p> <ul style="list-style-type: none"> Attendances across Urgent & Emergency Care at BHT were higher this year 13,740 compared to June last year 12,772 Performance continues to be variable ranging from 80-95%. 											
Impact	<p>Performance of the Emergency Department (ED) constitutional standard of patients seen or discharged within 4 hours has seen more variation throughout April compared to the recent month. In June the ED attendances were in excess of 500 on four days with the average around 458 per day, the highest recorded day was 560 patients on 17th June 2019.</p> <p>Type 1 A&E performance continues to be a challenge although there was an improvement from June.</p> <div data-bbox="422 1335 1204 1753" data-label="Figure"> <table border="1"> <caption>Type 1 - 4 hour performance</caption> <thead> <tr> <th>Month 2019</th> <th>Percentage</th> </tr> </thead> <tbody> <tr> <td>Mar-19</td> <td>75</td> </tr> <tr> <td>Apr-19</td> <td>79</td> </tr> <tr> <td>May-19</td> <td>76</td> </tr> <tr> <td>Jun-19</td> <td>81</td> </tr> </tbody> </table> </div> <p>Minors' breaches continue to pose a significant problem especially out of hours when all patients are managed through one single queue, however minors data not available for June 2019 at time of reporting.</p> <p>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 June and worked across the organisation to black actions.</p> <p>Escalation beds on St Joseph's continue to be utilised which impact the effectiveness</p>		Month 2019	Percentage	Mar-19	75	Apr-19	79	May-19	76	Jun-19	81
Month 2019	Percentage											
Mar-19	75											
Apr-19	79											
May-19	76											
Jun-19	81											

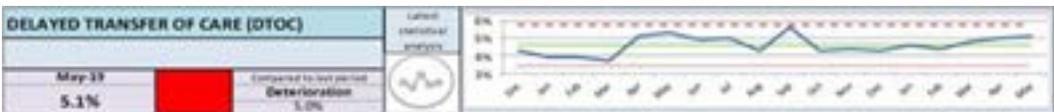
	<p>of delivering a medical day unit as well as a discharge lounge. There was also escalation beds opened in day surgery The plan is to move out of escalation from 1st June has not been possible.</p> <p>The length of stay (LoS) has remained stable although still above trajectory however ongoing work through the month through the 'SAFER' initiatives continue to support reducing the LoS of patients particularly those greater than 21 days.</p> <p>Check & Challenge on the wards has been introduced daily to support discharge & flow.</p>																										
<p>Key Actions to be taken to address variation</p>	<p>Date</p>																										
	<p>July 2019</p>	<p>Minors performance-</p> <ol style="list-style-type: none"> 1. To undertake a deep dive into the areas/days/times that are associated with breaches to clarify and identified which areas require focus work. 2. Undertake a staffing and activity review at UTC in WGH as there has been a notable increase in attendances as well as an increase in breaches- conference call on 15th July. Business case to be developed regarding staffing. 3. To contact/liaise with Surrey & Sussex Healthcare trust as they have been identified to have 100% performance. 																									
	<p>June 2019</p>	<p>Consultant connect –</p> <ol style="list-style-type: none"> 1. 'Consultant Connect' commenced in ED on 17th June 2019 to offer advice & guidance and assist UTC/SCAS. 																									
	<p>July 2019</p>	<p>AEC –</p> <ol style="list-style-type: none"> 1. AEC project – plan to utilise St Joseph's for planned patients in order to increase activity in AEC and in reach into ED. 2. To work with the site team to make capacity as St Joseph's continues to be used as escalation- has not been possible. 3. Trust wide workshop on processes and improvements in capacity and site management 																									
	<p>June-August 2019</p>	<p>Type 1 performance-</p> <ol style="list-style-type: none"> 1. To review, track, anticipate and prevent A&E breaches especially in the evening and overnight. 2. Tracker team & site team to monitor the flow of attendances hourly and as keep track of the plans identified by the clinicians. 3. To increase collaborative working between the NIC & EPIC- review & consider revising the roles & responsibilities. 																									
<p>Forecast date to return to plan / trajectory for recovery</p>	<table border="1"> <thead> <tr> <th></th> <th>Y1 M04 Plan 31/07/2019 Month 4</th> <th>Y1 M05 Plan 31/08/2019 Month 5</th> <th>Y1 M06 Plan 30/09/2019 Month 6</th> <th>Y1 M07 Plan 31/10/2019 Month 7</th> </tr> </thead> <tbody> <tr> <td>Accident and Emergency</td> <td>1,150</td> <td>1,240</td> <td>1,310</td> <td>1,230</td> </tr> <tr> <td>Accident and Emergency - 44 hour wait</td> <td>14,219</td> <td>12,903</td> <td>13,235</td> <td>13,527</td> </tr> <tr> <td>Accident and Emergency - Total Patients</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Accident and Emergency - Performance % 20% standard</td> <td>91.9%</td> <td>90.4%</td> <td>90.1%</td> <td>90.9%</td> </tr> </tbody> </table>			Y1 M04 Plan 31/07/2019 Month 4	Y1 M05 Plan 31/08/2019 Month 5	Y1 M06 Plan 30/09/2019 Month 6	Y1 M07 Plan 31/10/2019 Month 7	Accident and Emergency	1,150	1,240	1,310	1,230	Accident and Emergency - 44 hour wait	14,219	12,903	13,235	13,527	Accident and Emergency - Total Patients					Accident and Emergency - Performance % 20% standard	91.9%	90.4%	90.1%	90.9%
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<p>Monitoring</p>	<p>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.</p>																										

Performance Exception Report					
Month: May 2019	Executive Director:		David Williams		
	Completed by:		Janet Linacre		
Indicator/Performance standard	2WW referrals for suspected cancer - 93% or more of patients to be seen within 14 days of their referral				
	31 day subsequent treatment (surgery) - 94% or more of patients to be treated within 62 days of 2WW referral				
	31 day subsequent treatment (drugs) - 98% or more of patients to be treated within 62 days of 2WW referral				
	62 day - 85% or more of patients to be treated within 62 days of 2WW referral				
	62 day Screening target - 90% or more of patients to be treated within 62 days of referral				
Variation from plan	62 day – 83.9%				
	Cancer 62 day recovery	Feb 19	Mar 19	Apr 19	May 19
		M11	M12	M01	M02
	Breaches > 62 days - predicted	11.0	13.0	11.0	12.0
	Total treated - predicted	76.0	90.0	76.0	80.0
	Predicted Performance	85.5%	85.6%	85.5%	82.9% Revised trajectory
	Breaches > 62 days - actual	18	13.5	13.0	14.0
	Total treated – actual	87.5	97.5	78	87
	Monthly Performance - actual	79.4%	86.2	83.3%	83.9%
	104 day breaches	2.5	3	1.5	2.5
62 day screening – 80%. 4 breaches					
Reason for variation	62 day - Tumour sites not meeting the 62 day target of 85%:				
	Haematology	83.3%	6 patients treated – one referral breached (BHT) which accounts for 17%		
	Gynaecology	70%	6 patients treated –1.5 breaches both due to tertiary involvement, which account for 30%		
	Lower GI	47.1%	8.5 patients treated – 3 BHT breaches and 2 shared with tertiary		
	Lung	82.4%	8.5 patients treated – 1.5 breaches, 1 BHT &1 shared with tertiary		
	Urology	76.9%	13 patients treated – 3 BHT		

	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20%;"></td> <td style="width: 20%;"></td> <td style="width: 60%;">breaches</td> </tr> </table> <p>Due to:</p> <ul style="list-style-type: none"> • change in treatment plan • change of tumour site during investigations • specialist opinion required, especially for pathology • patient choice delay for diagnostics or OPA • radiotherapy capacity in OUH, PET scans at OUH • patient unwell, patient unfit • elderly age (90) of patient, asked for thinking time between stages <p>62 day screening. 4 breast breaches:</p> <ul style="list-style-type: none"> • Patient needed repeat biopsies and undecided between clinical trial & surgery • One capacity breach 4 days (unable to accommodate surgery) • One 7 day breach, needed additional pathology test , prior to treatment decision • Treatment plan changed from surgery (within time) to neo-adjuvant chemotherapy 			breaches											
		breaches													
<p>Impact (People/Safety/Money)</p>	<p>Clinical harm reviews are carried out on all patients breaching 104 days in line with national guidance.</p> <p>Management of current waiting list size at 62 days and 104 days has intensified due to delays in validation and results available causing over inflated size of backlog:</p> <table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <tr> <td style="width: 40%;"></td> <td style="width: 30%;">62 days</td> <td style="width: 30%;">104 days</td> </tr> <tr> <td>May</td> <td>195</td> <td>34</td> </tr> </table>		62 days	104 days	May	195	34								
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		Agenda planned 22/23 July.											
	July 19	The Trust is experiencing a constant growth of GP 2ww referrals; approx. 100 additional referrals are being received each month.											
Forecast date to return to plan/trajectory for recovery	The plan is to achieve the 2WW target for May 2019												
	Cancer	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
	Cancer Waiting Times - 2 Week Wait												
	Number Seen < 2 Wks	1,391	1,487	1,405	1,479	1,499	1,317	1,681	1,663	1,276	1,086	1,131	1,304
	Total Number Seen	1,496	1,590	1,489	1,574	1,609	1,405	1,754	1,716	1,332	1,168	1,179	1,377
	Performance % (93% standard)	93.0%	93.5%	94.4%	94.0%	93.2%	93.7%	95.8%	96.9%	95.8%	93.0%	95.9%	94.7%
	The plan is to achieve the 31 day target for May 2019												
Cancer Waiting Times - 31 Day First Treatment	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	
Treated < 31 Days	133	164	185	163	168	134	151	185	126	129	120	162	
Total Number Seen	137	168	190	169	171	139	156	190	130	133	124	168	
Performance % (96% standard)	97.1%	97.6%	97.4%	96.4%	98.2%	96.4%	96.8%	97.4%	96.9%	97.0%	96.8%	96.4%	
	The plan is to achieve the 62 day target for May 2019 with a predicted performance of 82.9%%												
Cancer Waiting Times - 62 Day GP Referr	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	

	al													
	Treated < 62 Days	65	63	70	71	72	65	65	72	60	72	65	72	
	Total Number Seen	76	76	84	84	84	76	76	84	70	84	76	84	
	Performance % (85% standard)	85.5%	82.9%	83.3%	84.5%	85.7%	85.5%	85.5%	85.7%	85.7%	85.7%	85.5%	85.7%	
	The plan is to achieve the 62 day screening target in May													
	Cancer Waiting Times - 62 Day Screening	M 1	M 2	M 3	M 4	M 5	M 6	M 7	M 8	M 9	M 10	M 11	M 12	
	Treated < 62 Days	12	13	15	15	17	12	17	12	11	14	11	15	
	Number Seen	13	14	16	16	18	13	18	13	12	15	12	16	
	Performance % (90% standard)	92.3%	92.9%	93.8%	93.8%	94.4%	92.3%	94.4%	92.3%	91.7%	93.3%	91.7%	93.8%	
	Monitoring	Trust Cancer PTL meetings (weekly), Red Alert action list (weekly), APMG (weekly), Escalation (weekly), Cancer Steering Group (monthly), Cancer & Haematology SDU meeting (monthly)												

Delayed Transfer of Care Exception Report	
Month: June 2019	Executive Director: David Williams
	Completed by: Tammy Nossiter
Indicator/ Performance standard	Delayed Transfer of Care (DTC) less than 4% = GREEN, between 4% and 5% = AMBER and above 5% = RED.
Variation	<p>There has been an increase in the Delayed Transfers of Care due to changes in availability of services external to the organisation.</p> <p>Discharge to Assess came to a conclusion in April 2019, this had provided access to domiciliary care and care home beds outside of hospital to allow for assessments to be completed away from an acute setting.</p> <p>Waiting times for Reablement has increased to approx. 7-10 day wait due to the number of patients being referred through that pathway.</p> <p>During winter self-funding patients were provided with access to a free brokerage service, this is now at a cost of £300 per person and is optional so we have seen a decline in the uptake of this service which has had a knock on effect.</p> <p>Patients on non-weight bearing pathways are referred to community hospitals alternatives to free capacity are being considered.</p> 
Highlights	<p>Highlights June 2019:</p> <p>A combined Adult In-Patient Discharge and Choice policy has been ratified and training dates set as part of Discharge Workshop to support staff with using it</p> <p>Work has commenced on an ICP Choice Policy</p> <p>Pilot underway in reducing the amount of CHC work completed in an acute setting</p>
Impact	Reducing the delayed transfers of care releases capacity in the system but requires proactive planning of the whole process of care, as well as active discharge planning. This can be achieved by having a clear pathway of care or flow model through the system for particular conditions.
Key Actions to be taken to address variation	Date
	<p>Sept 2019</p> <ol style="list-style-type: none"> To meet with Heads of Nursing to discuss Choice Policy and Implementation across their wards Continue the work with ICP on moving CHC assessments out of the acute Trust Working with Winter Director on alternative pathways for patients not requiring acute or community hospital beds
Forecast date to return to plan / trajectory for recovery	On-going.
Monitoring	Monitored in the IPR

Performance Exception Report – June 2019

Performance standard & definition	Category 3, 4 & unstageable Pressure ulcers – June 2019 performance
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Exception overview: *Brief explanation of performance driver (what is the problem & what caused it)*

The reporting of all pressure damage, irrespective of avoidable or unavoidable status will be mandated nationally from 1st April 2019. There were 30 recommendations of which BHT was fully compliant.

The aim is to improve standardization across trusts in England with the focus on learning and actions NOT on proving avoidability

BHT in June 2019, there were two pressure ulcers that developed in our care.

Both cases were within Community nursing settings. Both ulcers were challenging to prevent due to patient compliance issues.

- High Impacting Actions:** *Key Actions being taken to improve & address variation (no more than 2 or 3) – what doing about it & when will recover.*
- Debrief meeting held with key clinical staff to discuss care process, and prevention management
 - Mini RCA now requested for all BHT acquired category 2 pressure ulcers to highlight learning
 - Pressure Ulcer Prevention & treatment care plans now in use across BHT

- Improvements:** *This details additional activity over the next month*
- Review of Debrief process and reporting to ensure better divisional learning
 - Reinstating of Tissue Viability Steering Group to track trends and provide cross divisional learning
 - Combined pressure ulcer investigations to include other care providers
 - Revise of RCA documentation for category 1 & 2 ulcers

Performance Exception Report		
Month: July 2019	Executive Director:	David Williams
	Completed by:	Sarah Howard
Indicator/Performance standard	100% of all finished episodes of care within the month to be coded by working day 10 of the following month.	
Variation from plan	June 2019: 49% coded at day 10. Aim to complete June by 2 nd week of August 2019	
Reason for variation	There has been long term staff sickness; with no extra support to cover this period therefore the department are constantly reviewing working processes to enhance performance.	
Impact (People/Safety/Money)	The impact on not being fully coded is that any uncoded records will not attract the necessary PBR tariff and this will affect the Trusts income (mitigated by an agreed Block Contract). To ensure payment the Trust must code 100% of records by working day 10 following the month of the activity.	
Key Actions to be taken to address variation	Date:	Description:
	June 2019	Training and audit training have been stopped in order to create an increased capacity in the short term whilst the backlog is reduced. It should be noted that there is some mandatory training for coders that needs to be completed, within the next couple of months.
	June 2019	Action plan has been created and is currently being reviewed in order to improve performance. Coding targets for each member of staff will continue to be monitored on a daily basis. Coding has been taking place from Evolve since 18 th January 2019 and this has hindered the speed with which the coding now takes place.
	June 2019	The Clinical coding team has successfully recruited 2 more permanent Clinical coders during May into permanent posts; these were originally contractors for the department so no gain in man power to the team, only a financial saving to the Trust. The QI team are continuing to support the coding team.
	July 2019	Clinical Coding to review with Medical records the scanning process, and collection of red packs to support working by discharge date.
Forecast date to return to plan/trajectory for recovery	The aim is to be meeting the 90% compliance target for August data by the 10 th working day of September, dependent on variance in staffing levels and Trust activity.	
Monitoring	Daily monitoring by Head of Clinical Coding & Assistant Clinical Coding Manager	

Performance Exception Report		
Month: July 2019	Executive Director:	Carolyn Morrice
	Completed by:	Angela Brooke
Indicator/Performance standard	Number of Falls causing harm (defined as moderate harm or above) No more than 2 per month Benchmark For Falls with harm (moderate & above) over the last 5 years 2015/16 - 34 2016/17 - 32 2017/18 - 24 2018/9 - 15	
Variation from plan	June 2019: 3 Moderate/Severe harm falls reported 1 hip dislocation, Buckingham Community Hospital by bed 1 fractured neck of femur, NSIC in the shower (fell from shower seat) 1 fracture to face from fall standing up from a commode 16B, Wycombe	
Reason for variation	2 of these falls related to toileting & showering 1 patient confused and fall un-observed – slipped on floor	
Impact (People/Safety/Money)	Pain, distress to patients, carers & staff. Surgery required & longer length of stay and longer-term poor outcomes/independence/loss of confidence	
Key Actions to be taken to address variation	Date:	Description:
	July 2019	Continue to reinforce Stay in the bay to ensure patients are observed with 1:1 'Special' as required to increase observation especially when patients are confused
	July 2019	Re-inforce safety measure for bathroom and other transfers as patients are particularly vulnerable
	July 2019	Continue to promote Fallsafe key actions/audit
	July 2019	Develop monitoring of Falls CQINN - 3 High impact changes to include early cognitive screen, mobility assessment, careful administration of anti-psychotic & anxiolytic medication
Forecast date to return to plan/trajectory for recovery	To reduce Falls with harm to < 2 per month	
Monitoring	Through strong clinical leadership and safe staffing, SDU & Divisional Governance programmes, Patient safety team, Learning & Development, Trust wide Falls Group	

Performance Exception Report		
Month: June 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 15.9% at 30 June 2019	
Reason for variation	<p>The vacancy rate increased by 0.1% from May; nevertheless, this level is 1.3% than our original forecast (from March 2019). The following are key factors.</p> <ul style="list-style-type: none"> • Number of nurses with Nursing & Midwifery Council (NMC) registration recruited was 14.6fte. • 7 overseas staff obtained NMC registration during the month • During June there were 19.2fte nurse leavers; an increase of 12.6fte from our lowest recorded ever figure of 6.6fte in May. <p>As at 15 July, we are forecasting 11fte starters and 11.1fte leavers (2fte retirement and 9.1fte voluntary resignations); this is below the seasonal average of 17fte leavers.</p>	
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	
	July activities	<ul style="list-style-type: none"> • Increasing publicity through social media, using existing staff, alongside regular face to face events. Activity plan in place and includes: • Two school career fairs
Activities in progress	<p>Development of pipeline of existing staff into all nursing roles both unregistered and registered including:</p> <ul style="list-style-type: none"> • University of Bedfordshire qualifiers. 40 students due to qualify in September, of which 12 are in pre-employment process and 7 have fast-track interviews booked. The Education and Recruitment teams are following up with the other students. • Education & Recruitment Teams are working with Bucks New University to increase the number of new entrants for September 2019. • A cohort of 32 staff started a 2- year nursing associate programme in Autumn 2018 • English language training programme is in place to support up to 60 EU trained nurses to 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 	

	International																											
	W/C 22 July 2019	Porto and Coimbra recruitment events targeting newly qualified nurses; we are also meeting our next Erasmus participants.																										
	July 2019	Two non-EU overseas nurses were appointed following a targeted advertising campaign to support them through their OSCE (objective structure clinical examination).																										
Forecast date to return to plan/trajectory for recovery	<p>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.</p> <table border="1"> <thead> <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> </thead> <tbody> <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>15.9%</td> <td>16.1%</td> <td>16.0%</td> </tr> </tbody> </table>		Qualified Nursing : 19-20	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Vacancy rate	17.9%	17.8%	17.2%	17.0%	17.1%	16.9%	16.7%	16.6%	16.1%	15.9%	16.1%	16.0%
Qualified Nursing : 19-20	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20																
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Monitoring	Strategic Workforce Committee																											

Agenda item: 9

Enclosure no: TB2019/072

Safe & compassionate care,
every time

Buckinghamshire Healthcare **NHS**
NHS Trust

Trust Board July 2019

Details of the Paper

Title	Infection Prevention & Control Report –April & May 2019 Infection Prevention & Control Annual report 2018/19				
Responsible Director	Dr Tina Kenny				
Purpose of the paper	To provide IPC data for April and May 2019 IPC annual report 2018/19 for agreement				
Action / decision required (e.g., approve, support, endorse)	For information				
IMPLICATIONS AND ISSUES TO WHICH THE PAPER RELATES (PLEASE MARK IN BOLD)					
Patient Quality	<i>Financial Performance</i>	Operational Performance	<i>Strategy</i>	<i>Workforce performance</i>	<i>New or elevated risk</i>
<i>Legal</i>	Regulatory/ Compliance	<i>Public Engagement /Reputation</i>	<i>Equality & Diversity</i>	<i>Partnership Working</i>	<i>Information Technology / Property Services</i>
ANNUAL OBJECTIVE					
This relates to : Objective: MRSA bacteraemia annual objective – zero cases Objective: Clostridium difficile annual objective – 31 cases					
<i>Please summarise the potential benefit or value arising from this paper:</i> The report outlines Healthcare Associated Infection data for April & May 2019 IPC Annual report 2018/19 to provide an overview of the good work completed within IPC over the previous year.					
RISK					
Are there any specific risks associated with this paper? If so, please summarise here	<i>Non-Financial Risk:</i>				
	<i>Financial Risk:</i>				
LINK TO CARE QUALITY COMMISSION ESSENTIAL STANDARDS OF SAFETY AND QUALITY					
Which CQC standard/s does this paper relate to?					
Author of paper: Amanda Adkins Interim Matron IPC					
Presenter of Paper: Dr Tina Kenny DIPC					
Other committees / groups where this paper / item has been considered:					
Date of Paper: 25/06/2019					

13th Edition of Infection Prevention & Control Annual Report 2018 – 2019

9

Date Produced:	May 2019
Approved by:	Infection Prevention & Control Committee June 2019 Quality Committee Trust Board
Executive Director:	Dr Tina Kenny, Director of Infection Prevention & Control
Written & Compiled by:	Amanda Adkins, Interim Matron Infection Prevention & Control, The Infection Prevention & Control Team

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Glossary

IPCT	Infection Prevention and Control Team
DIPC	Director of Infection Prevention and Control
CQC	Care Quality Commission
WHO	World Health Organisation
A+E	Accident and Emergency
AOU	Assessment and Observation Unit
MRSA	Meticillin-Resistant Staphylococcus aureus
MSSA	Meticillin-Sensitive Staphylococcus aureus
VRE	Vancomycin-Resistant Enterococci
RCN	Royal College of Nursing
UCLH	University College London Hospital
IPS	Infection Prevention Society
CQUIN	Commissioning for Quality and Innovation
ATP	Adenosine Tri Phosphate
UVC	Ultra Violet-C
VIP	Visual Infusion Phlebitis score
GNBSI	Gram Negative Blood Stream Infection
SSIS	Surgical Site Infection Surveillance Service
CVAD	Central Venous Access Devices

Executive Summary

The Trust has a statutory responsibility to be compliant with the Health & Social Care Act 2008: Code of practice for the NHS on the prevention and control of healthcare associated infections (DH 2015). A requirement of this act is for the Board to receive an annual report from the Director of Infection Prevention & Control (DIPC). This report details Infection Prevention and Control (IPC) activity from April 2018 to March 2019.

Key Points:

- There was 1 Trust apportioned Meticillin Resistant *Staphylococcus aureus* bacteraemias (MRSA) reported against a target of zero. All Trusts have a target of zero, the table below shows the apportioned cases from our neighbouring Trusts.



MRSA Bacteraemia Trust Apportioned Cases - Annually

Organisation Name	2018/19
BUCKINGHAMSHIRE HEALTHCARE NHS TRUST	1
FRIMLEY HEALTH NHS FOUNDATION TRUST	0
LUTON AND DUNSTABLE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	1
MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	1
OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	2
ROYAL BERKSHIRE NHS FOUNDATION TRUST	0

- There were 45 Trust apportioned *Clostridium difficile* positive cases this year. 17 cases were deemed to be avoidable. Every Trust has an individual target therefore this is difficult to benchmark against other Trusts. The table below shows all the inpatient areas of BHT that did NOT have a *Clostridium difficile* positive case this year.

Areas with No cases of <i>Clostridium difficile</i>	
In-patient Ward/Area	Division
Bucks Neuro Rehab Unit	Integrated Medicine
Florence Nightingale Hospice	Integrated Elderly & Community Care
Waterside, Amersham Hospital	Integrated Elderly & Community Care
Intensive Care Unit, Wycombe Hospital	Surgery & Critical Care
Ward 7, Stoke Mandeville Hospital	Integrated Medicine
Ward 11, Stoke Mandeville Hospital	Surgery & Critical Care
Ward 15, Stoke Mandeville Hospital	Surgery & Critical Care
Ward 12a, Wycombe Hospital	Surgery & Critical Care
Ward 12b, Wycombe Hospital	Surgery & Critical Care
Ward 12c, Wycombe Hospital	Surgery & Critical Care
Neonatal Unit, Stoke Mandeville Hospital	Women, Children & Sexual Health Services
Rothschild Ward, Stoke Mandeville Hospital	Women, Children & Sexual Health Services
St Francis, National Spinal Injuries Unit, Stoke Mandeville Hospital	Specialist Services
St Joseph, National Spinal Injuries Unit, Stoke Mandeville Hospital	Specialist Services / Integrated Medicine
St Patrick, National Spinal Injuries Unit, Stoke Mandeville Hospital	Specialist Services

- There were 17 Meticillin Sensitive *Staphylococcus aureus* bacteraemias (MSSA). There is no national target for this.
- There were 251 positive *Escherichia coli* (E.coli) bacteraemia infections compared to the 230 identified last year. Klebsiella and Pseudomonas aeruginosa were added to the mandatory surveillance of blood stream infections for this year. There were 56 positive Klebsiella infections and 26 Pseudomonas aeruginosa infections. There was a total of 333 Gram Negative Blood Stream infections.

- There were 26 Vancomycin resistant enterococci (VRE) in the Intensive care units across Stoke Mandeville hospital & Wycombe hospital compared to 19 last year.
- Hand hygiene and Bare Below the Elbow compliance was audited monthly by the wards & departments. The overall percentage of hand hygiene compliance for the year was 99% against our local target of 95%.
- The Trust reported 18 Norovirus outbreaks over the year compared to 5 the previous year.
- The overall uptake of the influenza vaccine amongst staff was 68% compared to 60% last year. The CQUIN standard was to achieve 75% vaccination in frontline staff.
- Influenza was monitored and reported via the Trust Capacity meetings.

Infection Prevention & Control Arrangements

The Trust serves a population of approximately 500,000-525,000 people with inpatient beds at Stoke Mandeville, Wycombe, Amersham, and Buckingham Hospitals. Dr Tina Kenny continued in her role as Director of Infection Prevention & Control.

The Infection Prevention & Control Team (IPCT) included the following staff during 2018-2019

1 x Director of Infection Prevention & Control
1 x Infection Prevention & Control Doctor (Consultant Microbiologist)
3 x Consultant Microbiologists
1 x Interim Matron Infection Prevention & Control
1 x Band 7 Infection Prevention & Control Nurses
4 x Band 6 Infection Prevention & Control Nurses
2 x Band 5 Senior Infection Prevention & Control Clinical Assistants

- 1x Deputy Director of Infection Prevention Control remains on secondment.
- 1x band 7 vacancy due to secondment
- 4 Consultant Microbiologists provide on-call services.

The IPCT is line managed through the Deputy Chief Nurse and works directly with the DIPC. The DIPC meets regularly with the Chief Executive and Chairs the Infection Prevention & Control Committee. The DIPC is a member of the Trust board and reports Infection Prevention issues to the board and the Quality and Clinical Governance Committee.

Infection Prevention & Control Annual Programme

Appendix 1 outlines the IPC Annual Programme for 2018-2019. The Programme outlines the principles for the Trust in relation to Infection Prevention & Control activities as agreed by the Trust Infection Prevention & Control Committee which monitors the progress of the programme quarterly. The programme is based around the Health & Social Care Act 2008: Code of practice for the NHS on the prevention and control of healthcare associated infections

All items within the IPC Annual Programme have been addressed with the exception of Front End Deep Clean Programme with Hydrogen Peroxide Vapour / Ultra Violet c (HPV/UVC). This was piloted in 18/19 with positive results and a preparation for a tender process is underway.

Surveillance: Mandatory & Voluntary

Clostridium difficile & MRSA bacteraemia numbers are over our annual objectives. For MSSA bacteraemia, and MRSA non bacteraemia there was a decrease in numbers, for E.coli bacteraemia we saw an increase in numbers reported.

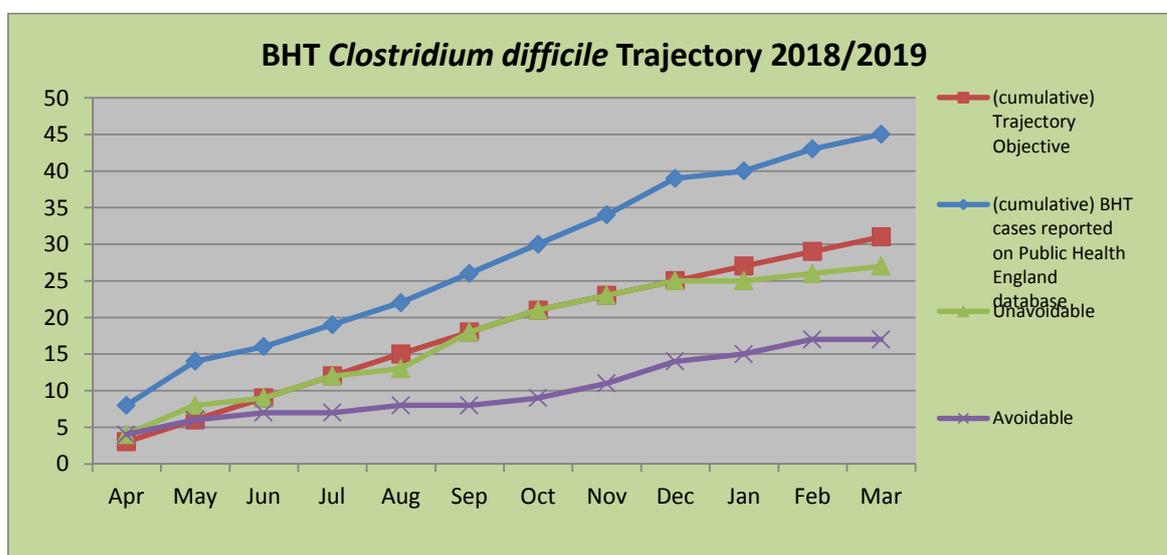
Clostridium difficile (Mandatory Surveillance)

We continue to participate in the mandatory reporting of *Clostridium difficile* Infection. The graph below shows our *Clostridium difficile* figures for the year. Our limit for the year was 31. Our year end numbers were 45 cases reported to Public Health England (PHE)

17 cases were identified as avoidable *Clostridium difficile* infection. A root cause analysis was undertaken for each case and identified the following factors:

- Samples - delay in sending samples, sending samples while on laxatives (not in line with Trust Guidelines)
- Antimicrobial use – not in line with Trust Guidelines
- Cleaning - ATP testing results highlight failures in cleaning
- Outstanding actions from audit reports

To decrease the environmental bio burden (organisms in the environment) a focused ‘deep clean’ decontamination using Hydrogen Peroxide Vapour (HPV) has been completed on the ‘front end’ and the medicine for older people wards.



Meticillin Resistant *Staphylococcus aureus* (MRSA) Bacteraemias (Mandatory Surveillance)

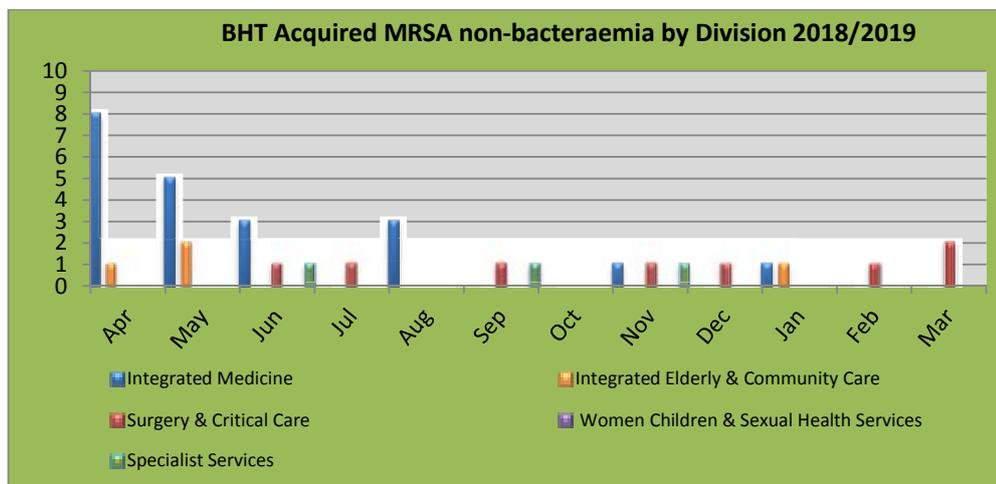
Mandatory reporting of MRSA bacteraemia continues. The limit was set at 0 avoidable cases. 1 case was reported to PHE.

Case 1: Post infection review highlighted staff to be reminded about carrying out good IPC practices e.g. hand hygiene, wearing of Personal Protective Equipment (PPE), audit of cleaning services, estates issues to be monitored and resolved, a Standard Operating Procedure for screening pre-supra pubic catheter insertion to be formulated.

Lessons learned were shared in the Infection Prevention & Control newsletter

Meticillin Resistant *Staphylococcus aureus* (MRSA) Non-bacteraemias (Voluntary Surveillance)

The number of BHT (attributable) non-bacteraemia MRSA cases, detected by the laboratory was 36. This is a decrease of 15 compared to 2017/2018.



Some of these cases were linked to one of the acute wards. Eight patients but no staff members were found to be positive. An outbreak meeting was instigated and the following issues were discussed and addressed:

- MRSA screening
- Environmental cleaning, UVC was completed to reduce the environmental cross contamination
- Hand hygiene
- Personal Protective Equipment

MSSA Bacteraemia (Mandatory Surveillance)

Total numbers detected after 48 hours of admission were 17, a decrease of 2 compared to last year. Those that are Trust associated with having invasive devices had a root cause analysis carried out.

Learning from Root Cause analysis where MSSA bacteraemias were related to devices highlighted the importance of:

- Staff to ensure Visual Infusion Phlebitis (VIP) charts are completed daily.
- VIP documentation trail often poor when transferred to wards.
- Blood cultures to be performed when patients spike temperatures (peripheral & Central Venous Access Device (CVAD))

Gram negative bloodstream infections (GNBSI) (Mandatory Surveillance)

There were 251 positive E.coli bacteraemias, 56 Klebsiellas and 27 Pseudomonas aeruginosas identified from blood cultures compared to 230 E.coli's, 56 Klebsiella's and 27 Pseudomonas aeruginosas identified in 2017/2018. The majority of these blood cultures were taken within our Emergency Department.

GNBSI's have been discussed nationally and regionally. Nationally the scale of the challenge has been recognised and timescales and targets have yet to be clarified. The focus locally has been on the value that is added following the completion of an investigation of each case. The outcome from these investigations highlighted that only 1 case was deemed to be 'avoidable' due to the antibiotics policy not being followed by the medical team.

Surgical Site Infection Surveillance Service (SSISS)

The Trust participated in the mandatory orthopaedic SSISS for Total Hip & Knee replacements for a 3 month period July to September 2018. SSISS for Fractured Neck of femur was completed October to December 2018

The figures are presented separately for Wycombe & Amersham (W&A) and Stoke Mandeville Hospital (SMH) because they are analysed and reported separately by the Centre for Infection in Colindale. The figures below include all infections (in-patients, readmissions and post discharge).

Total number of procedures October 2018 – December 2018				
	Totals	Infections	BHT Infection Rate	National Infection Rate
Repair of neck of femur	74		0.0%	1.2%
Total number of procedures July 2018 – September 2018				
	Totals	Infections	BHT Infection Rate	National Infection Rate
Hip replacements	88		0%	0.9%
Knee replacements	115		0%	1.3%

There were no infections in any of these groups of patients.

Outbreaks & IPC Serious Incidents

The Trust reported 18 Norovirus outbreaks during the year. This was an increase of 13 compared with 5 last year. These were separate bays and ward closures. The trust had a number of visitors reporting symptoms of diarrhoea and vomiting which made it difficult to identify the index case for the outbreak. There were incidents of patients being admitted and becoming symptomatic shortly after admission. Staff reporting symptoms of diarrhoea and vomiting was inconsistent.

During October and November there were 10 outbreaks recorded. This was declared a Serious Incident. Following discussion with the CCG a concise RCA was completed. The main actions were:

- Renew Norovirus guidelines
- Clinical areas to take responsibility and ownership of Infection Prevention & Control practices
- Investigate the installation of permanent hand hygiene sinks at entrance to wards
- 'Task force' to review the surgical floor layout
- Command and Control meeting to be instigated after first positive case.
- Heighten Infection Prevention & Control restrictions with one positive case.

Hand Hygiene

Hand Hygiene audits

BHT continued the monthly Hand Hygiene Observational Audits throughout 2018-2019. Each ward, department and staff group at the Trust undertake monthly auditing of hand hygiene practices and compliance with the Bare Below the Elbows principle. Each element of the WHO "Five moments for Hand Hygiene" is assessed separately for each staff group and bare below the elbows. Summaries are reported in the monthly Infection Prevention and Control Report. Compliance of at least 95% with each element is required. To ensure that the reporting gives a reliable indication of hand hygiene practices, ad hoc audits are carried out in addition by members of the IPC Team. If an area scores less than 95%, feedback is given and the ad hoc exercise repeated. Non-compliance is dealt with in real time during the audit. These ad hoc results are reported separately from the main audit results within divisional reports.

In February we commenced peer audits which are to be completed bi-monthly.

For 2018/19, the overall Annual self-reported compliance with hand hygiene for the Trust was 99%. This is consistent with previous years.

Link Practitioner Programme

Study days for the Infection Prevention & Control Link Practitioners were held throughout the year.

The programme covered a wide variety of topics:

Infection Prevention & Control Link Practitioners Study Day Programme 2018-2019
Study Day 1 – 16 th March 2018
<ul style="list-style-type: none"> • • Speaking out • Norovirus • Bladder Scanner Demonstration • Semmelweis Hand Hygiene Scanner • Sodexo Staff Training • Poster Presentation • Touch Tree Exercise
Study Day 2 - 7 th June 2018
<ul style="list-style-type: none"> • • Professional Standards – Quality & Patient Experience • Mindfulness • Sharps Audit Feedback • MRSA Cluster Management • Notifiable Infections • Back to the Basics Roadshow • Director Infection Prevention & Control • RCN Glove Awareness
Study Day 3 – 21 st November 2018
<ul style="list-style-type: none"> • • Norovirus Diaries • Grading Bristol Stool... • In Flew Enza – quiz, NLMS • Get Flu'd up and ready to go • Influenza – the bigger picture • Gama Healthcare • And now for something different – expect the unexpected • CQC – are you IPC ready

Patient Led Assessments of the Care Environment (PLACE)

Members of the IPCT were involved in the annual PLACE inspections during 2017-2018.

PLACE are annual assessments of the care environment undertaken over a period of weeks during spring and early summer. Results were published for 2017 on 15th August 2017.

The PLACE assessments are a self-assessment of non-clinical services which contribute to the environment in which healthcare is delivered. The focus of these annual inspections ensures that patients are fully involved in the process, working in partnership with NHS staff to identify how the Trust is currently performing against a range of criteria, and how services may be improved in the future. The ratio of patient representatives to NHS staff is required to be a minimum of 50%. Each hospital site was assessed, and the results are as follows:

	Stoke Mandeville	Wycombe	Amersham	Buckingham
Cleanliness				
National average 98.5%% BHT average 97.85%%				
2016	96.97%	98.60%	99.79%	100%
2017	97.12%	99.13%	99.28%	99.64%
2018	97.63%	99.20%	96.92%	98.04%
Food				
National average 90.2% BHT average 86.52%				
2016	91.10%	91.74%	95.62%	85.57%
2017	87.50%	74.46%	92.35%	84.56%
2018	85.54%	87.19%	92.62%	90.44%
Privacy, Dignity & Wellbeing				
National average 84.2% BHT average 80.75%				
2016	73.21%	70.22%	65.91%	71.79%
2017	79.88%	69.87%	83.14%	68.42%
2018	80.81%	83.99%	75.36%	73.26%
Condition Appearance & Maintenance				
National average 94.3% BHT average 93.88%				
2016	89.95%	96.99%	90.26%	91.88%
2017	92.73%	93.51%	95.34%	82.62%
2018	94.13%	94.96%	90.00%	91.82%
Dementia - added 2015				
National average 78.9% BHT average 62.75%				
2016	54.85%	57.50%	69.39%	73.48%
2017	68.56%	65.63%	81.67%	77.71%
2018	60.07%	68.67%	72.28%	68.22%
Disability - added 2016				
National average 84.2% BHT average 70.07%				
2016	66.32%	65.01%	74.11%	78.39%
2017	78.88%	76.96%	85.34%	79.55%
2018	67.08%	76.23%	81.76%	75.69%

It should be noted that due to changes in methodology and assessment criteria for food and hydration, and privacy and dignity in 2014, the scores of these two elements are not directly comparable. However it is useful information and provides a snapshot to compare the performance of individual sites within our Trust.

Also please note that Thame and Marlow are no longer inpatient sites, therefore were not part of the PLACE assessments.

Educational Activities

The IPCT continues to provide training to the Trust via e-learning modules and face to face monthly sessions. Separate modules are available for patient facing and non-patient facing staff. Hand hygiene practical face to face sessions are delivered monthly on set dates organised by the Training Department. IPCT also provide ‘Train the Trainer’ sessions to enable wards to deliver the hand hygiene practical element within their clinical areas.

Additional Statutory Face to Face training days are organised by the Training Department and IPCT deliver the Infection Prevention & Control session. There has been an increase in attendance compared to last year. See table below with last year’s figures in brackets .

Statutory Training Courses	Training Method	Trust Total % Attendance
Attendance required annually		
Infection Prevention & Control (staff with no direct contact with patients)	e-learning / face to face	92% (89%)
Infection Prevention & Control (staff with direct contact with patients)	e-learning / face to face	85% (85%)
Attendance required every 2 years		
Hand Hygiene Practical (staff with direct contact with patients)	Face to face	88% (84%)

Further training is delivered by the IPCT for:

- Trust induction
- Specific departments at their request
- Doctors Induction
- Clinical Staff Induction
- NSIC Induction
- HCA Development Pathway
- Other ad-hoc training on request

Audit Activity

The annual Infection Prevention & Control audit programme was delivered as per Appendix 2.

Formal reports were provided by Clinical Audit and Effectiveness Department. All formal reports were disseminated to relevant wards, departments and committees to highlight key findings and recommendations for action.

In the management of Clostridium difficile infection, the Department of Health recommends testing all patients with diarrhoea, defined as Bristol Stool Chart types 5-7. The stool sample must take on the shape of the container and ideally be at least 1/4 filled.

It was hypothesised that stool samples processed at SMH did not always meet DoH criteria for testing for CDI. To address this question, accuracy of use of the BSC was assessed: 36 healthcare professionals including microbiologists, biomedical scientists and medical laboratory assistants independently classified 20 stool specimens using the BSC. A range of 1 stool grade either side of the mean was considered acceptable. A proportion of stools were tested for GDH and toxin status.

The range of stool grades exceeded 1 grade of the mean for 30% of specimens. One specimen was identified as all grades 1 through 7. Using the DoH guidelines 25% of samples received by the laboratory would not have fulfilled criteria for CDI testing. Of these, 60% were GDH and toxin positive.

In summary, the poor correlation between users of the BSC to grade stools suggests a high degree of subjectivity and poor degree of reliability using this method to determine which stools should be tested for CDI. If DoH guidelines had been followed stringently a proportion of Clostridium difficile toxin positive specimens would have been missed. This audit suggests that at SMH routine testing of samples outside of DoH guidelines may lead to an increased number of positive specimens.

Other Activities

Building Projects

IPCT were involved with the estates team looking at a number of building projects throughout the year providing Infection Prevention guidance for the hospital environment.

Infection Control Times

The Infection Control Times newsletter has continued to be produced and distributed. It facilitates the sharing of best practice, latest IPC activity and any learning from IPC incidents or root cause analysis. This is well received by wards and departments.

Other Innovations/celebrations during the year:

May

- World Health Organisation (WHO) Global Hand Hygiene Day. The focus was on Sepsis and Hand Hygiene. The IPC Team asked staff for their support in promoting the risk of Sepsis and the importance of hand hygiene and the WHO 5 Moments of Hand Hygiene.
- Attended Glove awareness RCN study day and IPC Branch Conference

June

- Attended Healthcare Patient Safety Show at the ExCel London

July

- Visited University College London Hospitals for networking

August

- Visited Bournemouth Trust for networking
- Commencement of the joint 'Back to the tools' audits in conjunction with property Services (Trustwide).

September

- Attended Infection Prevention Society Conference in Glasgow.
- Influenza focused IC Times

December

- Supported Occupational Health and Wellbeing with Influenza peer vaccinations.

Appendix 1

Infection Prevention & Control Annual Programme 2018-2019

Subject	Action	Lead	Outcome	Evidence
Organisational Assurance				
Maintain Board level involvement in ensuring avoidable infections are reduced to a minimum.	The Board will receive an annual report from the Infection Prevention and Control Team (IPCT).	Director Infection Prevention & Control (DIPC)	Approval of report at Trust Board.	Minutes of Board meeting and Annual report
	The Board and Quality Committee will receive Infection Prevention & Control reports at every meeting.	DIPC	Executive and non-executive awareness of Healthcare Associated Infections (HCAI).	Minutes of Board meetings and reports
Surveillance: To continue to reduce Healthcare associated infections & continue mandatory surveillance				
Gram negative Blood Stream Infections (GNBSI) (Reduction of 50% by 2020)	Develop a process to identify hospital acquired gram negative blood stream infections (GNBSI) across the Trust post 48 hours of admission and select a sample for RCA.	Doctor of IPC IPCT	Reduction of cases following completion of RCA and Lessons Learnt.	Monthly IPC report
	From RCA's identify and implement actions to address key issues, changes in practice, policy or training corporately and provide clear direction to Divisions on actions required by them.	Doctor of IPC IPCT	Reduction of cases following completion of RCA and Lessons Learnt.	Monthly IPC report
	To reduce GNBSI identify KPIs and communicate across the Trust. Establish effective monitoring and reporting of the KPIs in the form of a dashboard.	Doctor of IPC IPCT	Reduction of cases following completion of RCA and Lessons Learnt.	Monthly IPC report
MRSA bacteraemia: zero cases	All Trust acquired cases to have a PIR completed. All findings / lessons to be	Divisional Leads Doctor of IPC	Zero MRSA bacteraemia	Monthly IPC report Weekly report to the CEO

Subject	Action	Lead	Outcome	Evidence
	learnt are to be presented by divisional representative at Infection Prevention & Control Committee to show how these have been addressed.	IPCT		
<i>Clostridium difficile</i> Infection (CDI) 18/19 : 31 cases	Support wards in developing a culture of responsibility about HCAI's by taking responsibility for all aspects of RCA. RCA for all Trust acquired cases to be completed and arrange scrutiny panel. Following the scrutiny panel all findings / lessons to be learnt are to be presented by divisional representative at Infection Prevention & Control Committee to show how these have been addressed.	Matrons Ward Manager Division Chief Nurses /Divisional Leads Antimicrobial Pharmacist	Lessons learnt disseminated to all areas to help reduce avoidable cases.	Monthly IPC report Weekly report to the CEO Minutes of IPCC meeting
	Front end Deep Clean Programme with HPV /UVC .	Property Services	To provide a clean safe environment for our patients thus reducing the risk of Healthcare associated infection.	Deep Clean completed
	Options appraisal for all inpatient areas Deep Clean Programme with HPV /UVC.	Property Services	To provide a clean safe environment for our patients thus reducing the risk of Healthcare associated infection.	Deep Clean programme
	To support team to develop a culture of antibiotic stewardship by completing an audit of antibiotic use within MFOP. To be completed by MFOP supported by Microbiology.	MFOP Microbiology	To reduce the risk of Healthcare associated infection.	Audit report
	Work based approach by IPC Nurse of patient focused teaching on high risk areas.	IPCT	To provide up to date knowledge of IPC practices thus reducing the risk of Healthcare associated infections and improving patient safety.	Written communication with Ward Managers
Minimise risk from invasive devices : Central & peripheral lines	To support the teams in developing a culture of responsibility about HCAs by taking responsibility for all aspects of	OPAT/IV Specialist Nurse	No avoidable device related infections.	IPC monthly reports Line Infections meeting

Subject	Action	Lead	Outcome	Evidence
Urinary catheters	RCA. OPAT/IV Specialist Nurses will report central line bacteraemia related infections to relevant areas by Datix. Relevant areas to complete RCA. Lessons learnt to be fed back to relevant areas to improve practice.			
	Peripheral line infection – bacteraemia related infections to be investigated and 72 hour report completed by Wards. All findings / lessons to be learnt to be discussed at Line Meeting to show how these have been addressed.	Ward Managers Matrons IPC Link Practitioner	No avoidable device related infections.	IPC monthly reports Line Infections meeting
Audit				
Undertake IPC audits as per annual audit programme	Wards with the support of IPC to take ownership of Snap shot audits as per IPC audit programme and to feedback results in real time.	Matrons IPC link Practitioners IPCNs	Safe practice and areas of improvement is highlighted.	Audit results and written communication.
	Perfect ward app to monitor MRSA admission screens are taken within 12 hours of admission.	Ward Managers Matrons DCN	Reducing the risk of Healthcare associated MRSA bacteraemia infections and improving patient safety.	Monthly IPC report Weekly report to CEO
	To highlight any estates issues an audit programme to be provided of all areas.	Property Services	Providing clean safe environment thus reducing the risk of Healthcare associated infections and improving patient safety.	Estates audit programme
	Reports of IPC elements from Perfect Ward App to be discussed at Infection Prevention & Control Committee meetings and in ward team meetings.	Patient Experience & Professional Standards Lead	Reducing the risk of Healthcare associated infections and improving patient safety.	Reports of IPC elements from Perfect Ward App

Subject	Action	Lead	Outcome	Evidence
Audit – Closing the Loop	All IPC audits to be part of the agenda for Divisional Quality Meetings where they are to be discussed and documented that all actions have been met.	DCN's IPCT	Assurance that recommendations have been actioned therefore promoting safe practice.	Minutes of meetings
Environmental & Equipment Cleanliness Monitoring				
To achieve high levels of environmental cleanliness which reduces HCAI	Prospective program of Adenosine Triphosphate (ATP) environmental swabbing in in-patient areas. All results to be discussed at Domestic Services Review Groups and in ward team meetings.	IPCT	To provide a clean safe environment for our patients. Reduction in Healthcare associated infections.	DSR meeting minutes ATP results
Environmental Defects	Monitoring of back log maintenance RAG issues.	Property Services	Safe and clean environment for patients and staff.	Environmental Defects Audit Programme Audit reports.
Making it easy to clean	Simplify use of cleaning products.	IPCT	Safe and clean environment for patients and staff.	RAG rating pocket guides
Escalation Process	To develop a cleaning escalation process for cleaning service providers.	Property Services	Collaborative working between service providers and staff.	An standard operating procedure of the Escalation Process.

Key

DIPC	Director Infection Prevention & Control	IPCT	Infection Prevention & Control Team
CQC	Care Quality Commission	IPCLP	Infection Prevention & Control Link Practitioners
DCN	Divisional Chief Nurses	HCAI	Healthcare Associated Infection
PLACE	Patient Led Assessment of Clinical Environments	CEO	Chief Executive Officer

Appendix 2

Infection Prevention & Control Audit Programme 2018/2019

This audit programme is not definitive and could be subject to change depending on IPC events e.g. outbreaks/ periods of increased incidence relating to IPC procedures.

Audit tools and instructions will be sent out in the preceding month via email to the following staff groups: Ward Managers; Matrons, with a request that they pass to the designated person undertaking this audit.

	Audit	To be undertaken by
Monthly	Hand Hygiene Observational Audit	All wards/areas/ departments
	Kitchen & Patient Equipment - <i>On a rolling programme</i> <i>(Note Environmental audits will be conducted by Estates & Property Services)</i>	IPCT
	Central Venous Devices - <i>On a rolling programme</i>	OPAT Team

Snapshot Audits

The following audits will be completed by the Infection Prevention & Control Team when there are increased incidences of Healthcare Associated Infections or Infection Prevention & Control practices are not being followed:

- Isolation Precaution Boards
- Personal Protective Equipment
- Stool Monitoring Chart
- MRSA Suppression Therapy
- MRSA Admission Screening
- UCAM Form
- VIP Form
- Cleaning of Patient Equipment
- Transfer Documentation

These audits are monitored monthly as part of the "Perfect Ward" where a report can be compiled if necessary.

IPCT will complete snap shot audits in relevant areas when necessary e.g. times of increased incidence of HCAI. The process for these audits is for 20 observations to be completed and the results to be fed back for action in real time.

May	HII Urinary Catheter Care Audit (insertion and on-going management)	All wards/areas/ departments
June	HII Peripheral Line Audit (insertion and continuing care including VIP form, DSU, Endoscopy, X-ray day stickers)	All wards/areas/ departments
September	HII Surgical Site Infection – General Surgery and Vascular procedures only	Theatres – Jo Causing / Phil Broadman
October	HII Surgical Site Infection –Trauma & Orthopaedic Elective and Emergency procedures only	Theatres – Jo Causing / Phil Broadman
November	Sharps Bins	Daniels Healthcare

Appendix 3

ANTIMICROBIAL STEWARDSHIP ANNUAL REPORT APRIL 2018 – MARCH 2019

Introduction

The cornerstone of Antimicrobial Stewardship at BHT is the Antimicrobial Stewardship Group (ASG) which reports to the Trust Infection Prevention and Control Committee (IPCC) and Medicine Safety and Quality Group (MSQG), the latter group having been formed in 2019. Its purpose is to develop and oversee the delivery of the Antimicrobial Stewardship (AS) Programme for Buckinghamshire Healthcare Trust with the aim of promoting the safe, rational, effective and economical use of antimicrobial agents. Dr Jean O'Driscoll, Consultant Microbiologist and Trust Antimicrobial Stewardship Lead, Chairs the ASG, supported by Claire Brandish, Lead Antimicrobial Pharmacist.

The purpose of the Antimicrobial Stewardship (AS) Strategy Programme 2018/19 was to formulate an organised antimicrobial stewardship programme to promote rational antimicrobial prescribing.

The BHT Antimicrobial Stewardship Strategy Programme was divided into the following sections:

1. Antimicrobial Management within the Trust
2. Operational delivery of antimicrobial stewardship
3. Clinical governance and risk management for antimicrobial prescribing
4. Education and training related to antimicrobials
5. Interface with primary care and other clinical developments

Progress on these areas is detailed below.

1. Antimicrobial Management within the Trust

- Minutes and resulting actions from ASG were reported to IPCC and MSQG.
- A business case was approved to expand the current pharmacy service to a structured infectious diseases/ antimicrobial stewardship team to support the delivery of the Trust-wide Antimicrobial Stewardship Programme. Capability of the service was increased by successful recruitment of an additional Band 8a Infectious Diseases pharmacist (HIV/ GUM/ Hepatology) and Band 7 Antimicrobial Pharmacist, both of whom started in post in April 2018 and a 0.5 WTE Band 2 administrative post who was started September 2018.
- The Lead Antimicrobial Pharmacist presented the Pharmacy business case to Trust Quality Committee to demonstrate achievements in terms of People, Money and Quality.
- A Consultant Antimicrobial Pharmacist from Southampton had undertaken a Peer Review of antimicrobial stewardship at BHT in November 2017. Recommendations to improve stewardship included:
 - A review of the restricted antibiotic list. This was updated as part of a review of the Antimicrobial Policy and was approved by the Trust Wide Policy Sub Group in February 2019.
- A review of the following National guidelines relevant to antimicrobial use took place:
 - NICE Guidance:
 - Urinary Tract Infection (recurrent) : antimicrobial prescribing, NG112, October 2018
 - Pyelonephritis (acute): antimicrobial prescribing, NG111, October 2018
 - Prostatitis (acute): antimicrobial prescribing, NG 110, October 2018
 - Urinary Tract Infection (lower): antimicrobial prescribing, NG109, October 2018
 - Urinary Tract Infection (catheter-associated): antimicrobial prescribing, NG113, November 2018
 - Bronchiectasis (non cystic-fibrosis), acute exacerbation: antimicrobial prescribing, NG117, December 2018
 - Chronic Obstructive Pulmonary Disease (acute exacerbation): antimicrobial prescribing, NG114, December 2018

- Chronic Obstructive Pulmonary Disease in over 16s: Diagnosis and management, NG115, December 2018
- An Antimicrobial Guardian section is included in the monthly newsletter (the Infection Control Times) highlighting findings from Antimicrobial Stewardship rounds, and other stewardship issues.

2. Operational delivery of antimicrobial stewardship

a) Trust wide guidelines

- In total, 38 Trust guidelines were written or reviewed and revised, where necessary, by the ASG over the past 12 months.
- A major review of the obstetric, gynaecology and surgical prophylaxis guidelines was undertaken to make information easier to find and to clarify duration of therapy.
 - Antimicrobial guidelines and key information pertaining to antimicrobial use continues to be updated on the RxGuidelines App which is supported by a database.
 - Regular monthly meetings with the Trust's Clinical Guidelines Lead were initiated in 2018 to ensure guidelines are updated in a timely manner.
 - The Trust Allergy Policy was approved and implemented in June 2018.
 - The annual Microbiology Antimicrobial Susceptibility report for 2018 was produced which enables guideline reviews to be informed by local sensitivity data. This was also shared with the CCG.

b) Antimicrobial Formulary

- There was a complete review of all antimicrobials on the Trust Formulary to ensure cost-effective and safe product selection in keeping with the Trust Reserved and Restricted Antimicrobial list and guidelines.
- Antimicrobial stock shortages were managed throughout the year without any major impact on Trust guidelines.
- Patient Group Directions for the use of various antimicrobials were reviewed and updated.

c) Advancements in Laboratory Methodologies to support diagnostics

- A business case has been prepared to support the introduction of procalcitonin in ITU and has been submitted to the Surgery and Critical Care division.
- A new antibiotic sensitivity machine has been installed in Microbiology which will provide rapid sensitivity testing results.

d) Antimicrobial Stewardship Ward Rounds and Individual Patient Reviews

- Continuation of daily visits to ITU by Microbiology, weekly MDT meetings with orthopaedics and haematology teams and fortnightly MDT meetings with Doctors from the National Spinal Injuries Centre to discuss complex patients requiring specialist input.
- Weekly Antimicrobial Stewardship ward rounds took place, with Antibiotic Care Bundle audits completed for each area visited. Interventions were logged and observations fed-back directly to prescribers to optimise antimicrobial use and/or used to inform areas for improvement, e.g. identify gaps in Trust guidelines, improved sampling.
- A referral database has been set up to pilot the referral of patients from pharmacists to the Antimicrobial Stewardship Team / Microbiology Consultants.
- The antimicrobial pharmacists have been given access to individual patient consultation advice records to aid communication and follow up of antibiotic plans.
- A summary of the interventions can be seen in the table below:

Intervention	March 2017- April 2018	March 2018- April 2019
Number of ward rounds	39	92
Patients reviewed	275	498
Duration of antibiotic course stated	55	94
Number of patients to have antibiotics stopped	65	100
Change/ de-escalate antibiotics	13	63
Request for microbiology tests	37	51
Addition/ prescription of antibiotics	13	9
Dose change/ advice	21	26
Allergies confirmed	15	12
Referral for investigation	8	16
Release further sensitivity results	2	5
Back –up antibiotic plan	5	34
IV to oral switch	12	46
Physical stop on prescriptions	-	26
Escalate antibiotic treatment	-	5

3. Clinical governance and risk management for antimicrobial prescribing

a) Audits

- Antimicrobial Care Bundle Audits (Monthly)*
Antimicrobial Care Bundle (ACB) audits have continued this year with the results being shared with the Divisions for discussion at Divisional and SDU Quality meetings. The aim is to assess whether a “Start Smart then Focus” approach is being adopted when antimicrobials are prescribed. Following the implementation of the ARK study (see below), the use of the ARK definitions has been included in the ACB audits as a standard. The 72 hour review, as part of the ACB audits was changed in line with the AMR CQUIN recommendations to stipulate that this should be undertaken by a senior (ST3 level doctor or above or infection specialist). This was reported as one of the Trust Key Performance Indicators on the Quality Improvement Plan. The targets for Q1, Q2, Q3 and Q4 were to achieve this in 25%, 50%, 75% and 90% of antibiotic prescriptions audited. The targets were achieved / surpassed in Q1-3 when senior reviews were evidenced in 77%, 84% and 75% of prescriptions. The Q4 target of 90% was not met with only 84% of prescriptions being reviewed by a senior though 90% was achieved in one of these months.
- Antibiotic Review Kit (ARK) Implemented in February 2018*
A series of education and training sessions together with an on-line learning tool supported the implementation of the Antibiotic Review Kit. The ARK tool involves stating at the initiation stage of antibiotics whether the presence of an infection is “probable” or “possible”. This strengthens the 24-72 hour review of antibiotics with a view to stopping antibiotics if there is no evidence for infection. The ARK study involved 12 weeks of data collection with feedback to the relevant teams. AMU, and Wards 4, 6, 7, 8, 9 and 10 were enrolled in the study. As a result, there has been an improvement in the quality of the 24-72 hour review with additional activities to support good antimicrobial stewardship being demonstrated. More decisions to stop or switch from IV to oral antibiotics have been noted compared to baseline where the default was to review and continue. The ARK has been subsequently rolled out to St Andrew, St Patrick, Ward 17 and Ward 5. The long stay drug chart has been approved and will be launched in June 2019 to include the ARK definitions in line with the existing short stay drug chart.
- Point Prevalence Audit February 2019*
Purpose: to benchmark antimicrobial prescribing with other regional, Thames Valley and South Coast Trusts. Final results and write-up are pending.

- **Audit of the Accuracy of Allergy Documentation in Buckinghamshire Healthcare NHS Trust, November 2018**

Purpose: To investigate the accuracy of allergy documentation on drug charts for patients in hospital. To measure against the standard set out by the Trust Policy for the documentation and recognition of hypersensitivity reactions including allergy and intolerance to medicines and related substances. Findings: 36% of patients with a documented allergy had no details of reactions recorded. Outcomes / recommendations: share findings in safety huddles and through a series of communication messages including Medication safety newsletter, use of 15 second 30 minute rule to raise awareness amongst prescribers at training sessions. To consider implementing allergy documentation on the perfect ward app as a way of highlighting the importance and monitoring of allergy information at ward level

To investigate if the SCR (what is this?) can be updated to make allergy details mandatory to include mandatory fields in the allergy status when electronic prescribing is implemented.

b) Antimicrobial Consumption

Targets for antibiotic reductions and a senior review of antibiotics within 72 hours of initiation are key performance indicators included on the Trust Quality improvement plans for 2018/19. The final year consumption report shows a 12% reduction in total antibiotic consumption against a target of 1% and an 18% reduction in carbapenem consumption against a target of 2% (reported as Defined Daily Doses per 1000 admissions).

c) Response to review of clinical incidents

- During this 12-month period, clinical incidents involving the prescribing of antimicrobial drugs were reported and reviewed by the ASG. Quarterly summaries were fed back to Divisions with a request that they be discussed at Divisional Quality meetings. A summary of incidents is also sent to the Drug Error / Patient Quality and Safety Groups to highlight serious and / or common antimicrobial errors.
- Identification of incidents involving antibiotics that require Therapeutic Drug Monitoring (TDM) were reviewed and step-by-step prescribing and monitoring guides were added to RxGuidelines for gentamicin, teicoplanin and vancomycin to address the issues. A review of these will take place.
- The ASG has supported the review of antimicrobial use in patients diagnosed with *C.difficile* infection.

d) Participation in Root Cause Analysis for patients with *C.difficile* infection

The antimicrobial history for each patient diagnosed with *C.difficile* infection was reviewed for the 12 months prior to infection to determine if there were any antimicrobial prescribing issues that needed to be addressed. There were 45 CDI cases in 2018/19, 17 of which were considered to be avoidable. Of the 17, 12 were classified as being related to antibiotic use not being in line with Trust Policy. Co-amoxiclav featured in 9 cases; 3 where the patient was >85 years, 3 where the patient was between 75 and 85 years old, and 3 where the patient was younger. Multiple antibiotic courses were given to 8 patients. Other problems identified included prolonged use of antibiotics in 2 cases. A summary of findings and actions taken to address these by the ASG is shown below:

Finding from CDI Root Cause Analyses	Action
Patients >85 years being treated with co-amoxiclav (n=3)	Avoidance of co-amoxiclav in the elderly is promoted during feedback from Antimicrobial Stewardship (AMS) ward rounds.
Patients aged 75 to 85 yrs being treated with co-amoxiclav (in line with current Trust Guidelines) (n=3)	Co-amoxiclav has been replaced with IV benzylpenicillin / oral amoxicillin in Trust guidelines - embedded into clinical practice through use of the App / E&T / Ward rounds.
Initial antibiotics started inappropriately / continued for longer than necessary	Feedback to clinicians from AMS rounds. Focus on AMU; Dr Pereira is Antibiotic Champion in Acute Medicine. He will use Antibiotic Care Bundle on ward rounds and Antimicrobial Pharmacist will be included on post-take ward rounds
Missed opportunities for sampling / diagnostics – empirical treatment being continued as unable to de-escalate	Feedback to clinicians from AMS rounds. Work initiated with A&E / emergency medicine to understand barriers to sampling. 2019/20 UTI CQUIN has an emphasis on diagnosis and sampling prior to treating with antibiotics.
Complex patients with diabetic foot infections (DFI) requiring long courses of antibiotics	MDT meetings initiated of Microbiology Consultants with Endocrinology Consultants to discuss individual patients. Pre-reg pharmacist audit on DFI planned for 2019
Exposure to multiple courses of antibiotics from various settings – not necessarily “broad-spectrum” abx use	Collateral damage needs to be addressed by an ICS approach, not just within secondary care. Indications on GP records when abx are issued

4. Education and training related to antimicrobials

- Delivery of face-to-face education and training in the prudent use of antimicrobials to pre-registration pharmacists (August 2018), junior pharmacists (September 2018), FY1 doctors (September 2018), FY2 doctors (October 2018).
- Updates given to GPs from Buckinghamshire CCG at their PLT session and non-medical prescribers working in the CCG in May 2018.
- Targeted gentamicin and vancomycin prescribing, administering and monitoring training given on ITU at SMH following clinical incidents.
- Provision of Grand Round, Medical Directorate, and ad hoc sessions to medical and other staff.
- Participation in World Antimicrobial Awareness Week and European Antibiotic Awareness Day in November 2018 with visits to GP practices. School poster / comic strip / rap / dance competition from October-December 2018 which saw submissions from local schools to raise awareness of AMR. Winners of the awards were invited to the hospital where they were able to display their work and have this filmed. BHT have been short-listed for the second year running for the National Antibiotic Guardian Children and Family Award 2019.
- Health Education England AMR e-module was adapted and has been implemented in the Trust as part of mandatory training (incorporated in the Level 2 IPC eLearning module).

5. Interface with primary care, and other clinical developments

- There is a CCG representative on the ASG, where there is a set CCG item on each Agenda.
- Antimicrobial elements of the OPAT service are reviewed as a standing Agenda item at ASG meetings
- Aylesbury Vale and Chiltern CCG (now merged to form NHS Buckinghamshire CCG), Primary Care Antibiotic Guidelines were extensively revised in 2018 following review of related NICE guidance).
- As of Feb 19 the CCG has achieved more than a 30% reduction in the no of trimethoprim items prescribed to pts aged 70 or over compared to target baseline set. In addition from Feb 19 the CCG achieved a reduction in no of antibiotic Rx below 2nd target threshold set of ≤ 0.965 items per STAR-PU.
- Monthly data analysis provided to all GP practices on antibiotic prescribing patterns made available as a dashboard giving comparisons to other practices within their locality and CCG averages and discussed at quarterly prescribing forums. Outlying practices supported by deeper dive using EPACT data and further medicines management support.
- Attendance at Regional Microbiologist Professional Development Group meetings held twice-yearly, including participation in audit activities.
- Attendance and engagement with South Central Antimicrobial Network regional meetings.
- Successful grant application to the Fleming Fund to collaborate with Nottingham Trent University and the University of Makerere to improve antimicrobial stewardship in the Wakiso district in Uganda as part of a 15 month project (1st February 2019-30th April 2020) overseen by Tropical Health and Education Trust and The Commonwealth Pharmacist's Association.

BHT Objectives set by Public Health England for 2019/2020 - Clostridium difficile 65 cases, MRSA bacteraemia 0 cases

	Limits set by PHE	Trust Total from April 2019	Integrated Medicine	Integrated Elderly & Community Care	Surgery & Critical Care	Women, Children & Sexual Health	Specialist Services
Clostridium difficile - HOHA (Hospital onset healthcare associated)	65	1	1	0	0	0	0
Clostridium difficile – COHA (Community onset healthcare associated) (Note – RCA is only completed when requested by CCG)		1 Total COHA RCAs completed = 1	0	0	1	0	0
MRSA Bacteraemia	0	1	1	0	0	0	0
MSSA Bacteraemia (BHT associated (post 48 hours))	n/a	3	3	0	0	0	0
Hand Hygiene Observational Audit Compliance %	n/a	n/a	99%	98%	99%	97%	98%

Clostridium difficile

Total of **2** Cases were identified in April 2019
HOHA = 1 case, COHA = 1 case

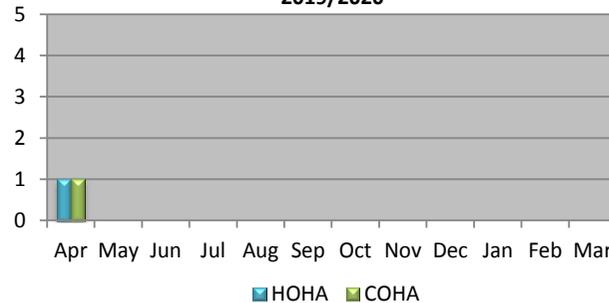
BHT / CCG Investigation Meeting has been undertaken for these cases and both these cases were deemed as:

Avoidable

A revised root cause analysis (RCA) process was carried out in conjunction with CCG IPC Lead and the clinical teams. The relevant clinical areas have been tasked with putting together an action plan based on the RCA findings for subsequent follow up and completion at their respective divisional governance meetings.

Totals for 2019/20 = 2 Avoidable, 0 Unavoidable

BHT Clostridium difficile HOHA & COHA Cases 2019/2020



BHT Clostridium difficile Avoidable & Unavoidable Cases 2019/2020



Meticillin Resistant Staphylococcus aureus (MRSA) Bacteraemia

1 Case identified in April 2019

This case was deemed **Unavoidable** – at Post Infection Review meeting held in conjunction with CCG. No medical representation at the meeting. The case was deemed a contaminant and unavoidable due to patient related factors.

Meticillin Sensitive Staphylococcus aureus (MSSA) Bacteraemia

3 Cases identified in April 2019

Those that are BHT associated with devices will have a Root Cause Analysis (RCA) carried out.

Hand Hygiene Observational Audits

These are carried out by each ward/ area/ department throughout the month. As from February 2019 every alternate month will be a peer audit.

Bacteraemia Line Infections

Aims & Ambitions

- Zero avoidable central line infections
 - Zero peripheral line infections
- Zero Serious Incidents (SI's) declared – secondary to line infections

		Year to Date	Current Month
Central Line	Avoidable	0	0
	Unavoidable	0	0
Peripheral Line Infections		0	0
Totals		0	0

Additional Information

There were no cases of line infections for April 2019.

Yearly Comparison Table

		17-18	18-19	19-20
Central Line	Avoidable			0
	Unavoidable			0
Peripheral Line Infections				0
Totals		31	30	0

BHT Hospital Onset Gram Negative Blood Stream Infections (GNBSI's)

Aims & Ambitions

Based on 2017 – 2018 figures:

- 25% reduction by 2021
- 50% reduction by 2024

	Year to Date	Current Month
E.coli	5	2
Klebsiella	4	2
Pseudomonas	1	1
Totals	5	5

Additional Information

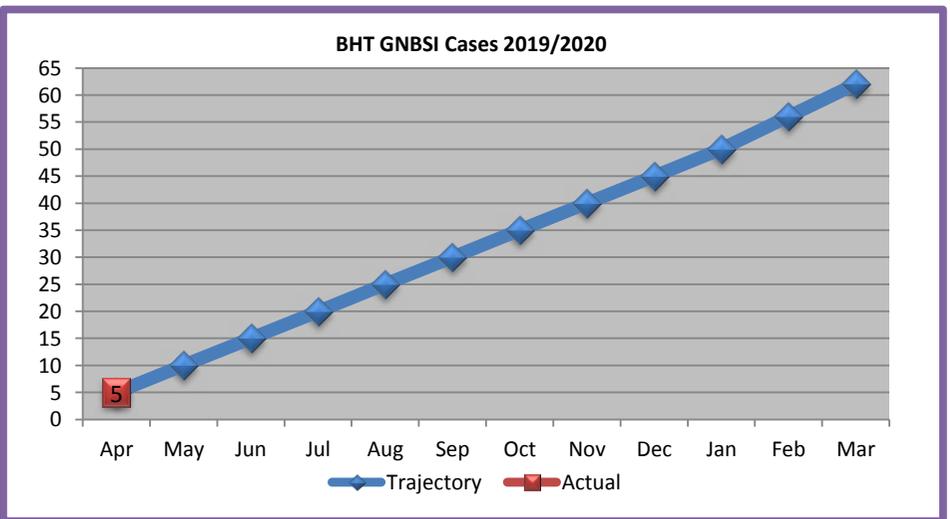
RCA's being completed for 2 cases during April .

Case 1 –to be determined

Case 2 –to be determined

Yearly Comparison Table

	18-19	19-20
E.coli	44	2
Klebsiella	13	2
Pseudomonas	11	1
Totals	68	5



Infection Prevention & Control Report – May 2019

BHT Objectives set by Public Health England for 2019/2020 - Clostridium difficile 65 cases, MRSA bacteraemia 0 cases

	Limits set by PHE	Trust Total from April 2019	Integrated Medicine	Integrated Elderly & Community Care	Surgery & Critical Care	Women, Children & Sexual Health	Specialist Services
Clostridium difficile - HOHA (Hospital onset healthcare associated)	65	8	3	2	1	0	1
Clostridium difficile – COHA (Community onset healthcare associated) (Note – RCA is only completed when requested by CCG)		1 Total COHA RCAs completed = 1	0	0	0	0	0
MRSA Bacteraemia	0	1	0	0	0	0	0
MSSA Bacteraemia (BHT associated (post 48 hours))	n/a	5	2	0	0	0	0
Hand Hygiene Observational Audit Compliance %	n/a	n/a	99%	99%	98%	98%	99%

Clostridium difficile

Total of **7** Cases were identified in May 2019
HOHA = 7 cases, COHA = 0 case

BHT / CCG Investigation Meeting has been undertaken for 5 of these cases and all 5 cases were deemed as:

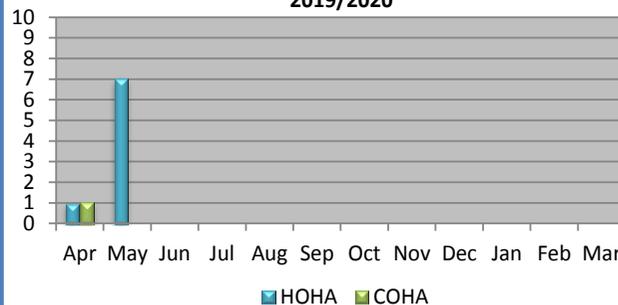
Avoidable

The further 2 cases will be discussed at the July 2019 meeting.

A revised root cause analysis (RCA) process was carried out in conjunction with CCG IPC Lead and the clinical teams. The relevant clinical areas have been tasked with putting together an action plan based on the RCA findings for subsequent follow up and completion at their respective divisional governance meetings.

Totals for 2019/20 = 7 Avoidable, 0 Unavoidable, 2 yet to be determined

BHT Clostridium difficile HOHA & COHA Cases 2019/2020



BHT Clostridium difficile Avoidable & Unavoidable Cases 2019/2020



Meticillin Resistant Staphylococcus aureus (MRSA) Bacteraemia

0 Cases identified in May 2019

Meticillin Sensitive Staphylococcus aureus (MSSA) Bacteraemia

2 Cases identified in May 2019
Those that are BHT associated with devices will have a Root Cause Analysis (RCA) carried out.

Hand Hygiene Observational Audits

These are carried out by each ward/ area/ department throughout the month. As from February 2019 every alternate month will be a peer audit.

Bacteraemia Line Infections

Aims & Ambitions

- Zero avoidable central line infections
 - Zero peripheral line infections
- Zero Serious Incidents (SI's) declared – secondary to line infections

		Year to Date	Current Month
Central Line	Avoidable	0	1
	Unavoidable	0	0
Peripheral Line Infections		0	0
Totals		0	1

Additional Information

There was 1 line infections for May 2019.

Lessons learned :

- Poor completion of referral documentation
- Training and information of VIP assessment need improving – this will be completed by the department and the OPAT team

Yearly Comparison Table

		17-18	18-19	19-20
Central Line	Avoidable	5	3	1
	Unavoidable	24	24	0
Peripheral Line Infections		3	4	0
Totals		32	31	1

BHT Hospital Onset Gram Negative Blood Stream Infections (GNBSI's)

Aims & Ambitions

Based on 2017 – 2018 figures:

- 25% reduction by 2021
- 50% reduction by 2024

	Year to Date	Current Month
E.coli	11	9
Klebsiella	5	3
Pseudomonas	2	1
Totals	18	13

Additional Information

RCA's being completed for 2 cases during May.

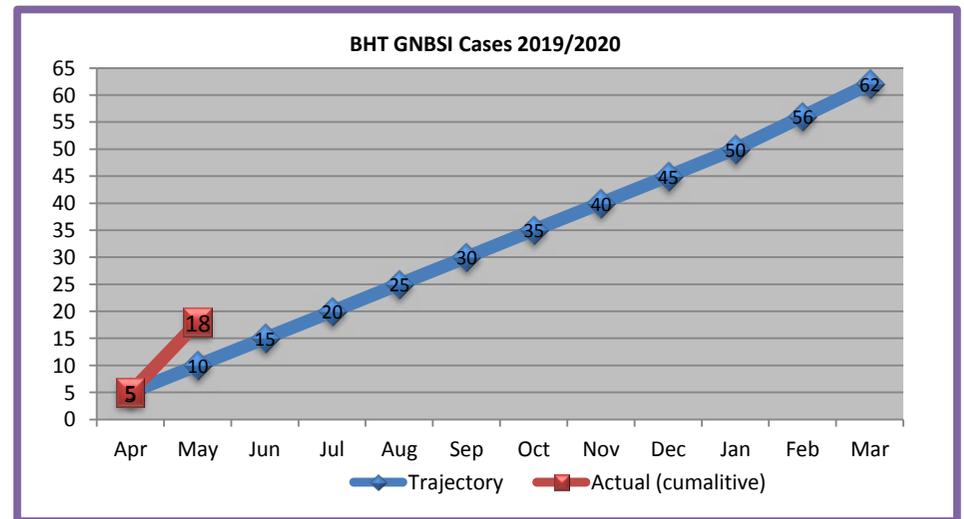
- Case 1 –to be determined
- Case 2 –to be determined

RCA's being completed for 2 cases during April .

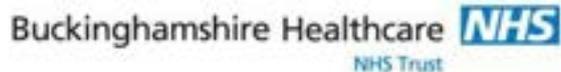
- Case 1 –to be determined
- Case 2 –to be determined

Yearly Comparison Table

	18-19	19-20
E.coli	44	11
Klebsiella	13	5
Pseudomonas	11	2
Totals	68	18



Agenda item: 10
 Enclosure no: TB2019/073



Trust Board 31st July 2019

Title	Care Quality Commission inspection report 2019
Responsible Director	Director for Governance
Purpose of the paper	The purpose of the report is to provide the Board with an overview of the outcomes following the CQC inspections and an overview of the next steps to those areas identified for improvement.
Action / decision required (e.g., approve, support, endorse)	The Board is asked to note 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?

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.	<p><i>Non-Financial Risk:</i> This report covers all risks relating to Quality and patient safety</p> <p><i>Financial Risk:</i> This report covers all risks relating to Quality and patient safety</p>
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LINK TO CARE QUALITY COMMISSION ESSENTIAL STANDARDS OF SAFETY AND QUALITY

Which CQC standard/s does this paper relate to?	Well led
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Author of paper Sue Manthorpe
Presenter of Paper: Sue Manthorpe
Other committees / groups where this paper / item has been considered: Risk and Compliance Group
Date of Paper: 24th June 2019

10

Agenda item: 10
Enclosure no: TB2019/073

1. Purpose

The purpose of the report is to provide the Committee with an overview of the outcomes following the CQC inspections and an overview of the next steps to those areas identified for improvement.

2. Background

The Care Quality Commission (CQC) inspected the Trust in February 2019 and then in March 2019. The core services the CQC inspected were in the acute hospital setting urgent and emergency care, medical care, surgery, out patients, end of life care and the hospice. In the community the CQC inspected community, community adults and community children and young people. All of these core service inspections were announced. The CQC Inspection report is now published on the CQC and BHT public websites.

The overall ratings for the trust by domain are:

Safe – Good

Effective – Good

Caring – Outstanding

Responsive – Good

Well-led – Requires Improvement

How this translates into an overall rating

In deciding on a rating, the CQC seeks to answer the following questions:

Does the evidence demonstrate a potential rating of good?

If yes – does it exceed the standard of good and could it be outstanding?

If no – does it reflect the characteristics of requires improvement or inadequate?

Each service inspected is rated against each domain: safe, effective, caring, responsive and well led.

For the purposes of the inspection services are rated in isolation. However, they do not operate in isolation. Only by multi-disciplinary working and cohesive and supportive leadership have services achieved the ratings they have. The overall rating for the trust is **Good** with the following sub-elements:

Agenda item: 10

Enclosure no: TB2019/073

• At **Stoke Mandeville Hospital** the CQC rated five of the trust’s services as good and one as outstanding. In rating the trust, the CQC took into account the current ratings of the three services not inspected this time. The outcome is shown in the table below:

Ratings for Stoke Mandeville Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good ↑ Jun 2019	Good ↔ Jun 2019	Good ↔ Jun 2019	Good ↑ Jun 2019	Good ↔ Jun 2019	Good ↑ Jun 2019
Medical care (including older people's care)	Good ↑ Jun 2019	Good ↑ Jun 2019	Good ↑ Jun 2019	Good ↔ Jun 2019	Good ↔ Jun 2019	Good ↑ Jun 2019
Surgery	Requires improvement ↔ Jun 2019	Good ↔ Jun 2019	Good ↔ Jun 2019	Good ↑ Jun 2019	Good ↑ Jun 2019	Good ↑ Jun 2019
Critical care	Good Mar 2014	Good Mar 2014	Outstanding Mar 2014	Good Mar 2014	Good Mar 2014	Good Mar 2014
Maternity	Good Mar 2014	Good Mar 2014	Good Mar 2014	Good Mar 2014	Good Mar 2014	Good Mar 2014
Services for children and young people	Good Mar 2014	Good Mar 2014	Good Mar 2014	Good Mar 2014	Good Mar 2014	Good Mar 2014
End of life care	Good ↑ Jun 2019	Good ↑ Jun 2019	Outstanding ↑ Jun 2019	Outstanding ↑ Jun 2019	Outstanding ↑ Jun 2019	Outstanding ↑ Jun 2019
Outpatients	Good Jun 2019	Good Jun 2019	Good Jun 2019	Good Jun 2019	Good Jun 2019	Good Jun 2019
National Spinal Centre	Good Mar 2014	Outstanding Mar 2014	Outstanding Mar 2014	Good Mar 2014	Good Mar 2014	Good Mar 2014
Overall*	Good ↑ Jun 2019	Good ↔ Jun 2019	Outstanding ↑ Jun 2019	Good ↑ Jun 2019	Good ↑ Jun 2019	Good ↑ Jun 2019

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Enclosure no: TB2019/073

- At **Wycombe Hospital** the CQC rated three of the trust’s services as good and one as outstanding. In rating the trust, the CQC took into account the current ratings of the three services not inspected this time. The outcome is shown in the table below:

Ratings for Wycombe Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people’s care)	Good ↑ Jun 2019	Good ↑ Jun 2019	Good ↔ Jun 2019	Good ↑ Jun 2019	Good ↑ Jun 2019	Good ↑ Jun 2019
Surgery	Requires improvement ↔ Jun 2019	Good ↔ Jun 2019	Good ↔ Jun 2019	Good ↑ Jun 2019	Good ↔ Jun 2019	Good ↑ Jun 2019
Critical care	Good Mar 2014	Good Mar 2014	Good Mar 2014	Good Mar 2014	Good Mar 2014	Good Mar 2014
Maternity	Good Mar 2014	Good Mar 2014	Good Mar 2014	Good Mar 2014	Good Mar 2014	Good Mar 2014
Services for children and young people	Good Mar 2014	Good Mar 2014	Good Mar 2014	Good Mar 2014	Good Mar 2014	Good Mar 2014
End of life care	Good ↑ Jun 2019	Good ↑ Jun 2019	Outstanding ↑ Jun 2019	Outstanding ↑ Jun 2019	Outstanding ↑ Jun 2019	Outstanding ↑↑ Jun 2019
Outpatients	Good Jun 2019	Good Jun 2019	Good Jun 2019	Good Jun 2019	Good Jun 2019	Good Jun 2019
Overall*	Good ↑ Jun 2019	Good ↔ Jun 2019	Good ↔ Jun 2019	Good ↑ Jun 2019	Good ↑ Jun 2019	Good ↑ Jun 2019

- In the **community services** the CQC rated two of the services as good and one as requires improvement. In rating the trust, the CQC took into account the current ratings of the one service not inspected this time. The outcome is shown in the table below

Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good ↑ Jun 2019	Good ↔ Jun 2019	Good ↔ Jun 2019	Good ↑ Jun 2019	Good ↑ Jun 2019	Good ↑ Jun 2019
Community health services for children and young people	Good ↑ Jun 2019	Good ↑ Jun 2019	Outstanding ↔ Jun 2019	Requires improvement ↔ Jun 2019	Good ↑↑ Jun 2019	Good ↑ Jun 2019
Community health inpatient services	Requires improvement ↔ Jun 2019	Good ↔ Jun 2019	Good ↔ Jun 2019	Good ↔ Jun 2019	Requires improvement ↔ Jun 2019	Requires improvement ↔ Jun 2019
Community end of life care	Good Mar 2014	Good Mar 2014	Good Mar 2014	Good Mar 2014	Good Mar 2014	Good Mar 2014
Overall*	Good ↑ Jun 2019	Good ↑ Jun 2019	Good ↔ Jun 2019	Good ↑ Jun 2019	Good ↑↑ Jun 2019	Good ↑ Jun 2019

Agenda item: 10

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What we can be proud of

The organisation was rated outstanding for caring and ends of life care. The CQC found several areas of outstanding practice in the emergency department core service, the outpatient core service, community health services for adults and end of life care core service.

Where we need to do further work.

There are many aspects of the CQC reports that are a fair reflection of the services the trust provides and the very positive experiences of our patients and staff. There are also elements of the reports that identify where the trust has further work to do.

The CQC identified areas for improvement including 18 breaches of legal requirements that the trust must put right and 52 issues the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement or to improve service quality.

Key areas of improvement are focused in Surgery, Community Hospitals, Health Visiting and Children's Community services. We will now work together to address these areas identified by the CQC and have already addressed some of the more pressing of these in response to initial feedback after the inspection in March.

Requirement Notices

The CQC has issued two requirement notices and have taken one enforcement action. The actions relates to three legal breaches at a trust-wide level. There are two requirement notices under Regulation 12, Safe Care and treatment (Diagnostic and screening procedures; Surgical procedures; Treatment of disease, disorder or injury). The CQC require the trust to monitor key aspects of care in a more consistent manner. There is one requirement notice under Regulation 17 Good Governance whereby The trust must ensure it is consistently using its risk management systems to identify and manage risk in a proactive manner.

The trust is currently taking action to close the breaches and will report these actions to the CQC in July. The actions to close the gaps will be monitored monthly at the Quality and Safety Group, by exception to EMC and quarterly reports to the Quality and Clinical Governance Committee

3. Recommendation

The Board is asked to note the report.

Agenda item 11
 Enclosure no: TB2019/074



PUBLIC TRUST BOARD MEETING 31st July 2019

Details of the Paper

Title	Safeguarding Annual Report 2018 - 2019
Responsible Director	Chief Nurse, Carolyn Morrice
Purpose of the paper	To provide assurance that the Trust is meeting its statutory requirements in respect of safeguarding and to report progress on previous year's report.
Action / decision required (e.g., approve, support, endorse)	To note and approve the contents of the report.

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

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

ANNUAL OBJECTIVE

Which Strategic Objective/s does this paper link to?

This relates to : Quality
 Objective: Enhance culture of safety
 Objective: Listen to Patient Voice
 Objective: Develop as a learning organisation

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

Shows evidence of the Trust's commitment to upholding its duties in respect of all aspects of safeguarding. Supports the application of the Trust's values and provides a framework for the ongoing achievements and future work plans in respect of Safeguarding.

RISK

Are there any specific risks associated with this paper? If so, please summarise here.

Non-Financial Risk:

1. Consistently achieving compliance against expectation in all areas of safeguarding training;
2. Being prepared for changes and developments in safeguarding work including forthcoming changes to MCA & DoLS

Financial Risk:

None noted

LINK TO CARE QUALITY COMMISSION ESSENTIAL STANDARDS OF SAFETY AND QUALITY

Which CQC standard/s does this paper relate to?

Regulation 13 – this is set out in detail within the report and its appendices
(if you need advice on completing this box please contact the Director for Governance)

Author of paper: Nuala Waide, Associate Director for Safeguarding

Presenter of Paper: Carolyn Morrice, Chief Nurse

Other committees / groups where this paper / item has been considered: EMC; Quality & Governance Committee; Safeguarding Committee

Date of Paper: 31st July 2019

Safe & compassionate care,
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Buckinghamshire Healthcare 
NHS Trust

Safeguarding Annual Report 2018 – 2019

11

Author Nuala Waide, Associate Director for Safeguarding

Presented by Carolyn Morrice, Chief Nurse

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Executive Summary

Throughout the year 31st March 2018 to 1st April 2019, the BHT safeguarding service has continued to mature and develop so that it can carry on leading the way in constantly improving the knowledge of Trust staff, with the ultimate staff aim of achieving better outcomes for patients and service users of all ages.

The Trust Safeguarding Team is committed to upholding and maintaining the standards required by CQC regulations, and in particular the standards set out in CQC Regulation 13. Similarly to the previous year's report, this report has been structured to reflect and to demonstrate accomplishment against these standards. Safeguarding activity within the Trust is robustly monitored by the monthly meetings of the BHT Safeguarding Committee.

Referral activity in all areas continues to increase which is an indicator of safeguarding training having an impact. Mental capacity training figures continue to be good but work will continue to embed understanding in respect of implementing the requirements of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) into practice. Signs of improvement in these areas are being noted and supported by the data to a degree.

Significant developments in safeguarding practice in all areas are noted in this report; advances in work around exploitation, missing people and mental health are particularly notable.

Incidents and complaints continue to be monitored by the Safeguarding Team in order to inform safeguarding training and practice. The top six adult safeguarding-related incidents for this reporting period and in order of frequency of reporting are:

- Pressure sore / decubitus ulcer
- Possible delay or failure to monitor
- Implementation of care or ongoing monitoring – other
- Discharge
- Abuse - other
- Slips, trips, falls and collisions

In addition the report highlights incidents reported via Datix about cancellation, and late notification regarding cancellation, of important multi-agency safeguarding children meetings.

The report highlights examples of effective partnership working and also brings attention to forthcoming changes especially in respect of:

- The new partnership arrangements that will replace Buckinghamshire Safeguarding Children Boards. BHT contributes significantly to case reviews, reports and plans aimed at identifying and minimising risk of harm from abuse.
- Reforms to MCA and DoLS that will bring about new liberty protection safeguards (LPS)

The Safeguarding Team is evolving continuously to help deliver the ever changing safeguarding agenda at both national and local level. The Team and the Trust can be proud of the achievements of the past year in respect of all areas of safeguarding responsibilities.

Introduction

This report builds on the achievements set out in the previous year's safeguarding annual report and provides assurance to the Board that the Trust has in place effective arrangements to safeguard patients from the harm caused by abuse. The report provides evidence that the Trust complies with all statutory safeguarding requirements and it sets out the work undertaken and key achievements for the period 1st April 2018 to 31st March 2019.

This report draws attention to areas of future development and planned safeguarding activity across the whole organisation for the coming year; it also records achievements against the plans set out in the previous year's report.

The Trust's responsibilities in respect of safeguarding work are determined by legislation and the Care Quality Commission (CQC) regulations. Whilst all CQC regulations set the criteria for the provision of safe and effective care, CQC regulation 13 is particularly pertinent. Regulation 13 is summarised below and set out in full in see Appendix 1.

The intention of this regulation is to safeguard people who use services from suffering any form of abuse or improper treatment while receiving care and treatment. Improper treatment includes discrimination or unlawful restraint, which includes inappropriate deprivation of liberty under the terms of the Mental Capacity Act 2005.

To meet the requirements of this regulation, providers must have a zero tolerance approach to abuse, unlawful discrimination and restraint. This includes:

- neglect
- subjecting people to degrading treatment
- unnecessary or disproportionate restraint
- deprivation of liberty.

The BHT Safeguarding Team is responsible on behalf of the Trust for ensuring that BHT upholds its safeguarding duties and for raising concerns when poor practice is identified in any partnership organisation. In order to fulfil these responsibilities all members of the Safeguarding Team continually ensure that they are well-informed with regards to any developments in legislation and guidance that may affect the organisation.

Systems and Processes

Systems and processes must be established and operated effectively to prevent abuse of service users.

Systems and processes must be established and operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse.
(CQC Regulation 13)

In addition to safeguarding-focused policies and activities, BHT espouses values, and has in place wide ranging strategies, policies and training to support staff in the delivery of safe and effective care for its patients. The Trust has in place:

- Effective governance arrangements
- Robust policies

- Training and support/supervision for staff
- HR policies and processes
- Freedom to Speak up Guardian

Safeguarding Training and Supervision

Staff must understand their roles and associated responsibilities in relation to any of the provider's policies, procedures or guidance to prevent abuse.

As part of their induction, staff must receive safeguarding training that is relevant, and at a suitable level for their role. Training should be updated at appropriate intervals and should keep staff up to date and enable them to recognise different types of abuse and the ways they can report concerns.

(CQC Regulation 13)

Safeguarding training continues to be provided as part of corporate induction and is also updated at regular intervals in accordance with specific roles and responsibilities. Bespoke face to face training is provided as requested by clinical teams.

As part of its regular monthly meetings, training is reviewed by the Safeguarding Team meetings so as to ensure that it reflects the requirements set out in legislation and national guidance documents (*Safeguarding Children and Young People: Roles and competencies for healthcare staff – published January 2019* and *Adult Safeguarding: Roles and Competencies for Health Care Staff – published August 2018*), as well as feedback received from Trust staff. Each training programme is supported by a corresponding training plan.

As a result of the recently published revised competency framework for children's safeguarding and the newly published competency framework for adults, a significant piece of work to update the BHT training matrix was started within the past year. The work is ongoing into the year 2019-20 and will ensure that:

- all staff receive training at the correct level for their roles;
- every training event is developed in accordance with the guidance set out in the above documents; and
- is accompanied by an evidence-based training or lesson plan.

It is important to note that, given the new requirements for an increased number of staff groups to be competent at level 3 for safeguarding children, it is likely that BHT will see a temporary drop in compliance figures during the year 2019-20. The Safeguarding Team is making plans to undertake additional level 3 training once the training matrix is completed and has been validated by the Trust Mandatory and Statutory Training Committee (MaST).

Within Maternity Services the Safeguarding Midwives provide level 3 training as part of the midwifery mandatory annual training.

Members of the Trust Safeguarding Team attend the training subgroups of the BSAB and BSCB to contribute to partnership work directed at improving single and multi-agency training. The team also provides safeguarding supervision for relevant staff groups and keeps records of this activity. Supervision is an important part of safeguarding work, enabling staff to be

challenged about practice and to reflect on their actions. The Safeguarding Midwives receive supervision from members of the BHT Safeguarding Team; the Safeguarding Midwives provide safeguarding supervision for midwifery staff.

Members of the Safeguarding Team receive supervision at level 4 requirements from external practitioners/supervisors.

Training Compliance Safeguarding Children

Table 1 and figure 1 below show the compliance achievement for safeguarding children training for the reporting period. The target of 90% compliance for level 1 training has been achieved for 9 out of 12 months during the past year, and during the quarter 4 has been sustained at a the appropriate level.

Whilst the trend in compliance at level 2 has been generally upwards, the target of 90% has not yet been achieved. A key goal in the coming year is to achieve and sustain the 90% compliance rate.

The compliance target for level 3 safeguarding children training has been set at 95% by NHS Buckinghamshire Clinical Commissioning Group BHT; attainment has been very close to this target for several months of the past year but has shown a troubling decline during quarter 4 and has dipped to just under 90%. The BHT Board requires 90% compliance at MaST.

Training compliance is being closely monitored by the Trust Safeguarding Committee via divisional reporting which identifies the specific staff groups who may need to be encouraged to undertake this statutory training.

For the future, training data reported to the Safeguarding Committee will include a breakdown of different staff and professional groups so as to be able to target for improvement those identified as being non-compliant.

Safeguarding Children Training Compliance 2018-2019

Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
% of staff completed Level 1	87.18	90.14	90.32	90.91	90.95	91.93	92.94	88.12	88.89	90.08	91.15	91.02
% of staff completed Level 2	78.73	82.59	85.52	85.16	85.07	86.74	87.60	86.53	85.67	86.46	83.02	88.38
% of staff completed Level 3	94.86	94.57	93.67	93.53	94.30	93.39	92.15	93.28	92.32	92.09	90	89.88

Table 1

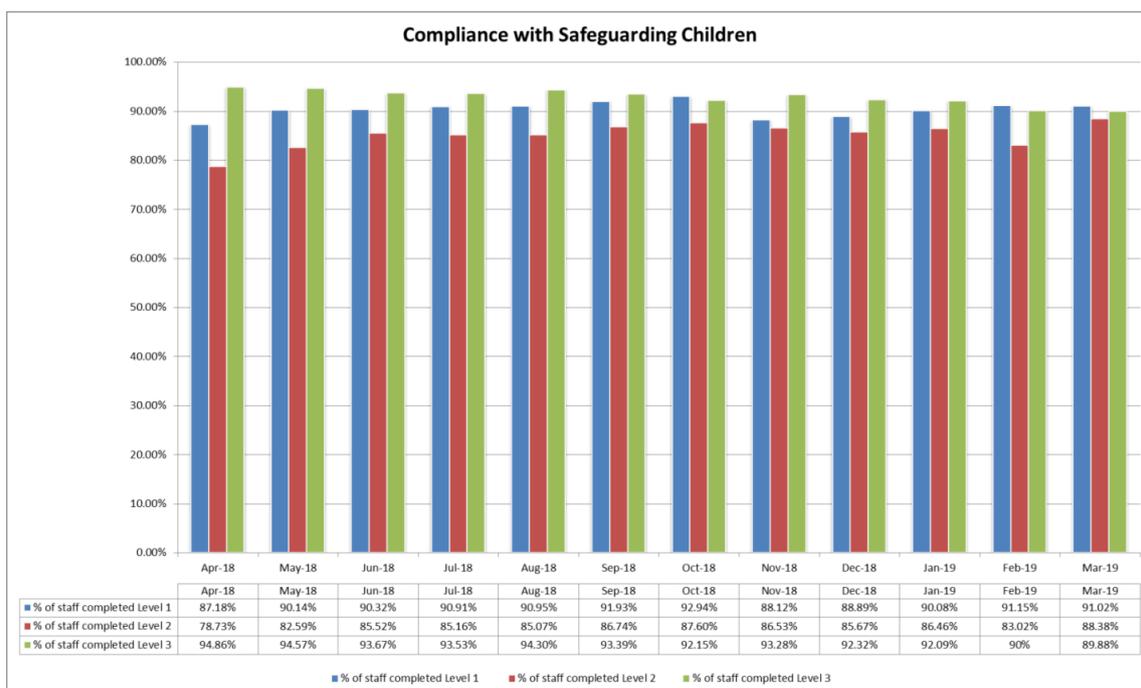


Figure 1

Training trajectories since 2016

Despite the concerns about consistency in compliance attainment for safeguarding children training throughout the past year, the data collected between 1st April 2016 and 31st March 2019 indicates good progress in general, and an upward trend across all 4 years. See table 2 and figure 2 below.

Trajectory for Safeguarding Children Training Compliance since 2016

Year ending	31 st March 2016	31 st March 2017	31 st March 2018	31 st March 2019
% of staff completed Level 1	81%	79%	88.23%	91.02%
% of staff completed Level 2	59.10%	65.85%	79.47%	88.38%
% of staff completed Level 3	56.79%	83.37%	94.05%	89.83%

Table 2

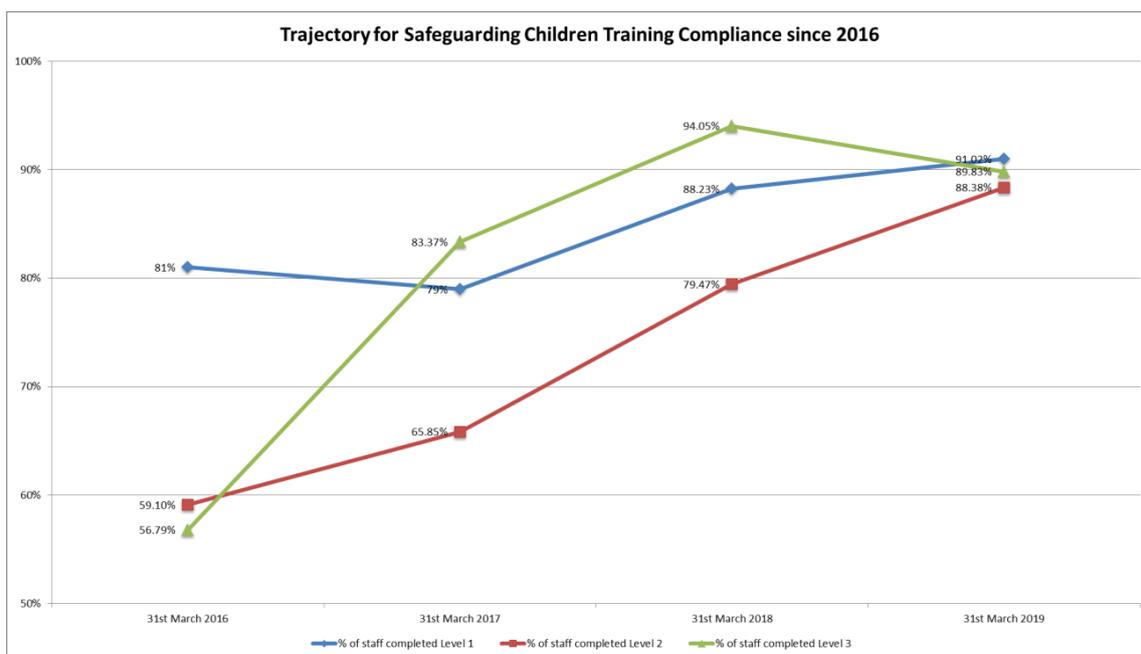


Figure 2

Training Compliance Safeguarding Adults

The compliance target for safeguarding adult awareness training is set at 90%; this has been achieved in 2 months during the reporting period, although the trend in compliance is generally upwards. During quarter 4 of the reporting period, compliance of 89% and above was sustained throughout – see table 3 and figure 3 below; the aim for the coming year is to sustain and build on this progress. As with safeguarding children training above, the Trust Safeguarding Committee assertively monitors this issue with the aim of ensuring that any falls in compliance can be quickly addressed.

During the past year the expected guidance in respect of adult safeguarding competencies for NHS staff was published, and as anticipated it sets new requirements for the training of health staff at different levels in accordance with their roles and responsibilities. The ongoing work in respect of the safeguarding training matrix, as reported above, will identify which staff groups require what level of training or competence attainment, and will contribute to the development of a strategy setting out how compliance will be achieved.

Safeguarding Adult Awareness Training Compliance 01/04/2018 – 31/03/2019

Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
% of staff completed	86	87.73	88.01	86.61	90	90.55	89.94	86.25	87.28	89	89.97	89.83

Table 3



Figure 3

Table 4 and figure 4 below show the overall trajectory in respect of safeguarding adult training compliance since 2016. Again, similarly to safeguarding children’s training, there has been an upward trend. The Trust will not be complacent however and the aim is to consistently achieve a compliance of over 90%.

As with the changes in competency requirements for children, the new safeguarding adult competency requirements are likely to affect compliance figures until such time as those staff requiring safeguarding adult competences at higher or different levels can be trained. This is likely to show in reporting data for quarters 3 and 4 of this coming year.

Trajectory for Safeguarding Adult Training Compliance since 2016

Year Ending	31st March 2016	31st March 2017	31st March 2018	31st March 2019
% of staff completed Safeguarding Adult Awareness	82%*	76.44%	86.26%	89.93%

Table 4

*Based on data for month ending 31st January 2016 – no data available for March 2016

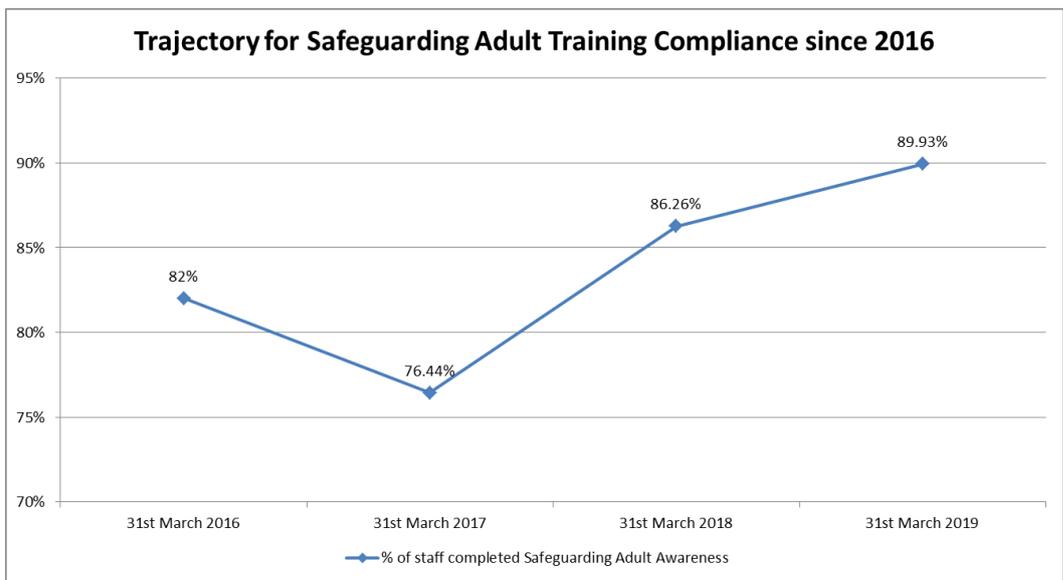


Figure 4

Training Compliance Mental Capacity Act and DoLS

Table 5 and figure 5 below show the data for MCA training compliance for the current reporting period and indicate an excellent uptake and a rising trajectory; the aim for the forthcoming year is to sustain this achievement.

Mental Capacity Act Training Compliance 01/04/2018 – 31/03/2019

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
% of staff completed	86.65	89.89	90.48	91.45	94.34	94.94	95.66	96.03	96.23	96.53	96.98	97

Table 5

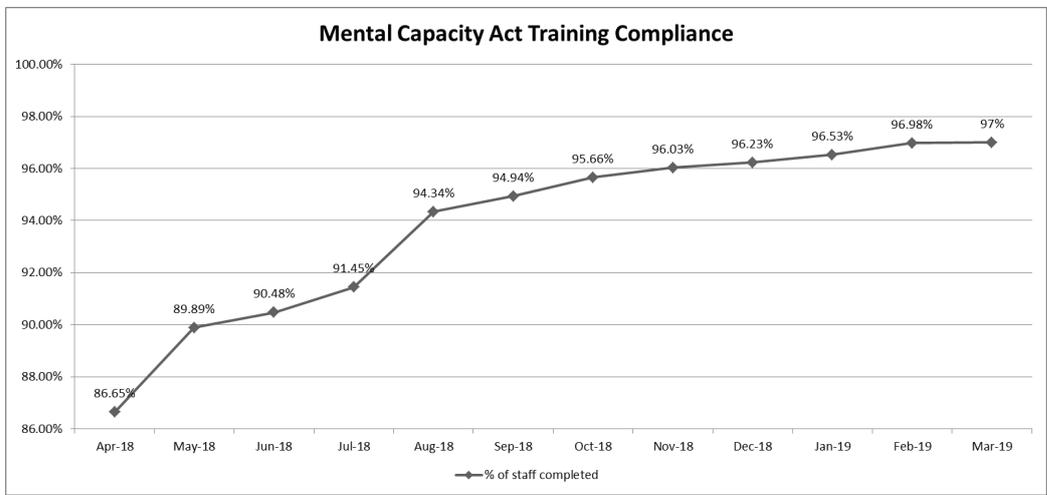


Figure 5

Table 6 and figure 6 below show the compliance for DoLS training in the reporting period; the picture is variable across the year but compliance has remained at 88.65% or above at all times. The safeguarding adult team, supported by the local authority DoLS Lead, has been encouraging more groups of staff to undertake DoLS training at a higher level. This extended training aims to develop greater knowledge within key staff groups, for example practice development nurses and matrons. The local dissemination of this learning will provide greater expertise within clinical areas and will help to drive up training compliance generally along with improved competence in practice.

Anecdotal evidence gathered through walkabouts by the safeguarding adult team is indicating there is generally an improved understanding of the DoLS process by BHT staff. Planned current and ongoing formal audit activity will provide more robust evidence of competence in practice.

Deprivation of Liberty Safeguards Training Compliance 01/04/2018 – 31/03/2019

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
% of staff completed	88.65	91.84	92.27	92.93	95.17	95.73	96.28	96.58	96.87	95.26	96.98	88.89

Table 6

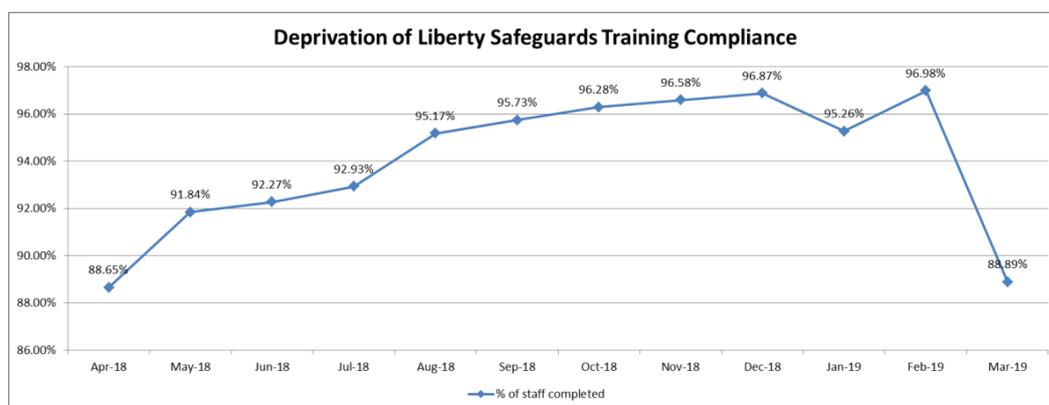


Figure 6

Training Compliance Prevent

Table 7 and figure 7 below show excellent steady and sustained figures within BHT in respect of the uptake of Prevent training. However in common with many other agencies within Buckinghamshire, Prevent referrals in BHT are low (2 referrals in the past year).

BHT is actively engaged in the regional Prevent network and works in collaboration with the police to ensure that the Trust is an effective partner as part of counter terrorist arrangements in Buckinghamshire.

The safeguarding adult team is supported by the wider safeguarding team members to deliver Prevent training; this includes support from learning disability and safeguarding children nurses. The revised statutory guidance – *Working Together to Safeguard Children 2018* – provides

additional guidance on recognising radicalisation as a threat to vulnerable children and young people as part of wider exploitation risks.

Prevent Training Compliance 01/04/2018 – 31/03/2019

	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19
% of staff completed WRAP training	88.48	90.02	90.77	91.83	91.75	93.27	93.78	94.19	96.64	95.39	96.13	96.68
% of staff completed Prevent E-Learning training	97.03	97.05	97.16	95.15	95.07	95.25	95.55	95.49	95.74	95.96	89.97	96.86

Table 7

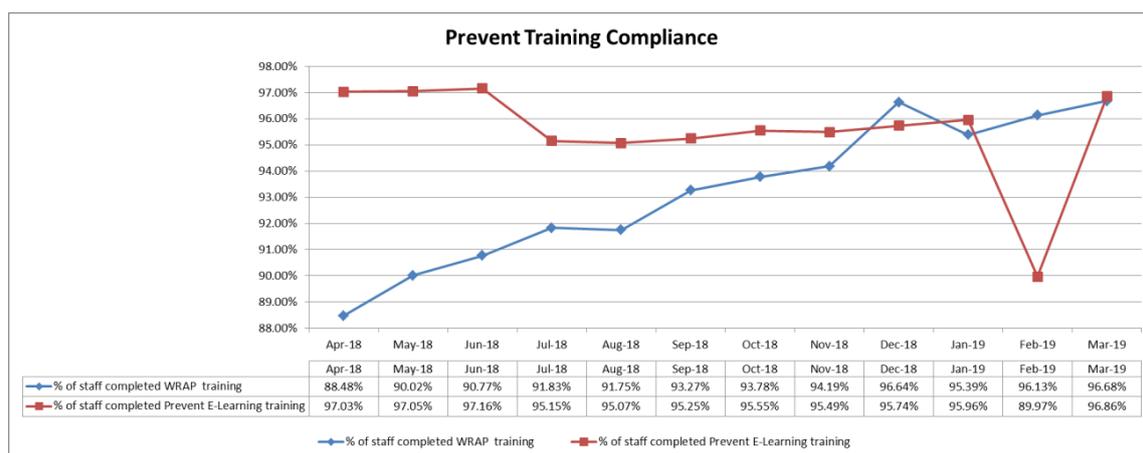


Figure 7

Training trajectories since 2016

Table 8 and figure 8 below show the trajectory for MCA, DoLS and Prevent training since 2106; an upward trend is demonstrated in all these training domains. Prevent training compliance in particular has shown a marked increase since its inception in 2016 and is a testament to the hard work of all members of the Safeguarding and Dementia Teams who have given time to develop and provide this training.

Trajectory for Training Compliance for MCA, DoLS and Prevent since 2016

Year ending	31 st March 2016	31 st March 2017	31 st March 2018	31 st March 2019
% of staff completed MCA training	81.51%*	84.78%	88%	97%
% of staff completed DoLS training	81.51%*	81.48%	90.49%	88.89%
% of staff completed Prevent training	9.31%*	91.69%	91.98%	96.77%

Table 8

*Based on data for month ending 31st January 2016 – no data available for March 2016

*Prevent training only recently started at this time.

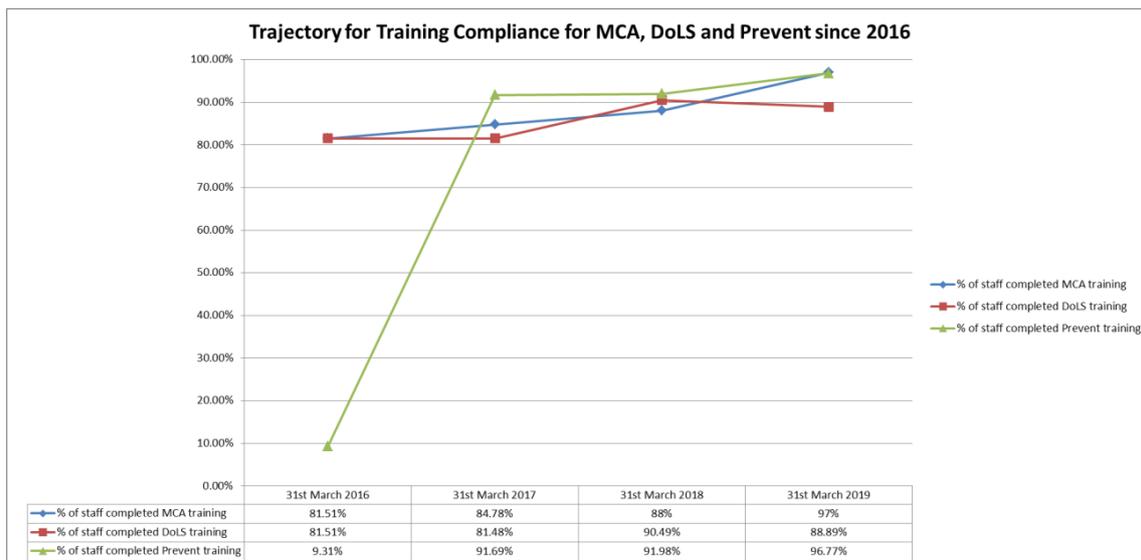


Figure 8

Referral Activity

Providers must take action as soon as they are alerted to suspected, alleged or actual abuse, or the risk of abuse. Where appropriate, this action should be in line with the procedures agreed by local Safeguarding Adults or Children Boards.

Providers and staff must know and understand the local safeguarding policy and procedures, and the actions they need to take in response to suspicions and allegations of abuse, no matter who raises the concern or who the alleged abuser may be. These include timescales for action and the local arrangements for investigation.
(CQC Regulation 13)

Safeguarding Adults

Recognising abuse and knowing when and how to make a referral forms part of all safeguarding training within BHT. The referral activity set out in table 9 and figure 9 below show the referral trends across the year 2018-2019, with a total of 285 referrals having being made. This represents a 102.13% increase on the previous year's referrals ($n=143$) and reflects increasing staff knowledge and awareness of their responsibilities in this matter.

Safeguarding Adult Referrals made by BHT staff 01/04/2018 – 31/03/2019

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Total referrals Per month	24	24	21	23	33	17	32	25	23	29	20	14	285

Table 9

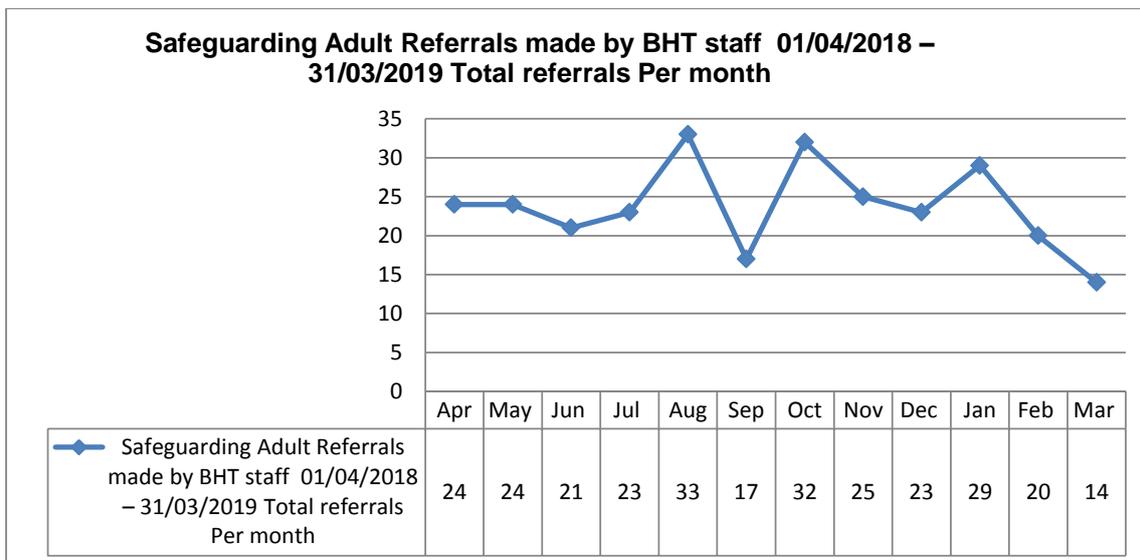


Figure 9

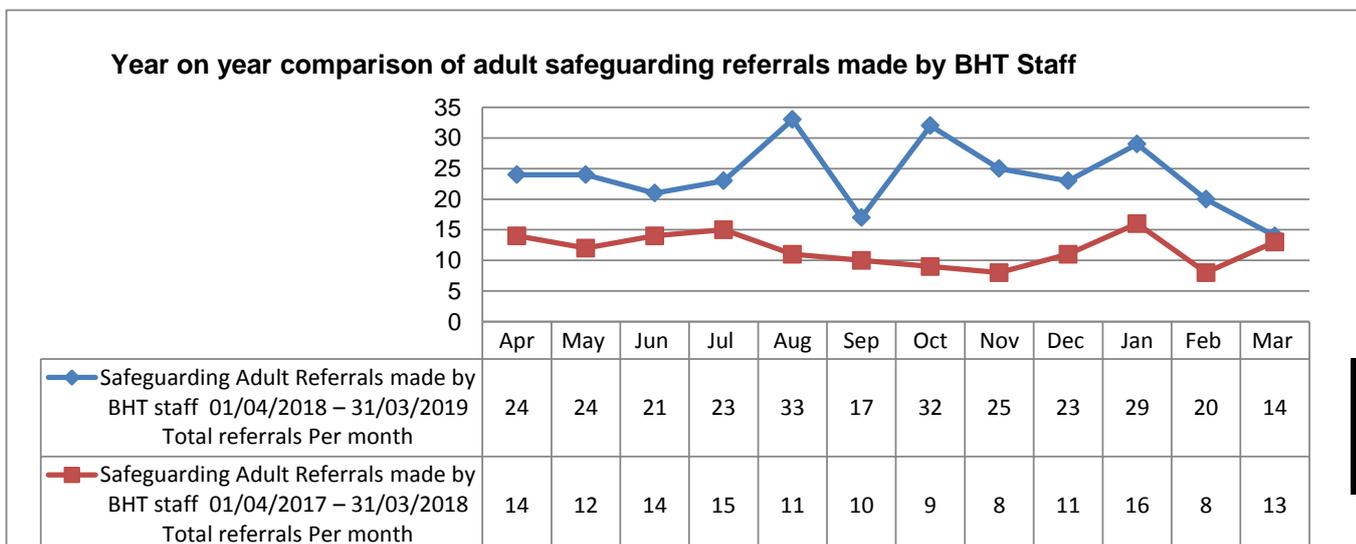


Figure 10

There is an evident upwards trend in adult referrals between the years 2017-18 and 2018-19 (see figure 10 above) which is an indicator of the positive impact of the training and support provided to BHT staff. In the year 2018-19 there are 3 main peaks of higher referral activity, as shown in August, October and January, with discernible dips in September and March. Whilst there is no obvious explanation for these fluctuations, further analysis of the nature and pattern of referrals is required; this will form part of the audit activity for the safeguarding adult team in the coming year.

Datix incident reporting in respect of safeguarding adult concerns does not exactly correspond to the pattern of safeguarding adult referral activity - (see table 22 below), since not every Datix incident translates into a referral to the Buckinghamshire County Council (BCC) social care adult safeguarding team.

The BHT safeguarding team advises that Trust staff tick the adult safeguarding concern box within the Datix incident form only when a corresponding referral is being made to adult social care, and the online Datix form asks specifically about this. Anticipated improvements in the online incident form, whereby this is made a mandatory field and requires evidence to support the fact that a referral has happened should improve data quality in this respect.

Work is ongoing aimed at improving the data collected for the Safeguarding Dashboard in respect of monthly monitoring of safeguarding referrals to adult social care compared against Datix incidents reported.

DoLS Activity

Tables 10 and 11 below show activity in respect of DoLS applications for the years 2017-18 and 2018-19; they demonstrate an upward trend (see also figure 11 below) which is a positive sign and is reflective of greater staff awareness as to how to respond when a patient may be being deprived of their liberty.

The data for 2018-19 (table 10 and figure 11) is incomplete (so far) but does seem to indicate that the number of DoLS applications being declined in the year 2018-19 is fewer than for the previous year; this is a good indication that the quality of applications is improving. The number of DoLS applications authorised shows those applications in which the local authority's Best Interests Assessors have been involved.

Not all patients for whom there have been DoLS applications will be assessed by the local authority Best Interests Assessor. The reasons for this are mainly twofold:

1. many of the patients for whom a best interests assessment apply may have been discharged prior to this happening; and
2. there is still a backlog of DoLS applications requiring assessment and which are sitting with the local authority; this reflects a national picture whereby capacity to undertake assessments is lacking.

DOLs applications 01/04/2018 – 31/03/2019

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Number of DOLs applications	19	21	30	24	21	36	20	31	22	21	25	25	295
Number of DOLs applications / authorised	0	1	0	1	0	1	2	0	0	*	*	*	5
Number of DOLs applications declined	3	6	8	3	0	9	2	12	5	*	*	*	48

Table 10

*Data not yet available

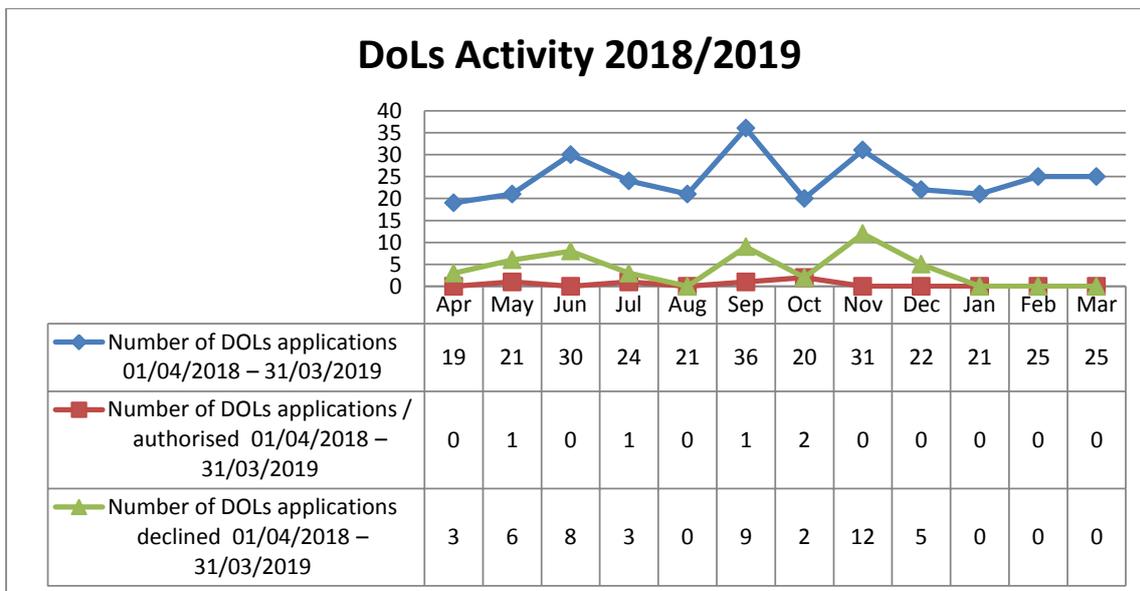


Figure 11

Table 11 below shows DoLS activity for the year prior to this reporting period whilst figure 12 shows a year on year comparison and demonstrates the upward trend in DoLS applications.

DoLS activity 01/04/2017 - 31/03/2018

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Tot
Number of DoLS applications	9	14	17	0	19	6	11	15	15	17	24	17	164
Number of DoLS applications / authorised	1	0	0	0	1	0	0	2	1	5	2	0	12
Number of DoLS applications declined	7	8	13	0	5	6	1	0	5	12	5	8	140

Table 11

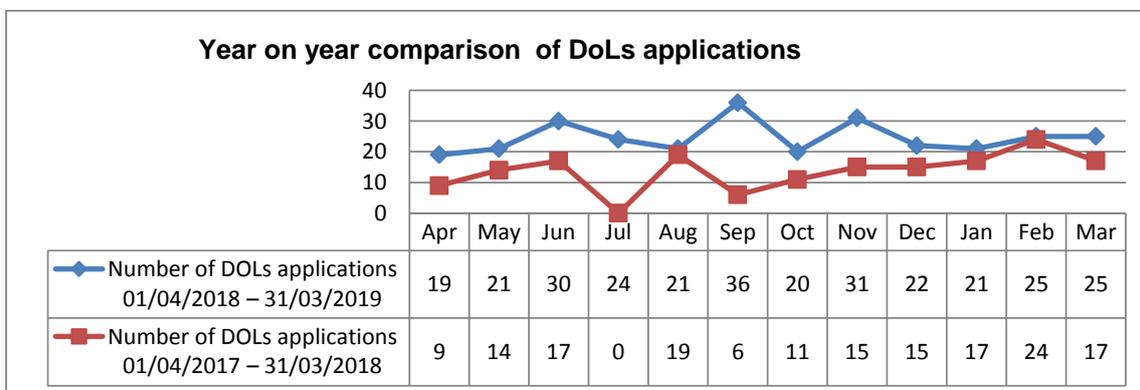


Figure 12

Good progress has been made in respect of reporting all DoLS applications to CQC; the BHT Named Nurse for Safeguarding Adults has worked closely with the Trust's CQC link to agree a process for reporting on notifications about which an outcome is known or if an application is withdrawn. The new system appears to be operating effectively.

There is still much to do to further embed good practice with regard to ensuring that all patients to whom they apply are made subject to a DoLS, and also in driving up the quality of all DoLS applications. The safeguarding adult team is carrying out an ongoing programme of formal audits in respect of DoLS applications, looking at the quality of applications and the presence and quality of a corresponding mental capacity assessment. The aim of the audits is to measure improvement and be able to respond to findings by providing additional training and support for staff.

Support for Trust staff from the safeguarding adult team is continuous, with regular walkabouts and ad hoc audits of records being a key part of this effort. The increased visibility of safeguarding staff is being welcomed by wards and teams within BHT who are finding the approach very supportive. Posters about DoLS have been made available for all clinical areas as prompts to good practice.

Changes in relation to DoLS will be brought about by the anticipated Mental Capacity (Amendment) Act 2019 which will generate modifications in practice and will have resource implications for frontline practitioners in both social care and health organisation. Please see below the section of this report on Future Work Plans and Developments.

Safeguarding Children

Children and Young People Emergency Department Attendances

Table 12 below shows attendance data for children and young people attending the Emergency Department (ED) for the years 2017-2018 and 2018-2019. This shows a pattern of ever increasing numbers of children accessing urgent care within BHT, with a year-on-year increase of $n = 1,147$ (5.2%). This is comparable with the increase of 5.5% for the year 2017-2018 as compared to 2016-2017 and indicates a continuing upward trajectory.

Figure 13 below shows the comparison in attendance at ED by children and young people for the years covered in table 12.

The increase in attendance of children at ED could partly be accountable for the small increase in the number of child protection referrals made by staff in ED by $n = 5$ (1.5%). See figure 15 below for year on year comparisons for all areas.

Children and young people ED attendances 2017-2018 & 2018 - 2019

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Total C&YP attendees 2017-2018	1750	1957	2170	1819	1345	1791	1865	2093	1733	1710	1638	2008	21,978
Total C&YP attendees 2018-2019	1772	1971	1908	1870	1342	1890	1981	2308	1970	2050	1862	2201	23,125

Table 12

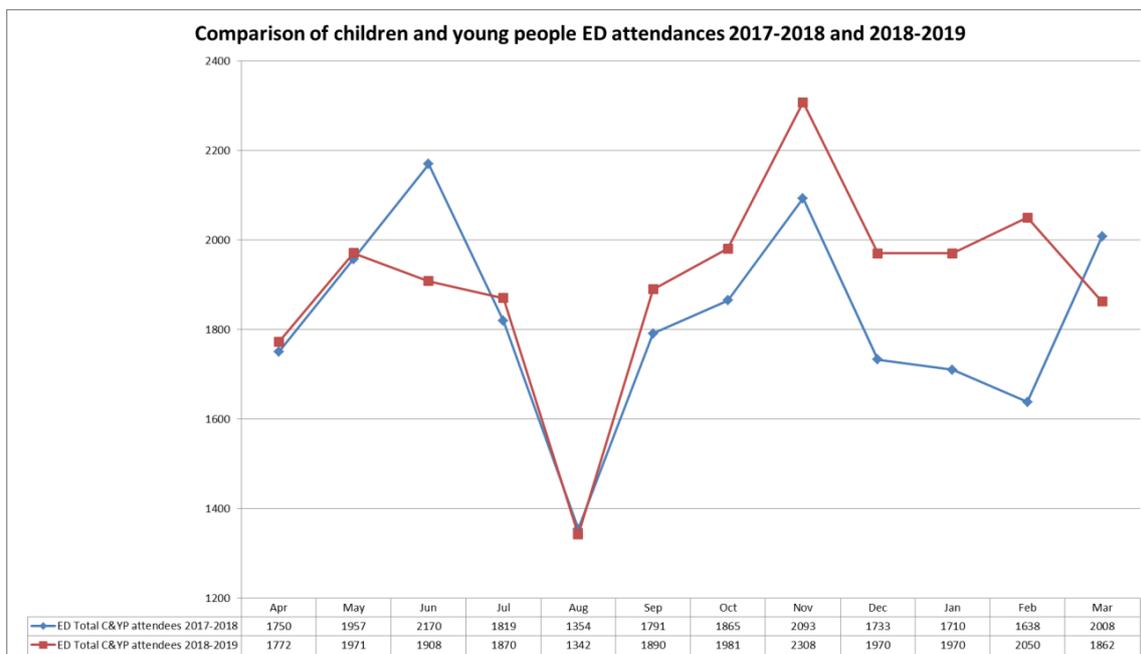


Figure 13

Safeguarding Children Referrals to Children’s Social Care

Overall, safeguarding children referrals – that is multi-agency referral forms (MARFs) completed and submitted to children’s social care from BHT - are showing an upward trend, as indicated by comparing tables 13 and 14 below. This can be interpreted as a positive sign in that it reflects the fact that training and support for staff are leading to greater confidence in being able to recognise and report abuse and other welfare concerns.

Table 13 and figure 14 below show the overall pattern of referrals to children’s social care for this period to be fairly stable across the reporting year, with no particular remarkable peaks or dips in activity. The total number of safeguarding referrals for children made in the reporting period was 633 which is in increase of $n = 64$ (11.25%) on the previous period.

Most of BHT safeguarding children referrals for this reporting period were made by ED staff; the data shows a small year on year increase in referrals ($n = 4$) but this does not entirely mirror the growing numbers of ED attendances by children. Given that the role of the Safeguarding Team’s Paediatric Liaison Nurse is to monitor all ED attendances by children with the aim of picking up any possible missed child protection referrals, it is unlikely that these figures can be interpreted to mean that children have been left at risk of harm.

The next highest referring area for children is maternity services with a small yet significant increase of $n = 14$ (3.8%). Year on year referrals made by health visitors (HVs) have increased by $n = 27$ (67.5%) and paediatric referrals by $n = 23$ (143%). Although these increases in referral activity are significant, caution needs to be applied when interpreting % increases for small

numbers. Increasing referrals can be interpreted as indicating better informed staff but may also reflect the changing nature of local demographics as well as in society as a whole.

The numbers of MARFs completed by school nurses have dropped from an already low base of $n=9$ for the previous year to $n=5$ for this reporting period and represents a decrease of 44.5%. This may reflect the small size of the school nursing service but also the fact that many referrals about children at school are made by education staff. Table 18 relating to MASH reporting data indicates that school nurses do make contact with the MASH to raise concerns or discuss cases.

The Safeguarding Team continues to quality assure all MARFs in terms of the appropriateness of the referral and the completeness of the information provided. Audit information from the local authority continues to indicate that BHT staff do not make excessively high numbers of inappropriate or poor quality referrals.

Number of multi-agency referrals forms sent by BHT to Children's Social Care 2018-2019

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Total MARFs from BHT	50	60	49	43	48	60	50	59	56	49	43	66	633
ED	30	29	27	19	25	43	33	39	34	31	27	39	376
Maternity	7	17	13	11	8	6	10	10	12	10	7	12	123
Health Visiting	8	8	4	6	6	3	4	8	7	3	2	6	67
School Nursing	0	2	0	1	0	1	0	0	0	0	1	0	5
Paediatrics	2	4	4	6	5	3	3	0	2	5	2	3	39
Other	3	0	1	0	4	4	0	2	1	0	4	6	25

Table 13

Number of multi-agency referrals forms sent by BHT to Children's Social Care 2017-2018

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Total MARFs from BHT	46	65	66	44	33	30	53	42	48	39	46	57	569
ED	29	43	56	37	17	20	31	30	34	21	25	28	371
Maternity	10	16	6	5	11	5	15	5	6	10	11	9	109
Health Visiting	3	2	2	0	3	3	3	3	6	3	5	7	40
School Nursing	1	1	1	1	0	0	1	1	1	1	1	0	9
Paediatrics	2	1	0	0	0	1	2	1	1	2	2	4	16
Other	1	2	1	1	2	1	1	2	0	2	2	9	24

Table 14

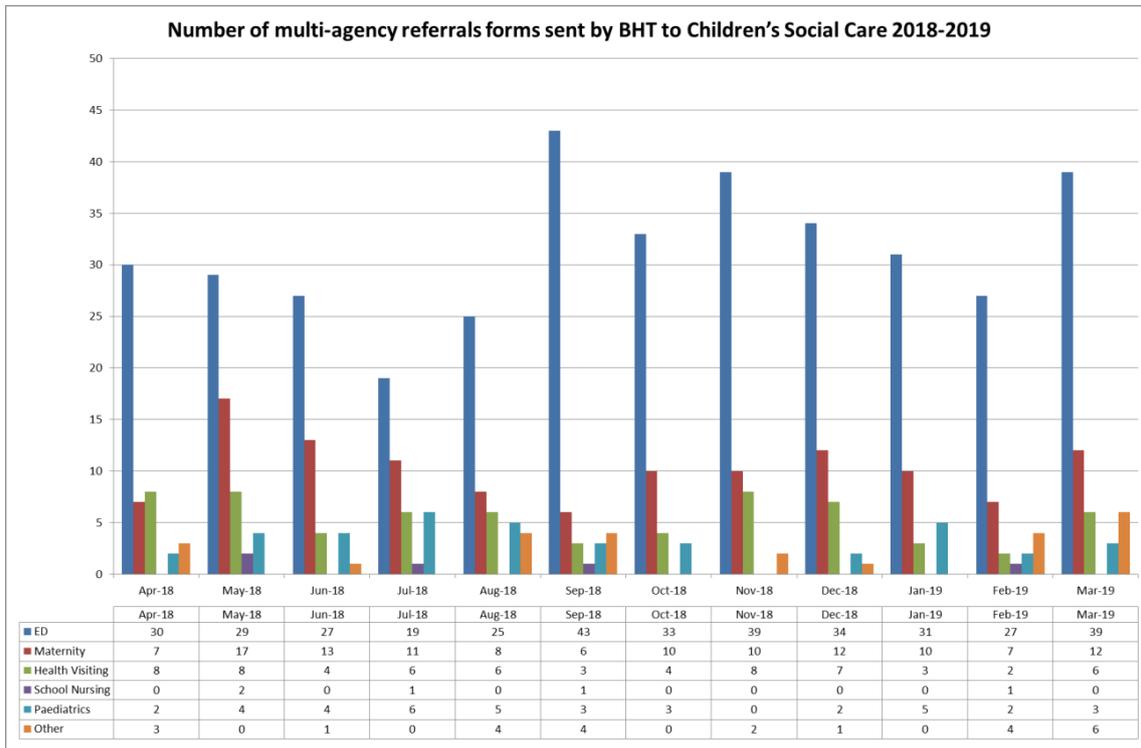


Figure 14

Figure 15 below sets out the comparisons between the number of MARFs for children completed by clinical area for the years 2017-2018 and 2018-2019.

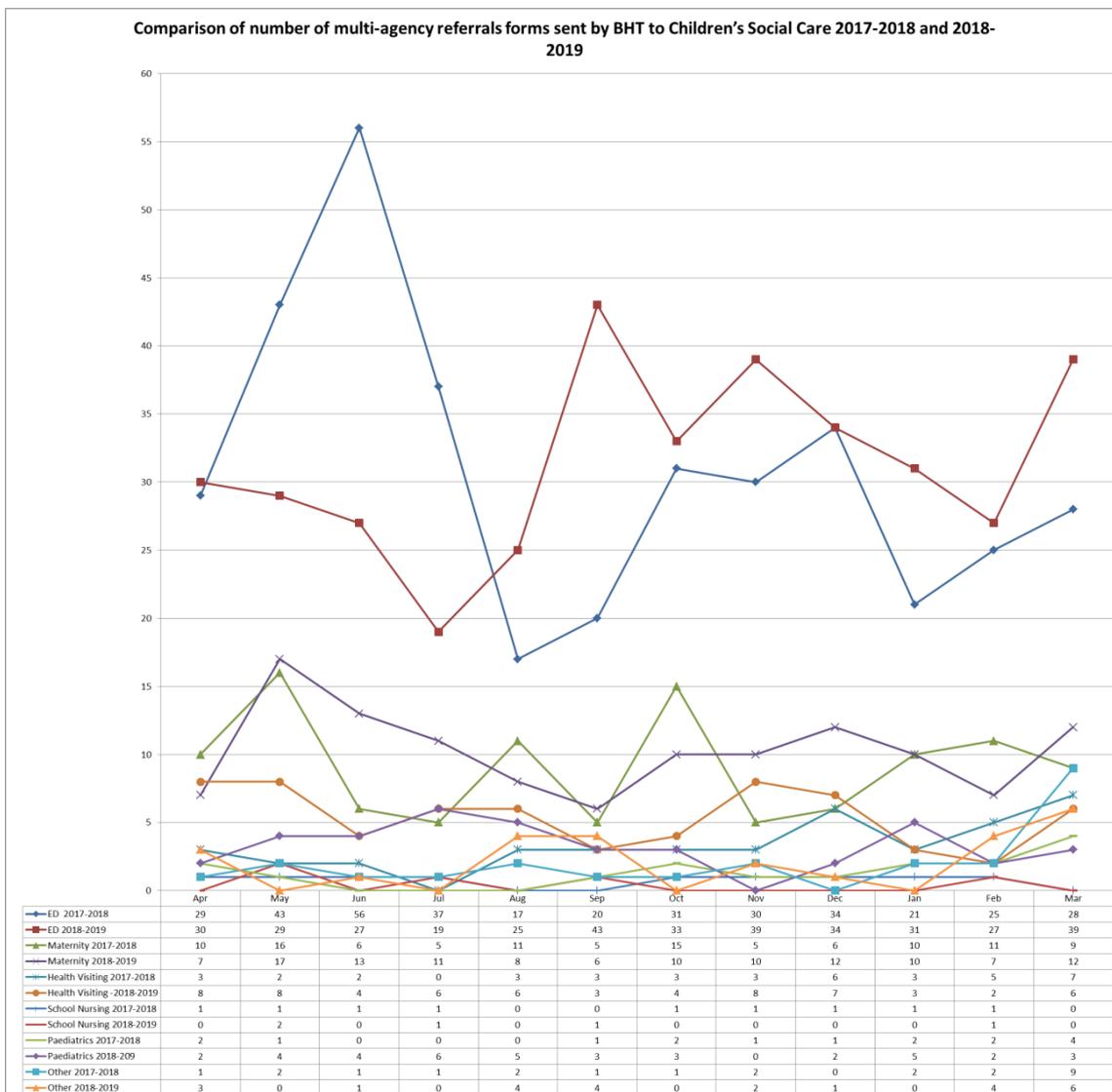


Figure 15

Children's MASH

BHT continues to provide regular nursing and administrative staffing for the children's MASH although at times this places a strain on Safeguarding Team resources. Whilst there are occasions when BHT cannot always provide nursing resource for the MASH due to competing priorities, there is still a good working relationship between BHT safeguarding personnel and all partners within the MASH.

The Safeguarding Team will continue to monitor the MASH commitment and will escalate concerns where necessary.

There has been positive feedback from the children’s social care MASH manager about the support provided by BHT personnel and it has been stated that virtual working by BHT children’s safeguarding team still enables the MASH to operate effectively, because the information required to inform MASH enquiries is still made available.

The BHT MASH administrator/researcher collates data about health activity and this is reported via the safeguarding dashboard. The data collected in respect of this reporting period is set out in table 15 and figure 16 below. BHT staff attend most MASH strategy meetings wherever possible.

Children’s MASH activity 01/04/2018 – 31/03/2019

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Tot
Total Number of MASH information requests	55	138	136	128	142	132	166	154	159	220	162	205	
Number of MASH enquiries	49	56	32	62	51	55	52	18	11	28	33	51	
Number of MASH Strategy meetings BHT requested to attend	50	74	49	38	37	38	48	39	55	41	14	41	

Table 15

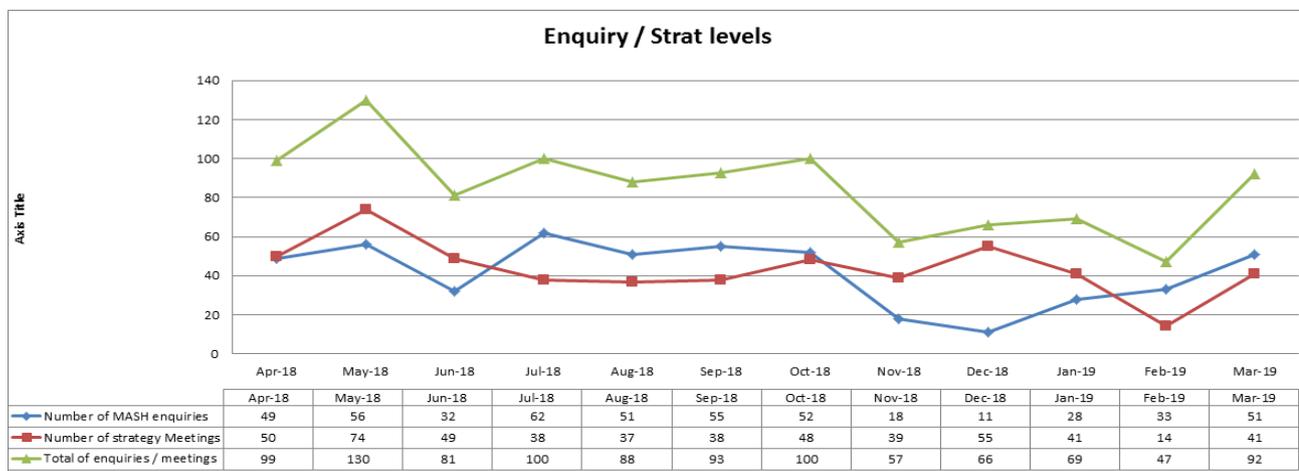


Figure 16

MASH contacts and referrals – general data

The reason that MASHs were initiated was to enable the rapid sharing of information in order to enable speedier risk assessment and appropriate responses to concerns raised by partner agencies about children who may be at risk of abuse. It must be noted that not all MARFs completed are passed to the MASH for consideration, so the data below does not reflect all the referrals (completed MARFs) for this reporting period made to children’s social care by BHT staff, and as set out in table 13 above.

All MARFs received by children’s social care are screened in order to assess the current risk and to also establish whether a child may be known already to a social worker. Where this is

the case, MARFs relating to open cases will in most circumstances by-pass the MASH and be sent directly to the social worker or team that knows the child or family.

Other circumstances in which a MARF does not reach the MASH are where the case is not judged to be in need of a child protection response and can be stepped down to family support or as a child in need. All referrals, whether accepted as requiring a social care response or not, should never result in “no further action”.

The data set out in tables 16, 17 and 18 below shows overall activity in relation to MASH referrals. The data has been shared by children’s social care so that partner agencies can see the nature and sources of concerns and referrals into the MASH. This is the first time that BHT has received data in this way; the continuing sharing of this information will assist partners in understanding patterns and in developing their services so that they may be able to better respond to the needs of children and their families.

Staff are able to contact the MASH to raise concerns about a child or family in order to seek advice, however not all of these concerns translate into child protection referrals. Table 16 shows the top 10 primary concerns identified in referrals to the children’s MASH

Top 10 primary concerns		
1st April 2018 – 31st March 2019	Contacts	%
Domestic violence (parent/carer)	285	22%
Request for information/agency check	180	14%
Neglect abuse	100	8%
Physical abuse	72	6%
Sexual abuse	71	6%
Mental health (child)	62	5%
Mental health (another person)	47	4%
Behavioural problems	46	4%
Alcohol misuse (parent/carer)	41	3%
Drug misuse (parent/carer)	34	3%
Other	348	27%
Grand total	1,286	100%

Table 16

Top 10 primary referrals		
1st April 2018 – 31st March 2019	Referral	%
Domestic violence (parent/carer)	96	22%
Sexual abuse	55	13%
Physical abuse	34	8%
Neglect abuse	31	7%
Mental health (child)	26	6%
Gangs	18	4%
Mental health (another person)	18	4%
Drug misuse (child)	17	4%
Alcohol misuse (parent/carer)	16	4%
Drug misuse (parent/carer)	16	4%
Other	100	23%
Grand total	427	100%

Table 17

Sources of contacts and referrals to Buckinghamshire children's MASH

Source of contacts and referrals				
1 st April 2018 – 31 st March 2019	Contacts	%	Referral	%
Anonymous	29	2%	8	2%
BCC services - other department	10	1%	6	1%
BCC services – social care child/adult	37	3%	28	7%
Education – not school	7	1%	5	1%
Health – A&E/111	76	6%	23	5%
Health - GP	33	3%	13	3%
Health – health visitor	25	2%	10	2%
Health – other primary service	42	3%	20	5%
Health – school nurse	31	2%	-	0%
Health services - other	3	0%	7	2%
Housing –LA or Housing Association	35	3%	2	0%
Individual – acquaintance, neighbour/childminder	69	5%	4	1%
Individual – family/relative/carer	2	0%	19	4%
Individual – other (stranger, MP etc)	22	2%	2	0%
Individual - self	82	6%	11	3%
Legal – court/ solicitor/CAFCASS	37	3%	-	0%
Legal – probation/prison	7	1%	5	1%
Other agency – independent/voluntary	16	1%	5	1%
Other local authority	67	5%	18	4%
Police (DV and other)	607	47%	214	50%
Schools	48	4%	27	6%
Unknown	1	0%	-	0%
Total	1,286	100%	427	100%

Table 18

Child protection conference activity

This is the second year of collating information regarding attendance at child protection conferences by BHT; data is also collected in respect of whether a written report has been submitted for the conference. BHT health professionals are expected to attend child protection conferences to which they are invited, especially when they have significant involvement with a child or family.

Attendance by BHT at Child Protection Case Conferences 01/04/2018 – 31/03/2019

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Invitation to Initial case conference	22	31	29	36	50	15	27	38	22	17	14	13	314
Attendance at both initial and review case conferences	52	71	67	85	79	31	76	65	39	55	33	17	670
Reports submitted to conference	46	82	68	69	78	34	86	66	37	75	30	11	682

Table 19

Attendance by BHT at Child Protection Case Conferences 01/04/2017 – 31/03/2018

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Invitation to Initial case conference	50	40	27	8	25	37	28	48	37	26	32	32	390
Attendance at both initial and review case conferences	68	85	145	30	60	136	42	113	56	47	59	81	922
Reports submitted to conference	54	46	41	28	36	51	53	107	69	75	71	90	721

Table 20

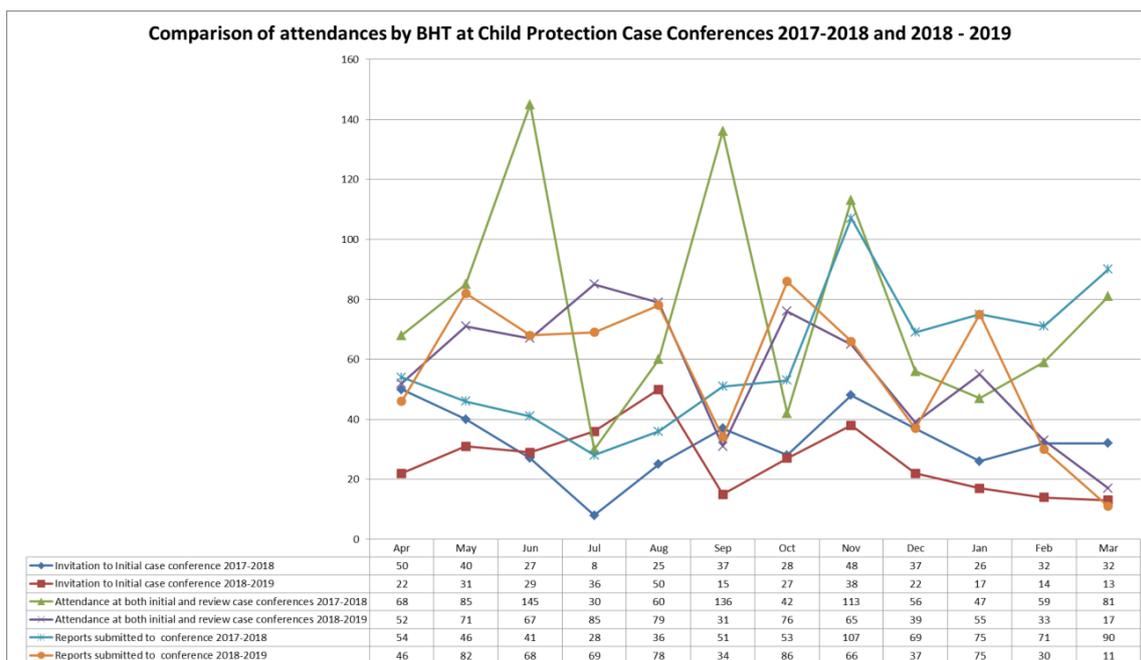


Figure 17

Tables 19 and 20 and figure 17 above show the activity over the past 2 years relating to child protection conferences. The year-on-year comparisons displayed in the charts above show that BHT staff are being invited to more conferences; this reflects the increasing number of child protection conferences that are taking place.

Attendance at child protection conferences is demanding on staff time and has ensuing consequences for the overall staff resource. The pressures on staff resources extend beyond attendance at conferences, since many BHT professionals are expected to attend additional meetings as members of the Core Group, to support the delivery of child protection plans. These issues are highlighted in the section on partnership working later on in this report.

Looked after children

The BHT looked after children (LAC) health team became part of the Safeguarding Team in April 2017. The service provides statutory initial and review health assessments for children coming into care and those who remain in care. A separate and detailed annual report in relation to LAC will be prepared by the NHS Buckinghamshire CCG Designated Nurse.

The Missing and Exploitation Hub

The Missing and Exploitation Hub (previously known as the Swan Unit) is based in Aylesbury Police Station and has been set up to provide a multi-agency response to address Child Exploitation (CE) within the Buckinghamshire area. The BHT Child Sexual Exploitation (CSE) Specialist Nurse is an integral partner of the co-located multi-agency unit; she is a member of the BHT safeguarding children team but works predominantly within the Missing and Exploitation Hub.

The Swan unit was originally established in order to focus on the recognised risks around Child Sexual Exploitation (CSE) but the remit now encompasses all aspects of Child Exploitation as there is increasing recognition of the fact that children and young people can be exploited in many different ways. A new approach to practice and system design known as **contextual safeguarding** is being adopted both nationally and locally in recognition that children and young people are frequently harmed within contexts of risk and vulnerability and in a range of settings beyond their families. Firmin (2017) recognises that:

Peer relationships are increasingly influential during adolescence, setting social norms which inform young people's experiences, behaviours and choices and determine peer status. These relationships are, in turn, shaped by, and shape, the school, neighbourhood and online contexts in which they develop. So if young people socialise in safe and protective schools and community settings they will be supported to form safe and protective peer relationships. However, if they form friendships in contexts characterised by violence and/or harmful attitudes these relationships too may be anti-social, unsafe or promote problematic social norms as a means of navigating, or surviving in, those spaces.

<https://contextualsafeguarding.org.uk/assets/documents/Contextual-Safeguarding-Briefing.pdf>

The recognition that sexual exploitation frequently coexists with many other forms of exploitation (e.g. modern day slavery, county lines and gang culture) and the move towards an approach of contextual safeguarding practice, has meant that the role of the CSE Specialist Nurse has expanded to encompass all aspects of child exploitation. The role has extended to include work not just with children and young people aged less than 18 years, but also young adults up to the age of 25 years, and entails the coordination of a health response to child exploitation within Buckinghamshire.

In addition to the developing work around contextual safeguarding, the 2018 revisions to the statutory guidance, *Working Together to Safeguard Children*, have recognised the changing nature of the vulnerabilities faced by children and young people, and advise that more attention is paid to children and young people who are:

- At risk of gang involvement and association with organised crime groups;
- Frequently missing/absent from home;
- Misusing drugs or alcohol themselves;
- At risk of modern slavery, trafficking, exploitation; or
- At risk of radicalisation.

Through effective partnership working, the Missing and Exploitation Hub works to reduce children and young people's vulnerabilities to child exploitation. The key aspects of the Missing and Exploitation Hub are;

- the identification of young people at risk of or who have experienced child exploitation,

- the co-ordination of information and intelligence about victims and perpetrators of child exploitation
- a strong focus on preventative work and reducing the risk of further harm.

Fortnightly MACE (Multi Agency Child Exploitation) meetings continue to be held in order to jointly assess the exploitation risks for each individual child who is referred, and a decision is made to accept or decline the referral into the Exploitation Hub for further assessment and intervention. In addition, action plans will be developed for the child, family and professionals already involved. Figure 18 below sets out the data relating to cases discussed. Data for previous years is not comparable because of the changes to the way the Missing and Exploitation Hub works and the move away from individualised health assessments being carried out by the Specialist Nurse.

Going missing is a key indicator of exploitation, so in order to assist the work of the Missing and Exploitation Hub, BHT has committed to using the multi-agency data base for the management of missing person cases (ELPIS). The use of the ELPIS software within the Trust has been presented to, and approved by all appropriate strategic and operational information governance groups within BHT.

The use of ELPIS also contributes to the effectiveness of the Missing Patient Policy which has been jointly developed by BHT in conjunction with Thames Valley Police (TVP) and also involves services delivered by BCC and Oxford Health NHS Foundation Trust (OHFT).

When patients or service users go missing a coordinated, multi-agency approach is required and ELPIS is a valuable tool which enables information to be shared securely in order to achieve this. Health information added to the ELPIS database will include the following:

- pertinent demographic/social information held by BHT that might aid the Police in their search;
- whether the missing person has attended acute services
- whether the missing person is known to BHT community services; and
- any diagnosis that may increase vulnerability or the risk of harm during the missing episode, such as diabetes.

Whilst the current focus of the BHT Specialist Nurse is on missing children and young people, future plans are to incorporate missing adults.

Whilst the nature of the work of the BHT Specialist Nurse has evolved, the post holder who is employed to work 0.6 WTE hours continues to ensure BHT practitioners have greater understanding and awareness of the risks to children when they go missing and of child exploitation. There has been an increase in the delivery and uptake of specialist training as well as the provision of advice and support to all staff within BHT and to other health practitioners in relation to child exploitation. This extension of the role of the CSE Specialist Nurse has inevitably placed an increased demand on the post holder as well as the wider Safeguarding Children team who work to support the role.

Figures for Children discussed within MACE- April 2018- end of March 2019

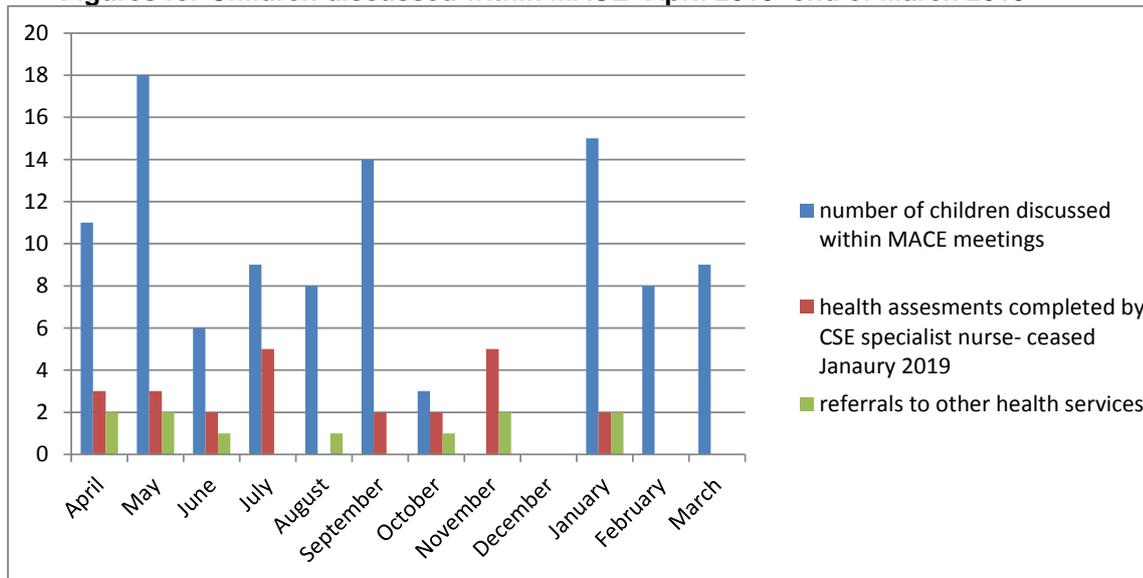


Figure 18

Learning Disability Liaison

The health needs of people with a learning disability continue to be well documented. The Learning Disability Liaison Nurses (LDLNs) strive to ensure that patients with a learning disability and their carers receive excellent care from BHT.

In the course of the past last 12 months the work of the LDLNs has continued to develop and the service continues to ensure that adults with a learning disability can be treated effectively through:

- direct patient contact with patients and their families by LDLNs;
- training and supporting BHT staff to work effectively with patients with LD;
- promoting a culture of making reasonable adjustments and ensuring that legislation is followed;
- supporting and promoting the principles of accessible information standards;
- promoting the “think TWICE” approach (see appendix 3).

During the past year the LDLNs have observed an increase in referrals and enquiries for patients with autism, not all of whom will have a recognised learning disability. Whilst the LDLN service was originally established to support adults with a diagnosed learning disability to successfully access hospital care, this does not necessarily prevent their expertise from being applied in other circumstances. This does mean however that that the LDLNs are supporting a wider population of patients who may have some additional communication needs.

The plan for the coming year is for the LDLNs to monitor whether a person has a learning disability, autism or both; this data will be reported in the safeguarding annual report for 2020-2021 and will help in the development of the current service.

The LDLNs are identifying an increasing need to provide support for more complex clinical cases, where greater planning and preparation is required in order to enable the patient to access the procedures they need. This work entails the person with LD meeting the LDLNs before an appointment in order to develop trust; assisting in visits to clinical areas to prepare the patient for forthcoming treatment and providing them with information in the form of photographs of clinical areas or specific clinical procedures. The LDLNs have developed guidance to assist in supporting people with a learning disability and this is available to staff on the Trust intranet.

The LDLNs have recognised that the Trust uses different patient information systems and are now flagging patients with learning disabilities to ensure that they are identifiable on Medway, Evolve and Rio. Currently the flagging of records applies only to adults with learning disabilities but a process is now being developed to ensure that people of transitional age are flagged also.

The LDLNs provide training at corporate induction along with the dementia specialist nurse. The joint session enables the specialist nurses to focus on the patient's needs regarding communication and the environment. The training has been very well received as it raises staff awareness of their responsibilities and also provides practical skills and advice.

The LDLNs are responsible for providing a wide range of training including bespoke programmes; departments including, physio and outpatients have received bespoke training to support their audit programmes. They also provide training for Trust staff at induction and support the delivery of training for MCA and DoLS, as well as providing practical support for staff in respect of mental capacity assessments.

In addition to all of the above, during the reporting period the Trust LDLNs have:

- worked closely with the Trust nutrition specialist nurse in respect of complex cases;
- worked with the Trust nutrition speech and language therapists regarding dysphagia;
- worked closely with education services to develop mandatory training for staff with regard to learning disability and autism;
- worked with partner agencies on LeDeR reviews - CCG, GPs, social care, other providers etc;
- monitored and reviewed the BHT do not resuscitate (DNACPR) guidance;
- presented a patient story to Trust Board;
- attended the county LD provider forum to provide advice/training and gather feedback on experiences of care within BHT;
- provided information and training on the ED grab sheet, expectations of partnership working and assisted in the development of handover information for when a person with LD comes in to hospital; and
- completed the NHSI benchmarking tool and look forward to the recommendations that emerge from this.

Table 21 and figure 19 below show the number of requests for assistance from the BHT LDLNs for the reporting period, both from within BHT and from external providers. Peaks in request can be observed for the months of August and November. Understanding the pattern of requests will require further analysis and will form part of the audit programme for the coming year, although susceptibility to winter illnesses may explain some of the high demand times.

Information in relation to LD liaison activity continues to be reported on the safeguarding dashboard. The data is indicative of increasing demand for the services; during the reporting

period the LDLNs received $n = 323$ referrals as opposed to 200 for the previous reporting period, an increase of $n = 123$ (61.5%). This increasing activity – see figure 20 below - shows greater staff awareness and appreciation of the service provided by LD liaison, and also demonstrates appropriate responses by staff to the needs and rights of people with LD who access health care.

Learning Disability- requests for advice/support 01/04/2018 – 31/03/2019

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Total Number of requests	28	22	20	26	38	21	26	44	31	23	12	32	323
From BHT	15	15	13	12	29	12	17	36	20	13	9	20	211
From external providers	13	7	7	14	9	9	9	8	11	10	3	12	112

Table 21

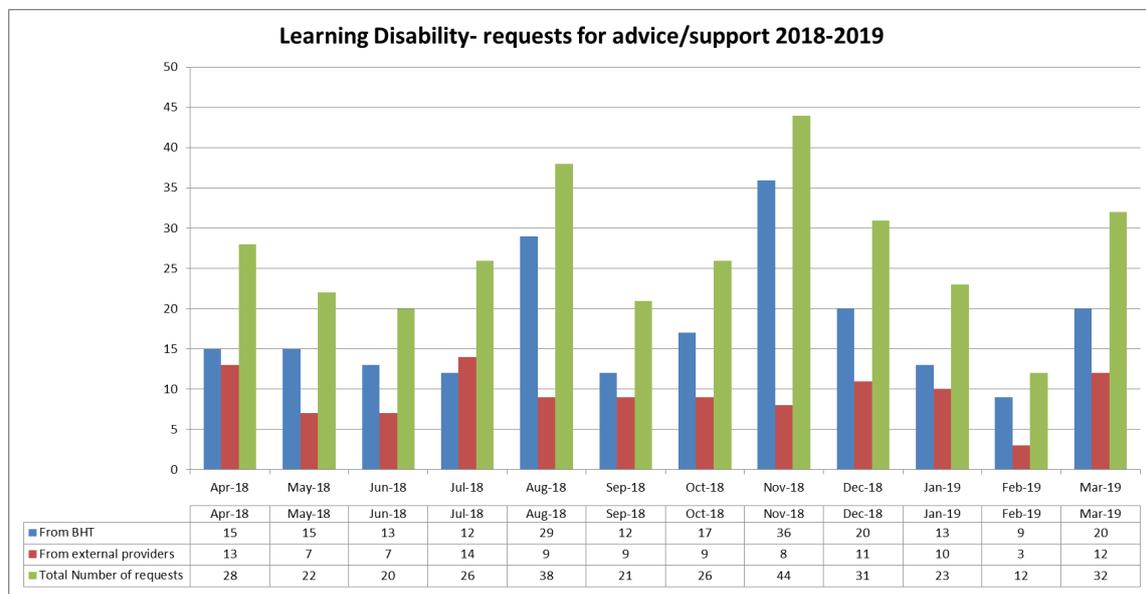


Figure 19

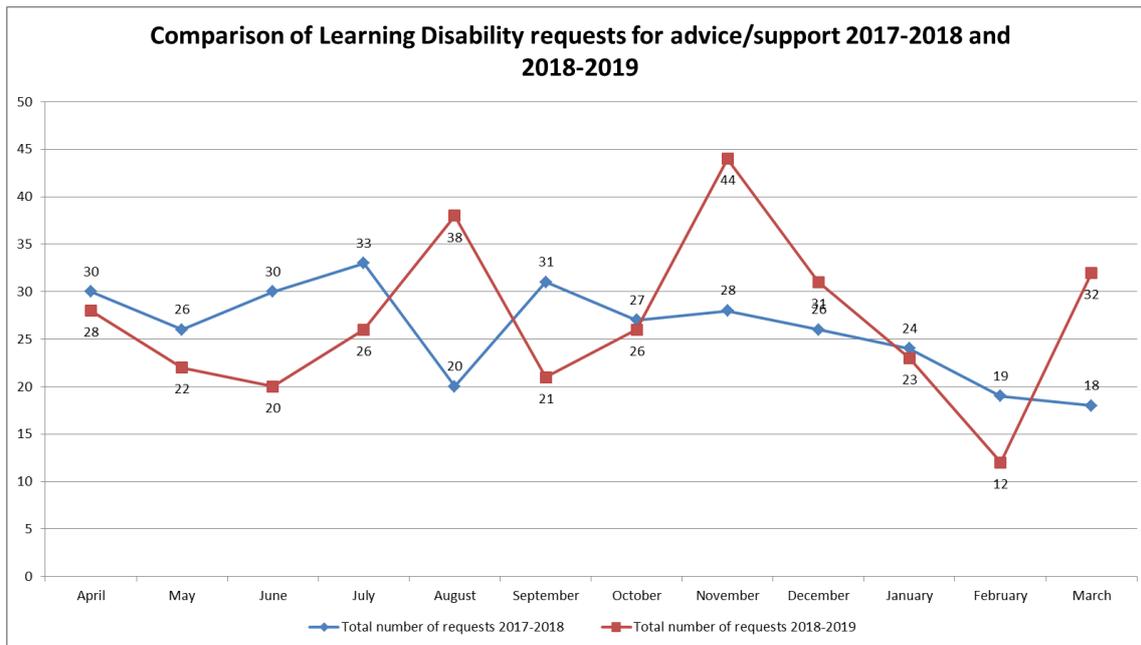


Figure 20

Incidents and Complaints

Providers should use incidents and complaints to identify potential abuse and should take preventative actions, including escalation, where appropriate.
(CQC Regulation 13)

The interface between the SI reporting and management process and local safeguarding procedures is articulated in the NHS England Serious Incident Framework. In determining whether a safeguarding-related incident meets the definition of an SI, the following criteria will be considered:

- Pressure Ulcer incidents that result in severe harm (Grade 4 pressure tissue damage);
- Abuse/alleged abuse of an adult patient by staff;
- Abuse/alleged abuse of an adult patient by a third party (if on Trust Premises or by another patient);
- Abuse/alleged abuse of a child patient by staff;
- Abuse/alleged abuse of a child patient by a third party (if on Trust Premises or by another patient);
- Actual or alleged abuse; sexual abuse, physical or psychological ill-treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking and modern day slavery where:
 - The Trust did not take appropriate action/intervention to safeguard against such abuse occurring; or abuse occurred during the provision of the Trust’s care.
 - This includes abuse that resulted in (or was identified through) a Serious Case

Review (SCR), Safeguarding Adult Review (SAR), Safeguarding Adult Enquiry or other externally led investigation, where delivery of NHS funded care caused/contributed towards the incident.

The Safeguarding Team continues to work closely with the patient Safety and Complaints Teams and Tissue Viability Nurses (TVNs), Trust senior managers and HR in order to support investigations of all types which may involve harm to a patient potentially having been caused by abuse.

Set out in table 22 are safeguarding incidents by division; as anticipated and as is consistent with the previous year's data, the Integrated Medicine and Elderly and Community Care divisions are the top two referrers. Since both these areas provide care for with some of the most complex and vulnerable patients, it is to be expected they will observe and report more safeguarding-related incidents. Higher levels of referral do not necessarily need to be viewed negatively and can be indicative of greater awareness and lower tolerance of abuse by staff. Conversely, extremely low referral rates may also be worthy of attention.

Datix Incident safeguarding adults reports by source 01/04/2018 – 31/03/2019

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Grand Total
Division of integrated Elderly & Community Care	18	19	12	15	12	12	26	10	12	7	8	6	157
Division of Integrated Medicine	9	16	18	18	11	4	9	6	5	9	9	15	129
Division of Surgery & Critical Care	3	1	5	2	1	1	0	1	1	0	2	3	20
Division of Specialist Services	3	0	5	1	0	0	0	0	0	0	0	1	10
Division of Women, Children & Sexual Health Services	0	1	0	0	0	1	1	0	3	0	0	0	6
Division of Corporate/Non Clinical Support Services	0	2	0	0	0	0	1	0	0	0	0	0	3
Monthly totals across all divisions	33	39	40	36	24	18	37	17	21	16	19	25	325

Table 22

Below – table 23 - are the top six safeguarding-related incidents reported using the Datix incident reporting system. Not all the incidents reported as safeguarding concerns on Datix translate into safeguarding adult referrals; nonetheless these incidents are worth further attention and exploration, especially those incidents relating to ongoing care and discharge.

Most reported safeguarding adult datix incidents by nature of concern 01/04/2018 – 31/03/2019

Incident detail	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Pressure sore / decubitus ulcer	13	10	14	9	11	6	12	3	5	5	5	6	99
Possible delay or failure to													

monitor	1	5	6	3	3	2	5	0	3	4	3	4	39
Implementation of care or ongoing monitoring - other	0	1	2	7	0	2	2	3	2	2	5	7	33
Discharge	2	3	3	2	3	1	5	2	1	1	0	3	26
Abuse - other	1	5	3	1	2	2	2	1	3	3	1	0	24
Slips, trips, falls and collisions	2	1	0	2	2	1	1	2	0	0	0	1	12

Table 23

The Safeguarding Team continues to support the Complaints Team and PALS in relation to complaints and has been consulted on several occasions in the past year. The main learning from these complaints has been to recognise that training must reinforce respectful communication by staff when pursuing a safeguarding concern.

When dealing with allegations of abuse against staff, the Trust follows the multi-agency procedures set out by the Buckinghamshire Safeguarding Adults Board (BSAB) and Buckinghamshire Safeguarding Children Board (BSCB).

Partnership Working

Providers should work in partnership with other relevant bodies to contribute to individual risk assessments, developing plans for safeguarding children and safeguarding adults at risk, and when implementing these plans.
(CQC Regulation 13)

BHT works responsively and transparently to recognise and report any possible risk to patients and service users, including any potential or identified risk from staff or volunteers of the organisation. The Trust works cooperatively with appropriate statutory agencies to address and monitor concerns and subsequent action plans. The Trust always refers to the relevant professional bodies whenever concerns have been raised about registered practitioners.

BHT continues to work in partnership with all relevant agencies in order to safeguard the most vulnerable children and adults at risk from abuse. This is done by attendance at key meetings at all levels and sharing information and escalating concerns with the aim of improving outcomes for all vulnerable people.

The Trust is able to provide evidence of attendance at all relevant partnership meetings by its staff, and at the right level of seniority for the particular meeting. These may be either frontline or more strategic meetings aimed at sharing information for strategic planning, responding effectively to people in mental health crisis, to families in need, to child protection and safeguarding adult concerns as well as to reports of exploitation, domestic abuse or radicalisation and include:

- Safeguarding adult and children’s board sub groups;
- Children’s Partnership Board;
- Corporate Parenting Panel;

- Domestic Abuse Multi-Agency Risk Assessment Committee (MARAC) operational meetings and steering group;
- CDOP;
- MACE meetings

Significant changes to partnership working are being initiated as a result of changes to statutory guidance (*Working Together to Safeguard Children 2018*); one of the most prominent changes is the replacement of Local Safeguarding Children Boards (LSCBs) with Safeguarding Partners.

In order to comply with the new Statutory *Working Together* guidance, from September 2019 Local Safeguarding Children Boards will be replaced by new local safeguarding arrangements, led by three safeguarding partners. BSCB is currently working on the transition to the new arrangements.

The revised statutory guidance states that Safeguarding Partners will consist of the following three agencies:

- Local Authorities;
- Clinical Commissioning Groups; and
- Chief Officers of Police.

These Safeguarding Partners will work with relevant appropriate agencies within their locality to safeguard and protect children. Relevant agencies are those organisations and agencies whose involvement the safeguarding partners consider may be required to safeguard and promote the welfare of children with regard to local need. The revised statutory guidance means that BHT will no longer be required to be a lead member of the new partnership arrangements.

All three Safeguarding Partners have equal responsibility for fulfilling the role. The revised statutory guidance stipulates that the three safeguarding partners should:

- agree on ways to co-ordinate their safeguarding services;
- act as a strategic leadership group in supporting and engaging others; and
- implement local and national learning including from serious child safeguarding incidents

BHT continues to contribute appropriately to statutory multi-agency reviews aimed at learning lessons from adverse outcomes in respect of safeguarding incidents and events. These reviews to which BHT currently contributes include:

- Child serious case reviews (SCRs);
- Child death overview panels (CDOP);
- Safeguarding Adult Reviews (SARs);
- Domestic homicide reviews (DHRs);
- Learning disability death reviews (LeDeRs)

The new safeguarding partnership arrangements for children, as explained above, may lead to different ways of learning from serious incidents relating to children.

The Trust makes annual financial contributions of £750 per annum per desk (there are 2 health desks) towards the operational costs of the Multi- agency safeguard hub (MASH) and also contributes financially to the safeguarding adults and safeguarding children's boards (BSAB and BSCB). Additional contribution to partnership working is achieved as follows:

- clinical and administrative personnel to work in the children's MASH;

- access to practitioners who able to provide information to assist enquiries being made by the adult MASH;
- a clinical practitioner to work in the Buckinghamshire Missing and Exploitation Hub
- regular involvement in the Risk Assessment Multi-agency Panel (RAMP) which supports practitioners working with high risk safeguarding adults cases.

Frontline practitioners in BHT work well in partnership with colleagues in social care and other agencies; this is often through the sharing of information in the form of referrals, contributing to investigations and attending meetings or conferences aimed at safeguarding adults or children when the risk of harm is considered to be high.

The continuing development of the national child protection information sharing system (CP-IS) within BHT is proving effective. CP-IS connects the systems used by local authority children's social care teams with those used by NHS unscheduled care settings. It ensures that health and social care professionals are notified when a child or unborn baby with a Child Protection Plan, or looked after child (LAC) status, is treated at an unscheduled care setting. As well as being fully operational in ED, CP-IS is now being used in maternity services and will become operational in children's ophthalmology urgent care setting in the coming year.

The Trust Safeguarding Team continues to work with and support partners in mental health services, including the psychiatric in-reach liaison service (PIRLS) and other practitioners employed by Oxford Health Foundation Trust (OHFT)

Members of the Team attend the monthly Partnership in Practice meeting (PiP) meetings at the Whiteleaf Center in Aylesbury; the meeting supports the joint care and treatment of people with mental health needs through:

- monitoring the use of section 136 MHA 1983 and the use of "place of safety" as defined in section 135(5) MHA 1983;
- addressing any concerns with regards to the application of the Mental Capacity Act / Mental Health Act;
- monitoring episodes of absence and absconsions from in-patient care;
- discussing concerns that have arisen between agencies in the preceding month and agreeing actions and responsibility to address those concerns.

The Trust's frontline practitioners work well with their counterparts in social care and other agencies; this is often through the sharing of information in the form of referrals; contributing to investigations and attending meetings or conferences aimed at safeguarding adults or children when the risk of harm is considered to be high. When necessary all partner agencies are expected to challenge each other when practice falls below the expected standards.

The revised statutory guidance, *Working Together to Safeguard Children (2018)* stipulates that "organisations and agencies challenge appropriately and hold one another to account effectively" (p.74). It is important that professional challenge is seen as a positive step which is directed at ensuring that children and their families receive the right level of intervention and support. The same principles apply in respect of safeguarding adults.

Where concerns are not addressed they must be escalated in accordance with agreed local multi-agency procedures. When this happens effectively there are more likely to be good outcomes for vulnerable children and adults at risk. Set out below is an example of professional challenge led by BHT community children's services.

Example of effective escalation to enable partnership working

Background

In the course of the past year, members of the Trust Safeguarding Children Team began to identify via anecdotal reporting by frontline community practitioners, that an apparently increasing number of multi-agency child protection meetings were not taking place. The reasons being given were either because of very late cancellation or non-attendance by children's social care.

The cancellation of these important meetings raised concerns about children possibly not being effectively safeguarded, and their families supported. The meetings involved and the supporting legislation are explained below and are also set out in table 18 and figure 21.

Accessing help and services for children and their families

Where a child's need is relatively low level, individual services and universal services may be able to take swift action. Where there are more complex needs, help may be provided under **Section 17** of the Children Act 1989 (children in need) and where there are child protection concerns, local authority social care services must make enquiries and decide if any action must be taken under **Section 47** of the Children Act 1989.

All assessments aimed at providing help and support to, or protecting children from harm require a coordinated multi-agency approach, including the holding of meetings to share information and formulate plans.

Children and families may need coordinated support and protection from a wide range of local organisations and agencies; the agency responsible for leading assessments to address concerns is local authority children's social care.

Section 17 of the Children Act 1989 requires that local authority children's services must determine what services should be provided to a **child in need**. Identifying and addressing the needs of children in need is a key element of early help and support. Children in need may be:

- children with special educational needs and disabilities (SEND);
- young carers;
- children who have committed a crime;
- children whose parents are in prison; or
- asylum seeking children.

The purpose of a child in need meeting is to enable professionals and family, including the child (where age appropriate), to meet together to share information, identify need, and agree the most effective inter-agency plan to meet those needs, with measurable outcomes for the child identified within stated timescales. Typical venues for these meetings might be a local children's centre, a school, a library/community centre or the Children's Services offices.

Child in need meetings may also identify that it is necessary to "step up" to a child protection plan by requesting a child protection conference take place.

A **child protection conference** must be convened when child protection enquiries (section 47 Children Act 1989) substantiate concerns of significant harm. The purpose of a child protection conference is to bring together and analyse, in an inter-agency setting, all relevant information and plan how best to safeguard and promote the welfare of the child or children.

The timing of the conference depends on the urgency of the case and must respond to the needs of the child and the nature and severity of the harm they may be facing. The **initial child protection** conference should take place within 15 working days of a strategy discussion, or the strategy discussion at which section 47 enquiries were initiated.

It is expected that all invited professionals provide information about their agency's involvement ahead of the conference and that they attend at the given date and time. All agency representatives who attend a child protection conference contribute to the decision as to whether or not a child or children are at risk of significant harm and need to be placed on a child protection plan.

When a child protection plan is agreed, progress will be monitored by a regular review process. This process includes regular **core group meetings** and **review child protection conferences**. The Core Group is responsible for the implementation, review and where necessary, the modification of the child protection plan, with the ultimate aim of making sure that the plan is keeping the child safe. The initial child protection conference identifies the membership of the core group of professionals and family members who will develop and implement the child protection plan, and establishes timescale for core group meetings.

A review child protection conference considers the reports from core group members and the effectiveness or otherwise of the agreed child protection plan, and decides whether the child is still at risk of harm and needs to remain on a plan or can be "stepped down" as a child in need.

Professional meetings can be convened by any practitioner who may be involved with a child and family. They are less formal in nature and have no legal status; they are however important meetings whereby professionals can get together to safely share information and agree whether more formal action needs to be taken.

A **LAC review** is a regular meeting that brings together those people who are closely concerned with the care a looked after child. It is an opportunity to:

- review the child's care plan;
- discuss progress against the plan;
- make plans for the future.

Promoting the health and well-being of LAC is a statutory requirement placed on local authorities but this can only be achieved through robust partnership working with health services.

Actions taken in respect of cancelled meetings

In response to the concerns raised by frontline practitioners, the initial response from BHT was that members of the children's safeguarding team raised concerns with managers in BCC children's social care. Whilst children's social care was open to challenge, without concrete evidence it was difficult to take the matter any further.

In order to establish whether this was a significant issue, the Safeguarding Team advised the health professionals who were involved to complete a Datix incident report for every meeting that did not take place. This practice started in October 2018 and the findings are showing that the issue is one of significance – see table 24 and figure 21 below.

A formal report analysing the information gathered has been prepared by the BHT Clinical Governance Coordinator for Children and Young People and the evidence has been shared with the BCC Children’s Services Head of Quality, Standards and Performance in her role as Chair of the BSCB Performance and Quality Assurance Sub-Group.

It is expected that by providing evidence of, and escalating concerns, any identified deficits in the provision of services for the most vulnerable children can be monitored more effectively and ultimately improved. The costs involved do not only have implications for the wellbeing of children and families, as there are also financial implications for the Trust with every missed or cancelled meeting.

The collection of data using Datix incident reporting continues into the current year, as the problem has not yet been resolved. The ongoing work being carried out by BHT community children’s services has been extended, in that it is now evaluating every cancelled meeting in relation to staff time wasted as well as travel and parking costs. The consequences of wasted NHS resources are that the capacity to provide services to vulnerable families may be negatively affected.

Children’s Meetings Cancelled 01/10/2018 – 31/03/2019

Meeting by type	CIN	ICPC	RCPC	Core Group	LAC Review	Professional Meeting	Grand Total
Total cancelled between 1st Oct 2018 & 31st March 2019	13	5	11	26	1	1	57

Table 24

Glossary of abbreviations used in table n

- CIN** Child in need
- ICPC** Initial child protection conference
- RCPC** Review child protection conference
- LAC** Looked after child

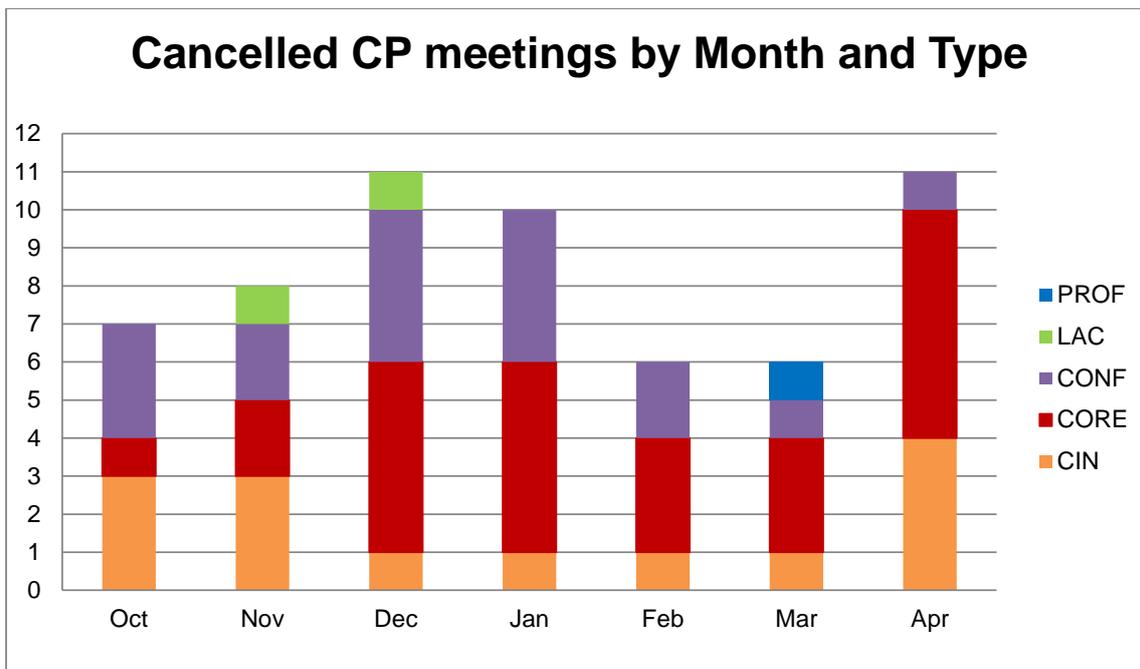


Figure 21

The Safeguarding Team

The Trust Safeguarding Team ensures that the Trust is fulfilling its safeguarding responsibilities through routine provision of training, supervision and day-to-day advice for staff, and through effective partnership with other agencies and bodies. Partnership responsibilities entail working together to ensure better outcomes for vulnerable children and adults at risk of abuse and escalating concerns when we identify deficits within the safeguarding system.

For the period of this report the BHT Safeguarding Team has included the following functions:

- Learning Disability Liaison
- Looked After Children
- Safeguarding Adults
- Safeguarding Children

As of 1st April 2019 the Looked after Children’s Team has reverted to the Children and Young Peoples 0-19 service.

In line with national and local requirements a separate stand-alone report will be provided for the Trust Board in August 2018 in order to provide assurance that BHT is meeting statutory requirements for LAC.

Safeguarding Adults

The BHT safeguarding adult service continues to develop in response to increasing demand and regulatory expectations. The team members are developing well and demonstrating that

they are able to work independently and understand the needs adults at risk as well as those of BHT staff. They have developed excellent working relationships with all BHT clinical and non-clinical teams so that the principles of safeguarding, as well as MCA and DoLS activity can be embedded into every day practice.

It is anticipated that this section of the safeguarding team will need to develop further in order to be in a position to help implement the forthcoming reforms to MCA and DoLS which will see the new liberty protection safeguards (LPS) replace current DoLS arrangements.

The Trust may also need to consider appointing a Named Doctor for Safeguarding Adults as has happened in other NHS organisations; whilst this role is not a statutory requirement in the same way that is the equivalent role in children's safeguarding, to create this post would reinforce the commitment by BHT already demonstrates to safeguarding adults.

Safeguarding Children

Similarly to the adult's safeguarding team, the Trust children's safeguarding team continues to evolve in accordance alongside changes to statutory guidance as well as local partnership requirements. A new Named Doctor for Safeguarding Children joined the service in quarter 4 of the reporting period and is working closely with the Children Team Named Nurses to make a real difference to clinical practice.

The children's team continues to be visible across all Trust services in order to build and strengthen relationships with all practitioners; this is largely done through:

- daily walkabouts in the paediatric areas;
- the role of the paediatric liaison nurse;
- attendance at team, and governance meetings,
- working assertively with assigned divisions;
- delivery of training – routine and ad hoc on request;
- delivery of safeguarding supervision;
- ad hoc consultations with various staff groups. .

Learning Disability

The LDLNs are a much appreciated part of the Safeguarding Team and add value in a range of different ways; they are particularly skilled in communicating well with hard to reach patients and are able to share those skills with the wider team. Their knowledge in the application of the MCA and DoLS is also a bonus, and they have supported frontline staff in respect of a wide range of patients - not always those with a learning disability – to correctly assess mental capacity and, where necessary implement DoLS. Their work is more fully explained above.

Safeguarding Week

In February 2019 the Safeguarding Team held another safeguarding week; this is the second time such an event has been undertaken and the team was able to build on the previous year's experiences to make this an even better occasion.

The aim of the event was to promote safeguarding, making it highly visible throughout the organisation. Walkabouts, special training events and safeguarding promotional stalls were held in a wide range of sites and venues across the whole of the county. In preparation for the event

a range of safeguarding information posters and leaflets were developed and printed, and these were delivered to every clinical area with a view to them being prominently displayed so as to provide guidance for staff.

The event was formally evaluated and a summary report was written and shared at the Trust Safeguarding Committee and at other meetings.

Mental Health

The Mental Health Act is identified by CQC as a key piece of legislation in respect of safeguarding people. A great deal of work has been happening in BHT to ensure that patients who present with mental health conditions receive the best care possible.

BHT has in place a Mental Health Act Administration Policy which is available on Swanlive. This was developed in conjunction with our colleagues from Oxford Health Foundation Trust, especially Psychiatric In-Reach & Liaison Service (PIRLS). The policy has been promoted to key groups of staff, especially those working in ED and the Site Team.

The Trust now has a Mental Health Group that meets quarterly. Membership comprises key personnel from within the Trust and from external partner agencies. This is an embryonic group and has met 3 times in the past year. It is hoped that the group will develop and mature over time in order to support good practice and provide evidence of BHT's MH activity.

The Trust has worked with colleagues from Oxford Health Foundation Trust on a joint response and action plan following a Healthwatch Bucks survey on patients' experiences of health services following a self-harm injury, and in particular ED. An action plan has been developed and will be monitored via the MH Group.

The Safeguarding Team has been actively working with the Public Health Lead for Mental Health in order to better understand and engage more effectively in local mental health networks. As part of this work, an opportunity to undertake a Suicide First Aid course was offered free of charge to BHT personnel. A member of the BHT Chaplaincy Team has successfully undertaken this training and has started to deliver the programme. It is anticipated that other members of the Trust will undertake the training to support this individual.

The maternity safeguarding team has increased as a result of additional funding secured by the Head of Midwifery; in addition to a band 7 Mental Health Midwife (1WTE), a band 6 midwife (1WTE) and a band 3 Maternity Support (1WTE) worker have been recruited. This will support more continuity of care for mothers, and closer working with the Specialist Health Visitor for Maternal and Infant Mental Health.

Whilst there is evidence that progress has been made in the area of mental health, it is recognised that further development is still required in respect of the provision of mental health care to BHT patients.

Update on Previous Year's Objectives and Future Work Plans and Developments

The following provides an update on the progress made by the Safeguarding Team against the objectives set out in the Safeguarding Annual Report for the year 2017 – 2018:

- **MCA and DoLS** – the team has put a lot of effort into supporting clinical areas and, although there is more to do there are signs of progress as witnessed when the team walks the wards and also in the data presented for this report.
- **Making Safeguarding Personal** – this is all about personalised care and engaging with patients, carers and families in accordance with expectations set out in the Care Act 2014. The principles have been promoted through training events and at team meetings, as well as opportunistically. The Team has worked with local authority colleagues to promote the “What might good look like guidance” – see link below. This work will continue.

<https://www.local.gov.uk/sites/default/files/documents/25.27%20-%20CHIP%20Making%20Safeguarding%20Personal%3B%20What%20might%20%E2%80%98good%E2%80%99%20look%20like%20of.-2.pdf>

- **Self-neglect** – this is an area of concern for many practitioners and in particular those working in community services. The topic is covered in training and the Team has worked to support clinical teams in managing individual cases. Whilst learning happens as a result of managing patients who self-neglect, these are often complex and distressing situations for the staff involved. The Safeguarding Team provides ongoing support and supervision for clinicians working with these cases.
- **Supporting staff in ED** who work with children and young people to respond effectively and consistently to suspected child abuse. The safeguarding children named nurses and paediatric liaison nurse have worked assertively throughout the past year to support staff in ED. There has been a notable improvement in practice which is supported by the data showing increased numbers of safeguarding children referrals.
- **Care of children and young people aged over 16 years on adult wards** – Greater numbers of staff working on adult wards have received safeguarding children training and the named nurses have spent more time within the past year supporting staff in these areas. When the safeguarding nurses become aware of any incident, especially gang-related, that leads to the admission of a young person to an adult ward; assertive support is provided for the relevant clinical areas.
- **Working with children’s and adult services to ensure seamless transitions for children and their families into adult services** - A transitions group has been established by one of the Trust’s consultant paediatricians. This group is supported by the LDLNs, the LAC nurse and wider safeguarding team and has been promoted to external partners with the aim of achieving support from social care in particular. The NHS 10 year forward plan will also address the issue of transitions to adult services.
- **Exploitation in all its forms** – Progress continues to be made in this area and the development of a “contextual safeguarding” approach as described in this report is shaping the way all partner agencies work with vulnerable children and young people.
- **Develop robust staff training for domestic abuse and ensure that learning from all case reviews in respect of domestic abuse issues can be embedded into practice.** This work has started but will need more development. The safeguarding adult team has been working closely with Buckinghamshire Women’s Aid, inviting them to visit ED and to deliver training programmes within the Trust. During this year’s safeguarding week the topic of domestic abuse was a key feature, and members of Women’s Aid attended events to promote their work and deliver training. The Trust is a key member of the newly established MARAC Strategy Group. The “think family” approach is promoted as part of safeguarding training and new posters about this have been printed and were circulated widely during safeguarding week.

- **Missing persons** – During the past year, the Trust has worked closely with external partners, in particular the police, to develop better ways of responding when vulnerable people go missing. The use of the Elpis multi-agency database is being taken up in some areas of practice, in particular the exploitation unit. The Safeguarding Team has worked assertively with the Trust IT and Information Governance leads to enable the use of Elpis within BHT. More progress needs to be made in this regard.
- **End of life care for people with learning disabilities** – The LDLNs have been working assertively in this area as reported above.
- **People with LD who access ED** – Training of ED staff has been commenced but pressures within the LDLN team have meant that they have not achieved as much here as they had anticipated. This work will continue.
- **Working with midwifery and gynaecology services as well as children’s social care to ensure effective identification and reporting of female genital mutilation (FGM).** This work is constant and is led by the Safeguarding Midwife.
- **Discharge planning for patients with LD** – This work has commenced and will continue; the LDLNs have forged good relationships with community LD teams and other partners.

For the forthcoming year 2019 – 2020 the Safeguarding Team will be focusing on the following key areas of work:

- Supporting innovations in the BHT Emergency Department. Patients who repeatedly attend healthcare facilities represent between 1-2% of Emergency Department attendances annually. Literature suggests these patients also frequently access other health and social facilities and generate greater admission rates and a greater burden of chronic disease. Furthermore, frequent attendance at Emergency Departments is known to be associated with increased stress and dissatisfaction amongst patients. The mortality rate is double that of the “average” population. This cohort has a higher burden of alcohol and substance misuse, and psychiatric illness. The Safeguarding Team will be actively involved in the work with ED around managing high impact patients in conjunction with implementing and developing further the use of Elpis, the software for monitoring vulnerable people who go missing.
- LDLNs will be working with the Trust patient experience lead to identify different ways of gathering patient feedback;
- The successful delivery and operation of the new liberty protection safeguards;
- Develop and strengthen work around transitions of children and young people to adult services;
- Develop the work around contextual safeguarding, including training staff to identify where there may be concerns about exploitation and gang-related concerns;
- Develop further the use of Elpis, the software for monitoring vulnerable people who go missing;
- Support the new partnership arrangements in respect of safeguarding children and that replace the BSCB;
- Further develop mental health work in the Trust including working with public health around suicide prevention.

Appendix 1 CQC Regulation 13 in full

1. Service users must be protected from abuse and improper treatment in accordance with this regulation.
2. Systems and processes must be established and operated effectively to prevent abuse of service users.
3. Systems and processes must be established and operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse.
4. Care or treatment for service users must not be provided in a way that—
 - a. includes discrimination against a service user on grounds of any protected characteristic (as defined in section 4 of the Equality Act 2010) of the service user,
 - b. includes acts intended to control or restrain a service user that are not necessary to prevent, or not a proportionate response to, a risk of harm posed to the service user or another individual if the service user was not subject to control or restraint,
 - c. is degrading for the service user, or
 - d. significantly disregards the needs of the service user for care or treatment.
5. A service user must not be deprived of their liberty for the purpose of receiving care or treatment without lawful authority.
6. For the purposes of this regulation—

'abuse' means—

 - a. any behaviour towards a service user that is an offence under the Sexual Offences Act 2003(a),
 - b. ill-treatment (whether of a physical or psychological nature) of a service user,
 - c. theft, misuse or misappropriation of money or property belonging to a service user, or
 - d. neglect of a service user.
7. For the purposes of this regulation, a person controls or restrains a service user if that person—
 - a. uses, or threatens to use, force to secure the doing of an act which the service user resists, or
 - b. restricts the service user's liberty of movement, whether or not the service user resists, including by use of physical, mechanical or chemical means.

Appendix 2 CQC Regulation 13 - Related Legislation

Children Act 1989

Children Act 2004

Children and Young Persons Act 1933

Equality Act 2010

Equality Act 2010: Chapter 1 (protected characteristics) Chapter 2 (prohibited conduct) and Chapter 3 (services and public functions)

Human Rights Act 1998

Mental Capacity Act 2005 and associated Code of Practice

Mental Health Act 1983 (amended 2007) and associated Code of Practice

Protection of Freedoms Act 2012 – links to The Protection of Freedoms Act 2012 (Disclosure and Barring Service Transfer of Functions) Order 2012

Safeguarding Vulnerable Groups Act 2006

Appendix 3 Think Twice

Think Twice

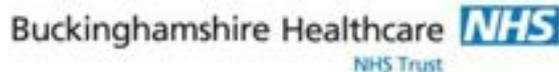
People with a learning disability/autism have the same health needs as the general population but they often need additional support to access health services. So at BHT we encourage staff to 'think twice'.

- T** **Time** do you need to give the individual more time, do you need a different appointment?
- W** **Where** is the environment right for the individual or do you need to find an alternative space
- I** **Include** the individual and their family / carers; they will know the patient best
- C** **Communication** – do you need different methods of communication for example signing or pictures
- E** **Extra** – provide extra monitoring and support - for example, does your patient need a red tray?

If you know a patient who may appreciate support from our **BHT learning disability liaison nurses** you can contact them from Monday to Friday, 8.30-4.30pm on 01296 316991



Agenda item: 12
 Enclosure no: TB2019/075



PUBLIC BOARD July 2019

Details of the Paper

Title	Emergency Preparedness, Resilience and Response Annual Assurance Process Update
Responsible Director	David Williams, Interim Chief Operating Officer
Purpose of the paper	<p>These are the documents submitted to the NHS England South East Emergency Preparedness, Resilience and Response (EPRR) team for the annual NHS England EPRR Core Standards assurance assessment audit for 2018-2019.</p> <p>The documentation and evidence was scrutinised and approved by Buckinghamshire CCG prior to final approval by our regional NHS England EPRR team. The Trust's rating for 2018-2019 was confirmed as Substantially compliant. The areas we were unable to achieve are either due to waiting for further national guidance or sit with third parties (these issues are being considered by the national NHS England EPRR team).</p> <p>The assurance process requires the approved documentation and confirmation of compliance status to be noted through the Public Board. The 2019/20 process has now begun and will be reported in November 2019.</p>
Action / decision required (e.g., approve, support, endorse)	To Note

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

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

ANNUAL OBJECTIVE

Which Strategic Objective/s does this paper link to?
 Quality

Please summarise the potential benefit or value arising from this paper:
 This report is submitted to the board for information

RISK

Are there any specific risks associated with this paper? If so, please	<p><i>Non-Financial Risk:</i> There is a risk that if we do not have a robust assurance process for emergency response we are not meeting our responsibilities under the Civil Contingencies Act.</p>
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Agenda item: 12

Enclosure no: TB2019/075

summarise here.	<i>Financial Risks: None</i>
LINK TO CARE QUALITY COMMISSION ESSENTIAL STANDARDS OF SAFETY AND QUALITY	
Which CQC standard/s does this paper relate to?	Well Led, Safety <i>(if you need advice on completing this box please contact the Director for Governance)</i>

Author of paper: Gordon Austin, Emergency Planning Officer
Presenter of Paper: David Williams, Interim Chief Operating Officer
Other committees / groups where this paper / item has been considered: EMC meeting Friday 18 January 2019. Resilience Committee
Date of Paper: 16 July 2019

Emergency Preparedness, Resilience and Response Annual Assurance Process Update

1. Background

This paper gives an outline of the annual NHS England core standards for Emergency Preparedness, Resilience and Response (EPRR) assurance arrangements and the current position prior to the commencement of the 2019-2020 audit.

2. EPRR assurance process 2018-2019

The NHS needs to plan for, and respond to, a wide range of incidents and emergencies. These could be anything from extreme weather conditions to an outbreak of an infectious disease or a major transport accident. The Civil Contingencies Act (2004) requires NHS organisations, and providers of NHS-funded care, to show that they can deal with such incidents while maintaining services.

NHS England has published NHS core standards for EPRR arrangements. These are the minimum standards which NHS organisations must meet. As part of the annual national EPRR assurance process for 2018-2019, Buckinghamshire Healthcare NHS Trust has completed the assessment process against these core standards. Overall the Trust was substantially compliant.

See Appendix 2 for details of the agreed improvement plan for 2018/2019. This plan sets out actions for the three areas that Trust was unable to achieve full compliance against. This action plans was approved by the Trust and Buckinghamshire Clinical Commissioning Group (BCCG) in September 2018

3. Interim Actions

Meeting 4 February 2019 – BCCG Head of Urgent Care and System Resilience Manager and BHT Emergency Planning Officer

Full update of current status provided by the EPO. For the items on the improvement plan:

- Deep Dive 1 – Incident Coordination Centre: awaiting NHS England guidance, to be reviewed once guidance is published. Guidance is expected to be published in late March or early April.
- Core Standard 55 – awaiting clarification from regional NHS England EPRR team as to whether it would be necessary to provide all ad hoc / short term suppliers or just commissioned or contracted supplier's Business Continuity Plans to be able to fulfil this Core Standard requirement. Question asked of regional NHS England EPRR team, who in turn referred the request to the national level for guidance.
- Core Standard 40 – BCCG Head of Urgent Care liaised with NHS England regional EPRR team as to whether executive representation of appropriate nominated representative / deputy would count for all organisations as having 'attended' Local Health Resilience Partnership meetings.

Meeting 25 April 2019 meeting with System Resilience Manager BCCG and BHT Emergency Planning Officer

The EPRR assurance process was discussed and progress of items on the improvement plan reviewed:

- Deep Dive 1 – Incident Coordination Centre: NHS England have now published the awaited guidance; “NHS England Emergency Preparedness, Resilience and Response (EPRR) Resilient Telecommunications Guidance from NHS England and the NHS England in England”. The Trust is currently working towards putting the necessary equipment in place.
- Core Standard 55 – now awaiting national level guidance from NHS England as whether it would be acceptable for only details of commissioned or contracted supplier’s Business Continuity Plans to be able to fulfil this Core Standard requirement.
- Core Standard 40 – Cooperation: Confirmation received from NHS England that Thames Valley Provider Trusts are covered by the attendance of the AEO from Milton Keynes University Hospital NHS Foundation Trust to fulfil this core standard requirement.

4. Summary

Confirmation of actions / guidance from the regional NHS England EPRR regional team is still required to enable the first two actions listed in the improvement plan to be completed. The guidance around telecommunications required in Incident Command Centres has been published in July 2019 and the EPO is working with the IT and Estates team on ensuring the required equipment is available in the various control rooms on the SMH and Wycombe sites.

Apart from the items listed in the improvement plan there have been no substantial changes to the Trusts position on the core standard requirements in the assurance process. The 2019/20 Assurance process has been commenced in July 2019. An update will be provided for the November Board on progress.

Appendix 1 – BHT Annual EPRR Statement of Compliance 2018-2019

Appendix 2 – EPRR Improvement Plan 2018-2019

Appendix 1 – BHT Annual EPRR Statement of Compliance 2018-2019



Annual EPRR Statement of Compliance

The NHS needs to plan for, and respond to, a wide range of incidents and emergencies that could affect health or patient care. These could be anything from extreme weather conditions to an outbreak of an infectious disease or a major transport accident. The Civil Contingencies Act (2004) requires NHS organisations, and providers of NHS-funded care, to show that they can deal with such incidents while maintaining services.

NHS England has published NHS core standards for Emergency Preparedness, Resilience and Response arrangements. These are the minimum standards which NHS organisations and providers of NHS funded care must meet. The Accountable Emergency Officer in each organisation is responsible for making sure these standards are met.

As part of the national EPRR assurance process for **2018/19**, Buckinghamshire Healthcare NHS Trust has been required to assess itself against these core standards. The outcome of this self-assessment shows that against 64 of the core standards which are applicable to the organisation, Buckinghamshire Healthcare NHS Trust:

- is fully compliant with 62 of these core standards; and
- will become fully compliant with 2 of these core standards by March 2020.

The attached improvement plan sets out actions against all core standards where full compliance has yet to be achieved.

The overall rating is: Substantially Compliant

Natalie Fox
 Chief Operating Officer (Accountable Emergency Officer)
 Buckinghamshire Healthcare NHS Trust
 17 September 2018

NHS England South East EPRR Assurance compliance ratings

To support a standardised approach to assessing an organisation’s **overall preparedness rating** NHS England have set the following criteria:

Compliance Level	Evaluation and Testing Conclusion
Full	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation’s Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation’s Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation’s Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation’s Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

Appendix 2 – EPRR Improvement Plan 2018-2019

EPRR Improvement Plan: Buckinghamshire Healthcare NHS Trust Version: 1.0 17 September 2018

Buckinghamshire Healthcare NHS Trust has been required to assess itself against the NHS core standards for Emergency Preparedness, Resilience and Response (EPRR) as part of the annual EPRR assurance process for 2018/2019. This improvement plan is the result of this self-assessment exercise and sets out the required actions that will ensure full compliance with the core standards.

This is a live document and it will be updated as actions are completed.

Core standard	Current self-assessed level of compliance (RAG rating)	Remaining actions required to be fully compliant	Planned date for actions to be completed	Lead name	Further comments
CS 40 – Cooperation – LHRP attendance	Amber = Partially compliant	This matter to be discussed with the TVLHRP as local arrangements prevent Acute Providers for achieving this standard as detailed at the present time.	March 2020	Gordon Austin Emergency Planning Officer	Full compliance with this core standard will depend on local arrangements for attending the LHRP going forward.
CS 55 – Business Continuity – Assurance of commissioned providers / suppliers BCPs	Amber = Partially compliant	Further discussions required through the Business Continuity Project group and then considered by the Resilience Committee. Work will be required in liaison/cooperation with the Trust's procurement and Estates teams and PFI contractors (Sodexo /Medirest /Vinci)	April 2020	Gordon Austin Emergency Planning Officer	Full compliance for this core standard will be dependent on the cooperation of private companies and their ability / willingness to share BCP arrangements with the Trust.
Deep Dive Standard 1 – Incident Coordination Centre – Communication and IT equipment	Amber = Partially compliant	Awaiting publication of NHS England guidance specifically related to this standard. This standard will be reviewed once the guidance is made available.	Up to 12 months after publication of the relevant NHS England Guidance.	Gordon Austin Emergency Planning Officer	Full compliance for this Deep Dive standard will depend on the publication date of the relevant NHS England guidance.

Agenda item: 13
 Enclosure no: TB2019/076



PUBLIC TRUST BOARD MEETING Wednesday 31st July 2019

Details of the Paper

Title	Clinical Audit Plan 2019/20
Responsible Director	Carolyn Morrice, Chief Nurse
Purpose of the paper	To provide assurance to the Trust that a robust clinical audit programme is in place for 2019/20 and that the audits identified for completion support the trust priorities and corporate objectives.
Action / decision required (e.g., approve, support, endorse)	For approval and information

IMPLICATIONS AND ISSUES TO WHICH THE PAPER RELATES (PLEASE MARK IN BOLD)					
<i>Patient Quality</i>	<i>Financial Performance</i>	<i>Operational Performance</i>	<i>Strategy</i>	<i>Workforce performance</i>	<i>New or elevated risk</i>
<i>Legal</i>	Regulatory/ Compliance	<i>Public Engagement /Reputation</i>	<i>Equality & Diversity</i>	<i>Partnership Working</i>	<i>Information Technology / Property Services</i>
ANNUAL OBJECTIVE					
<i>Which Strategic Objective/s does this paper link to?</i>					
<i>Please summarise the potential benefit or value arising from this paper:</i>					
RISK					
Are there any specific risks associated with this paper? If so, please summarise here.	<i>Non-Financial Risk:</i>				
	<i>Financial Risk:</i>				
LINK TO CARE QUALITY COMMISSION ESSENTIAL STANDARDS OF SAFETY AND QUALITY					
Which CQC standard/s does this paper relate to?	<i>(if you need advice on completing this box please contact the Director for Governance)</i>				

Author of paper: Lynda Oswald, Clinical Audit and Effectiveness Manager
Presenter of Paper: Carolyn Morrice, Chief Nurse
Other committees / groups where this paper / item has been considered: EMC, Quality and Patient Safety Group, Quality and Clinical Governance Committee
Date of Paper: 20th June 2019

Clinical Audit Programme 2019/20

1. PURPOSE

This year we have been challenged by the Trust Board to reduce the number of audits on the Trust Clinical Audit Programme with greater focus on ensuring all audits, both national and local, have clear action plans and result in changes which can be monitored and show improvements in patient care. The purpose of this paper is to provide assurance to the Trust that a robust clinical audit programme is in place and that the audits identified for completion have been reviewed at SDU and divisional level to ensure they support Trust priorities and corporate objectives. This paper will outline the planned Clinical Audit Programme for 2019 / 2020 and its approval process.

2. BACKGROUND

It is important for the organisation and divisions to maintain a strategic overview of how clinical audit time and resources are being used to deliver quality improvements and assurance regarding the quality of patient care. Each year the divisions are responsible for agreeing their own clinical audit programmes and these together with any Trust wide audits form the Trust's Clinical Audit Programme.

Agreement of the Trust Clinical Audit Programme follows the same process each year and is as follows:

- All applicable audits from the NHS England Quality Accounts list for the year are added to the programme.
- Any other audits known to be a Trust priority, such as the Infection Control audits, NEWs audits or audits required to monitor performance as part of the Trust Quality Improvement Programme (QIP) are added to the programme.
- The programme is then shared with the divisions for their review.
- The divisions then circulate the programme to their Service Delivery Units (SDUs) who add any other clinical audits they plan to carry out.
- Once this process is complete the final version of the programme is submitted to their Divisional Clinical Governance Committee for review and sign off before a copy is forwarded to the Clinical Audit and Effectiveness (CAE) Team for their record.
- The completed programme is then presented to the Trust Quality and Clinical Governance Committee to provide assurance in readiness to be formally agreed at the Trust Audit Committee

Any audits added to the programme by the division or SDU are required to link to their divisional and SDU priorities and before adding to the programme should first be discussed at the relevant SDU/Divisional Governance Board for assurance they are in line with current SDU/divisional objectives and that a lead clinician who will be responsible for leading action planning and completion has been identified.

It is acknowledged that it may be necessary to add additional clinical audit projects to the programme during the course of the year. Any further audits added during the year are should follow the same process and require sign off at the relevant Clinical Governance Committee.

3. CLINICAL AUDIT PROGRAMME 2019/2020

All audits registered on the clinical audit database have a priority rating applied according to their importance.

There are currently 75 priority one and two audits registered on the Clinical Audit Programme for 2019/2020. This includes 53 NHS England Quality Account audits which NHS England advises Trusts to prioritise for partition and inclusion in their Quality Accounts for 2019/20.

LEAD DIVISION	No. of audits	Priority 1	Priority 2
Integrated Medicine	29	28	1
Integrated Elderly & Community Care	6	3	3
Surgery & Critical Care	22	19	3
Women and Children	6	6	-
Specialist Services	4	-	4
Corporate	8	1	7
TOTAL	75	57	18

Priority 1 Very high Strategic Importance

- Projects reported in Quality Accounts: NCAPOP, NCEPOD and CEMACH, National Patient Surveys
- CQUINS, Schedule 3 and other commissioner priorities
- Infection Control Monitoring
- NHS Litigation Authority
- Cancer Peer Review Audit
- Audits resulting from Serious Incidents
- Doctor Foster alerts or significant variance in key clinical indicators
- CQC Reviews
- Re-audits of any of the above

Priority 2 High Strategic Importance

- National Audits not part of NCAPOP
- Audit need identified by Risk Monitoring Group/Healthcare Governance Committee
- Audits demonstrating compliance with regulation requirements e.g.: NICE technology appraisals, clinical guidelines and public health guidance, NSFs, NPISA alerts
- Clinical risk issues e.g.: Projects resulting from complaints/claims/incidents
- Priorities identified via Patient and Public Involvement initiatives
- Access to services
- Patient Safety First
- Re-audits of any of the above
- Audits relating to pressure ulcers, care planning and record keeping

The Clinical Audit and Effectiveness Team (CAE) prioritise their time and resources to ensure the completion of priority one and two audits. However, where possible, they also support the completion of other audits including those carried out by Foundation doctors to support the training requirement in section 4 of their Syllabus which relates to proving evidence of contributing to quality improvement.

The full programme for priority one and priority two clinical audits can be found in appendix one of this paper.

4. REVIEW AND APPROVAL

4.1 Divisional approval

Prior to submission for inclusion in the Trust's Clinical Audit Programme the individual Divisional Clinical Audit Programmes are required to be reviewed, approved and signed off at the appropriate Divisional Clinical Governance Committee. This sign off provides assurance that the programme has been carefully reviewed and all audits identified for completion support both divisional and corporate objectives and have a clinical lead who will be responsible for leading action planning.

To date we have received confirmation of sign off from the following areas/divisions;

- Specialist Services
- Infection Prevention & Control
- Acute Paediatrics
- Sexual Health
- Surgery & Critical Care
- Integrated Elderly & Community Care

The following areas/divisions have confirmed their Divisional Clinical Audit Programmes will be signed off at their June Clinical Governance Committee meeting;

- Obs & Gynae
- Integrated Medicine
- C&YP

4.2 Governance and reporting

The Clinical Audit Programme for 2019/2020 will be presented at June Quality and Patient Safety Group meeting and will then be formally approved at the Trust Audit Committee. Assurance will be provided to the Trust Quality and Clinical Governance Committee and progress of the programme will be monitored quarterly through the Quality and Patient Safety Group.

5. CONCLUSION AND RECOMMENDATIONS

This paper has described the process for compiling the Clinical Audit Programme for 2019/2020 and seeks to provide assurance to the Trust that a robust clinical audit programme is in place and that the audits identified for completion support the Trust priorities and corporate objectives and that on completion all audit will have clear action plans that result in changes which can be monitored and show improvements in patient care.

Lynda Oswald, Clinical Audit and Effectiveness Manager

Joanna Atkins, Associate Chief Nurse

20th June 2019

APPENDIX 1

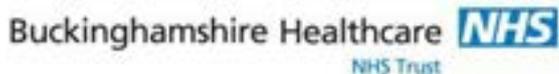
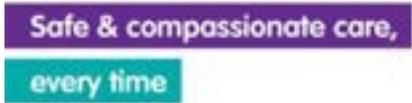
TRUST CLINICAL AUDIT PROGRAMME 2019/20 - PRIORITY 1 AND 2 AUDITS (20th June 2019)

Key	Title of Audit/Project	Lead Division	Priority	Audit Category
5738	Seven Day Hospital Services	Corporate	1 - Very high	Quality Improvement
5781	HII Surgical Site Infection Audit September 2019	Corporate	2 - High	Infection Control Monitoring
5780	HII Peripheral Line Audit June 2019	Corporate	2 - High	Infection Control Monitoring
5779	HII Urinary Catheter Care Audit May 2019	Corporate	2 - High	Infection Control Monitoring
5782	HII Surgical Site Infection Audit October 2018	Corporate	2 - High	Infection Control Monitoring
5795	Audit of Nursing Handover on Acute Wards	Corporate	2 - High	Quality Improvement
5476	Record Keeping Audit	Corporate	2 - High	Record Keeping
5798	Smoking & Alcohol CQUIN	Corporate	2 - High	Commissioners etc
5702	National Audit of Inpatient Falls (NAIF) (FFFAP)	Integrated Elderly & Community Care	1 - Very high	National Audit in Quality Accounts
5701	Fracture Liaison Services (FLSDB) (FFFAP)	Integrated Elderly & Community Care	1 - Very high	National Audit in Quality Accounts
5679	National Audit of Care at the End of Life (NACEL) 2019/20	Integrated Elderly & Community Care	1 - Very high	National Audit in Quality Accounts
5592	Audit of the 'Getting it Right for Me' End of Life Care Plan	Integrated Elderly & Community Care	2 - High	Quality Improvement
5652	Bed Rails Audit 2019	Integrated Elderly & Community Care	2 - High	Quality Improvement
5800	Frailty Assessment Audit	Integrated Elderly & Community Care	2 - High	Commissioners etc
5709	National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	Integrated Medicine	1 - Very high	National Audit in Quality Accounts
5707	National Audit of Cardiac Rhythm Management Audit	Integrated Medicine	1 - Very high	National Audit in Quality Accounts
5710	National Heart Failure Audit	Integrated Medicine	1 - Very high	National Audit in Quality Accounts
5708	Myocardial Ischaemia National Audit Project (MINAP)	Integrated Medicine	1 - Very high	National Audit in Quality Accounts
5750	NCEPOD Management of Out of Hospital Cardiac Arrests	Integrated Medicine	1 - Very high	NCEPOD/CEMACH
5678	National Audit of Cardiac Rehabilitation 2019	Integrated Medicine	1 - Very high	National Audit in Quality Accounts
5759	National Diabetes Pump Audit	Integrated Medicine	1 - Very high	National Audit in Quality Accounts
5714	National Diabetes Transition Audit	Integrated Medicine	1 - Very high	National Audit in Quality Accounts
5713	National Core Diabetes Audit 2019	Integrated Medicine	1 - Very high	National Audit in Quality Accounts
5712	National Diabetes Inpatient Audit (NaDIA) 2019	Integrated Medicine	1 - Very high	National Audit in Quality Accounts
5715	National Pregnancy in Diabetes Audit 2019	Integrated Medicine	1 - Very high	National Audit in Quality Accounts
5711	National Diabetes Foot Care Audit 2019	Integrated Medicine	1 - Very high	National Audit in Quality Accounts

Key	Title of Audit/Project	Lead Division	Priority	Audit Category
5704	RCEM Mental Health Care in Emergency Departments 2019	Integrated Medicine	1 - Very high	National Audit in Quality Accounts
5698	RCEM Assessing Cognitive Impairment in Older People	Integrated Medicine	1 - Very high	National Audit in Quality Accounts
5699	RCEM Care of Children in the Emergency Department 2019	Integrated Medicine	1 - Very high	National Audit in Quality Accounts
5722	Sepsis CQUIN Audit 2019/20	Integrated Medicine	1 - Very high	National Audit in Quality Accounts
5674	Major Trauma Audit (TARN) 2019/20	Integrated Medicine	1 - Very high	National Audit in Quality Accounts
5703	Inflammatory Bowel Disease (IBD) Registry 2019	Integrated Medicine	1 - Very high	National Audit in Quality Accounts
5717	National Oesophago-gastric Cancer (NOGCA) 2019 (2017-18 data)	Integrated Medicine	1 - Very high	National Audit in Quality Accounts
5744	National COPD Pulmonary Rehabilitation Audit 2019/20	Integrated Medicine	1 - Very high	National Audit in Quality Accounts
5720	National Smoking Cessation Audit 2019	Integrated Medicine	1 - Very high	National Audit in Quality Accounts
5676	National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP)	Integrated Medicine	1 - Very high	National Audit in Quality Accounts
5686	National Lung Cancer Audit 2019	Integrated Medicine	1 - Very high	National Audit in Quality Accounts
5716	National Early Inflammatory Arthritis (NEIAA) 2019	Integrated Medicine	1 - Very high	National Audit in Quality Accounts
5706	National Audit of Seizure Management in Hospital (NASH3)	Integrated Medicine	1 - Very high	National Audit in Quality Accounts
5723	National UK Parkinson's Audit 2019	Integrated Medicine	1 - Very high	National Audit in Quality Accounts
5692	Sentinel Stroke National Audit Programme (SSNAP) 2019	Integrated Medicine	1 - Very high	National Audit in Quality Accounts
5741	NCEPOD Dysphagia in Parkinson's Disease 2019	Integrated Medicine	1 - Very high	NCEPOD/CEMACH
5775	WHO Safety Checklist Audit - Endoscopy	Integrated Medicine	2 - High	Other
5761	Neutropenic Sepsis Audit 2019/20	Specialist Services	2 - High	Quality Improvement
5763	Trustwide VTE Assessment and Treatment Audit 2019/20	Specialist Services	2 - High	Quality Improvement
5791	Investigating Medication Prescribing Accuracy for Critical Error Types (iMPACT)	Specialist Services	2 - High	Quality Improvement
5805	Antimicrobial Care Bundle Audit 2019/20	Specialist Services	2 - High	Quality Improvement
5672	ICNARC Case Mix Programme 2019-20	Surgery and Critical Care	1 - Very high	National Audit in Quality Accounts
5721	Perioperative Quality Improvement Programme (PQIP)	Surgery and Critical Care	1 - Very high	National Audit in Quality Accounts
5683	National Cardiac Arrest Audit 2019/20	Surgery and Critical Care	1 - Very high	National Audit in Quality Accounts
5684	National Emergency Laparotomy Audit (NELA) 2019/20	Surgery and Critical Care	1 - Very high	National Audit in Quality Accounts
5693	GIRFT Surgical Site Infection National Audit 2019.	Surgery and Critical Care	1 - Very high	National Audit (not Quality Accounts/NCAPOP)

Key	Title of Audit/Project	Lead Division	Priority	Audit Category
5673	Elective Surgery (National PROMS Programme)	Surgery and Critical Care	1 - Very high	National Audit in Quality Accounts
5691	National Vascular Registry	Surgery and Critical Care	1 - Very high	National Audit in Quality Accounts
5718	National Bowel Cancer Audit (NBOCA) 2019	Surgery and Critical Care	1 - Very high	National Audit in Quality Accounts
5677	National Audit of Breast Cancer in Older Patients (NABCOP)	Surgery and Critical Care	1 - Very high	National Audit in Quality Accounts
5688	National Ophthalmology Audit 2019/20	Surgery and Critical Care	1 - Very high	National Audit in Quality Accounts
5772	UK National Flap Registry (BAPRAS)	Surgery and Critical Care	1 - Very high	National Audit (not Quality Accounts/NCAPOP)
5685	National Joint Registry 2019/20	Surgery and Critical Care	1 - Very high	National Audit in Quality Accounts
5700	National Hip Fracture Database (NHFD) (FFFAP) 2019/20	Surgery and Critical Care	1 - Very high	National Audit in Quality Accounts
5671	BAUS Urology Audit: Radical Prostatectomy	Surgery and Critical Care	1 - Very high	National Audit in Quality Accounts
5670	BAUS Urology Audit Percutaneous Nephrolithotomy (PCNL)	Surgery and Critical Care	1 - Very high	National Audit in Quality Accounts
5669	BAUS Urology Audit: Nephrectomy	Surgery and Critical Care	1 - Very high	National Audit in Quality Accounts
5668	BAUS Urology Audits: Female Stress Urinary Incontinence	Surgery and Critical Care	1 - Very high	National Audit in Quality Accounts
5667	BAUS Urology Audit: Cystectomy Audit	Surgery and Critical Care	1 - Very high	National Audit in Quality Accounts
5690	National Prostate Cancer Audit 2019.	Surgery and Critical Care	1 - Very high	National Audit in Quality Accounts
5760	An Audit to Assess the Referral and Management of Unerupted Maxillary Incisors	Surgery and Critical Care	2 - High	National Audit (not Quality Accounts/NCAPOP)
5770	International Burns Injury Database	Surgery and Critical Care	2 - High	National Audit (not Quality Accounts/NCAPOP)
5799	National Outcome Audit of Hypospadias (NOAH)	Surgery and Critical Care	2 - High	National Audit (not Quality Accounts/NCAPOP)
5794	National Asthma and COPD Audit Programme - Children and Young People Asthma 2019/20	Women, Children & Sexual Health Services	1 - Very high	National Audit in Quality Accounts
5719	National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	Women, Children & Sexual Health Services	1 - Very high	National Audit in Quality Accounts
5689	Diabetes (Paediatric) NPDA 2019/20	Women, Children & Sexual Health Services	1 - Very high	National Audit in Quality Accounts
5682	National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12) 2019	Women, Children & Sexual Health Services	1 - Very high	National Audit in Quality Accounts
5675	Maternal, Newborn and Infant Clinical Outcome Review Programme 2019-20 (MBRRACE)	Women, Children & Sexual Health Services	1 - Very high	National Audit in Quality Accounts
5687	National Maternity & Perinatal Audit - online continuous prospective audit of key interventions	Women, Children & Sexual Health Services	1 - Very high	National Audit in Quality Accounts

Agenda item: 14
 Enclosure no: TB2019/077



PUBLIC BOARD MEETING 31 July 2019

Details of the Paper

Title	NHSR Maternity Incentive Scheme 2019
Responsible Director	Carolyn Morrice
Purpose of the paper	To provide the Board with evidence that the maternity service meets the 10 maternity safety actions outlined in the NHSR maternity incentive scheme. To provide the template for Board level sign off.
Action / decision required (e.g., approve, support, endorse)	Final approval and signing of Board declaration form prior to submission to NHSR

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

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

ANNUAL OBJECTIVE

Which Strategic Objective/s does this paper link to?
 Quality

Please summarise the potential benefit or value arising from this paper:
 Assurance to board that maternity services are compliant with the ten national maternity safety actions

RISK

Are there any specific risks associated with this paper? If so, please summarise here.	<i>Non-Financial Risk:</i>
	<i>Financial Risk:</i> Failure to achieve 10% reduction in CNST payment (circa £400k)

LINK TO CARE QUALITY COMMISSION ESSENTIAL STANDARDS OF SAFETY AND QUALITY

Which CQC standard/s does this paper relate to?	Safe Well Led Responsive Effective Caring <small>(if you need advice on completing this box please contact the Director for Governance)</small>
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Author of paper: Heidi Beddall- Head of Midwifery

Presenter of Paper: Heidi Beddall- Head of Midwifery

Other committees / groups where this paper / item has been considered: CCG approved, EMC

Date of Paper: 16th July 2019

Board report on Buckinghamshire Healthcare NHS Trust progress against the Clinical Negligence Scheme for Trusts (CNST) incentive scheme maternity safety actions

Date: 12th June 2019

Introduction

The maternity safety strategy set out the Department of Health's ambition to reward those who have taken action to improve maternity safety. The CNST incentive scheme is in year 2 and subject to available funds it will provide a 10% reduction in CNST payment to Trusts who meet the 10 maternity safety actions. NHS Resolution requires assurance that Trusts meet the following standards:

- Use of the National Perinatal Mortality review Tool (NPMRT) to review perinatal deaths
- Submit data to the Maternity Services Data Set (MSDS) to the required standard
- Can demonstrate that transitional care facilities are in place and operational to support the implementation of the ATAIN Programme
- Demonstrate an effective system of medical workforce planning
- Demonstrate an effective system of midwifery workforce planning
- Demonstrate compliance with all four elements of the Saving Babies' Lives (SBL) care bundle
- Demonstrate a patient feedback mechanism for maternity services, such as the Maternity Voices Partnership (MVP) forum and regularly act on feedback
- 90% of maternity unit staff have attended 'in-house' multi-professional maternity emergencies training session within the last training year
- Demonstrate that the Trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues
- Reported 100% of qualifying 2017/18 incidents under NHS Resolution's Early Notification Scheme

NHS Resolution set out minimum evidential requirements for each of the ten standards, see link below:

<https://resolution.nhs.uk/wp-content/uploads/2018/12/maternity-incentive-scheme-year-two.pdf>

Evidence was collated by the Head of Midwifery and reviewed collaboratively by the maternity leadership multidisciplinary team prior to submission to the CCG for discussion in June 2019. Thereafter it will be submitted to the Trust Board for ratification and sign off by the CEO. This paper provides assurance to the CCG and Trust Board that maternity services within the organisation are compliant with the 10 maternity safety actions.

The evidence is referenced in Section A below and submitted for discussion and ratification as an attached zip file.

SECTION A: Evidence of Trust's progress against 10 safety actions:

Safety action – please see the guidance for the detail required for each action	Evidence of Trust's progress	Action met? (Y/N)
<p>1). Are you using the National Perinatal Mortality Review Tool (NPMRT) to review perinatal deaths?</p> <p>Required Standard and minimum evidential requirement:</p> <p>A review of 95% of all deaths of babies suitable for review using the Perinatal Mortality Review Tool (PMRT) occurring from Wednesday 12 December 2018 have been started within four months of each death.</p> <p>At least 50% of all deaths of babies who were born and died in your Trust (including any home births where the baby died) from Wednesday 12 December 2018 will have been reviewed, by a multidisciplinary review team, with each review completed to the point that a draft report has been generated, within four months of each death.</p> <p>In 95% of all deaths of babies who were born and died in your Trust (including any home births where the baby died) from Wednesday 12 December 2018, the parents were told that a review of their baby's death will take place and that their perspective and any concerns about their care and that of their baby have been sought.</p> <p>Quarterly reports have been submitted to the Trust Board that include details of all deaths reviewed and consequent action plans.</p>	<p>1. PMRT quarterly reports</p>	<p>Yes: NHS Resolution will use MBRRACE data to cross reference this. All qualifying cases have been submitted to MBRRACE by BHHST.</p>

<p>2). Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?</p> <p>Required Standard and minimum evidential requirement:</p> <p>NHS Digital will issue a monthly scorecard to data submitters (Trusts) that can be presented to the Board. The scorecard will be used by NHS Digital to assess whether each MSDS data quality criteria has been met and whether the overall score is enough to pass the assessment. It is necessary to pass all three mandatory criteria and 14 of the 19 other criteria (please see table below for details).</p>	<p>1. Email from NHS Digital</p>	<p>Yes: MSDS data submitted to NHS Digital for January – March 2019 met criteria</p> <p>April data to be submitted 30th June – on track for compliance. NHS Digital data will be used by NHS Resolution to cross reference this.</p>
<p>3). Can you demonstrate that you have transitional care facilities that are in place and operational to support the implementation of the ATAIN Programme?</p> <p>Required Standard and minimum:</p> <p>Pathways of care for admission into and out of transitional care have been jointly approved by maternity and neonatal teams with neonatal involvement in decision making and planning care for all babies in transitional care.</p> <p>A data recording process for transitional care is established, in order to produce commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data Set (NCCMDS) version 2.</p> <p>An action plan has been agreed at Board level and with your Local Maternity Systems (LMS) and Operational Delivery Network (ODN) to address local findings from Avoiding Term Admissions Into Neonatal units (ATAIN) reviews.</p> <p>Progress with the agreed action plans has been shared with your Board and your LMS & ODN.</p>	<p>1. SOP Transitional care on postnatal ward</p> <p>2. Transitional care Activity report February – May 2019</p> <p>3. ATAIN action plan</p> <p>4. ATAIN progress report</p>	<p>Yes: NHS resolution will cross check Trusts with Neonatal Operational Delivery Networks</p>

<p>4). Can you demonstrate an effective system of medical workforce planning?</p> <p>Required Standard and minimum evidential requirement:</p> <p>Formal record of the proportion of obstetrics and gynaecology trainees in the Trust who 'disagreed/strongly disagreed' with the 2018 General Medical Council National Training Survey question: 'In my current post, educational/training opportunities are rarely lost due to gaps in the rota.'</p> <p>In addition, a plan produced by the Trust to address lost educational opportunities due to rota gaps.</p> <p>An action plan is in place and agreed at Board level to meet Anaesthesia Clinical Services Accreditation (ACSA) standards 1.2.4.6, 2.6.5.1 and 2.6.5.6.</p>	<ol style="list-style-type: none"> 1. June O & G SDU Governance meeting minutes to follow 2. ACSA accreditation report 3. ACSA self-assessment report 	<p>Yes: No exception reports required as no lost training opportunities. Not on risk register for Deanery</p>
<p>5). Can you demonstrate an effective system of midwifery workforce planning?</p> <p>Required Standard and minimum evidential requirement:</p> <p>A systematic, evidence-based process to calculate midwifery staffing establishment has been done.</p> <p>The obstetric unit midwifery labour ward coordinator has supernumerary status (defined as having no caseload of their own during that shift) to enable oversight of all birth activity in the service.</p> <p>Women receive one-to-one care in labour (this is the minimum standard that Birthrate+ is based on).</p> <p>A bi-annual report that covers staffing/safety issues is submitted to the Board.</p>	<ol style="list-style-type: none"> 1. Birth rate plus report 2. Safe staffing guideline 3. Head of Midwifery staffing reports x 2 	<p>Yes</p>

<p>6). Can you demonstrate compliance with all 4 elements of the Saving Babies' Lives (SBL) care bundle?</p> <p>Required Standard and minimum evidential required:</p> <p>Each element of the SBL care bundle implemented or an alternative intervention in place to deliver against element(s).</p> <p>Trusts should be evidencing position at end of July 2019.</p>	<ol style="list-style-type: none"> 1. Thames Valley Survey 12 2. Thames valley Survey 13 to follow 	<p>Yes: NHS resolution will cross check this with NHS England</p>
<p>7). Can you demonstrate that you have a patient feedback mechanism for maternity services, such as the Maternity Voices Partnership Forum, and that you regularly act on feedback?</p> <p>Required Standard and minimum evidential required:</p> <p>Acting on feedback from, for example a Maternity Voices Partnership.</p> <p>User involvement in investigations, local and or Care Quality Commission (CQC) survey results.</p> <p>Minutes of regular Maternity Voices Partnership and/or other meetings demonstrating explicitly how a range of feedback is obtained, the action taken and the communications to report this back to women.</p> <p>Trusts should be evidencing position from January to July 2019.</p>	<ol style="list-style-type: none"> 1. MVP minutes December 2018 2. MVP minutes March 2019 3. MVP minutes June to follow 4. Patient Experience Quarterly report January – March 2019 5. Picker Survey Action Plan 18/19 	<p>Yes</p>

<p>8). Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?</p> <p>Required Standard and minimum evidential required:</p> <p>Evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year through Board sight of a staff training database or similar.</p>	<ol style="list-style-type: none"> 1. Multiprofessional maternity emergency training progress report 2. Lesson plan obstetric emergencies 	<p>Yes</p>
<p>9). Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?</p> <p>Required Standard and minimum evidential required:</p> <p>The Executive Sponsor for the Maternal and Neonatal Health Safety Collaborative (MNHSC) is actively engaging with supporting quality and safety improvement activity within: i. the Trust ii. the Local Learning System (LLS.)</p> <p>The Board level safety champions have implemented a monthly feedback session for maternity and neonatal staff to raise concerns relating to relevant safety issues.</p> <p>The Board level safety champions have taken steps to address named safety concerns and that progress with actioning these are visible to staff.</p>	<ol style="list-style-type: none"> 1. Diary screen shots 2. Speak up about safety poster 3. Risk management strategy 4. Feedback communication to follow 	<p>Yes</p>
<p>10). Have you reported 100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification scheme?</p> <p>Required Standard and minimum evidential required:</p> <p>Reporting of all qualifying incidents that occurred in the 2018/19 financial year to NHS Resolution under the Early Notification scheme reporting criteria.</p>	<ol style="list-style-type: none"> 1. Email from Trust litigation, governance leads and NHSR 	<p>Yes: 3 qualifying cases</p> <p>NHSR will cross check this with national database</p>

Agenda item: 15
Enclosure no: TB2019/078

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Buckinghamshire Healthcare **NHS**
NHS Trust

PUBLIC BOARD MEETING 31 July 2019

Details of the Paper

Title	Medical Appraisal & Revalidation Annual Report 2018/2019
Responsible Director	Dr Tina Kenny - Medical Director/Responsible Officer
Purpose of the paper	To provide assurance to the Trust Board that internal processes for Medical Appraisal and Revalidation are robust, and to report on the 18/19 activity.
Action / decision required (e.g., approve, support, endorse)	The board are asked to agree to this report. The board are asked to delegate approval for the CEO to sign the 'Statement of compliance' Annex E confirming that the organisation, as a designated body, is in compliance with the regulations.

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

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

ANNUAL OBJECTIVE

Which Strategic Objective/s does this paper link to?

- Quality - excel in the delivery of clinical care, safety and patient experience.
- People – employ, engage, develop and retain the highest calibre dedicated people who are proud to work for Buckinghamshire Healthcare

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

Provides assurance to the Trust Board, Patients and staff that internal processes for Medical Appraisal and Revalidation are robust, and to report on the 17/18 appraisal activity.

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?

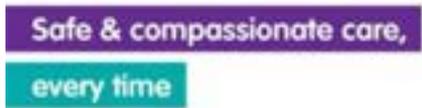
Regulation 17 – Good Governance
Regulation 6 – Safe care and treatment
Regulation 19 – Fit and proper persons

Agenda item: 15

Enclosure no: TB2019/078

	<i>(if you need advice on completing this box please contact the Director for Governance)</i>
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Author of paper: Sarah Klamut, HR Manager Medical Appraisal & Revalidation / Dr Tina Kenny, Medical Director/Responsible Officer
Presenter of Paper: Dr Tina Kenny, Medical Director/Responsible Officer
Other committees / groups where this paper / item has been considered: EMC QUALITY AND CLINICAL GOVERNANCE COMMITTEE
Date of Paper: 06/06/19



Annual Board Report

Medical Appraisal and Revalidation Summary of 2018-2019 Appraisal Year

Author	Sarah Klamut, Medical HR
Lead executive	Dr Tina Kenny, Responsible Officer/Medical Director



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1.0 Executive Summary

- 1.1 This report covers the 18/19 medical appraisal activity from 1st April 2018 – 31st March 2019.
- 1.2 By the 31st March 2019 **423** Doctors had a GMC prescribed connection to the Trust for medical appraisal and revalidation. This includes Consultants, SAS doctors, trust doctors and locum bank doctors.
- 1.3 Arrangements are in place to ensure doctors are appraised to a standard that meets the requirements of the Responsible Officer (RO) Regulations and are revalidated in a timely manner are working effectively.
- 1.4 In the 2018/2019 appraisal year, 350 out of 423 GMC prescribed doctors were required to undertake a medical appraisal and 99.43% of 350 doctors had a completed appraisal.
- 1.5 One doctor did not have a medical appraisal and in consultation with the RO a decision was made to raise a non-engagement early concern to the GMC. There were 68 doctors who did not complete an appraisal. The RO accepted reasons for these, which included new starters joining the organisation and therefore not appropriately due an appraisal in this period, long term sickness and maternity leave.
- 1.6 Revalidation recommendations to the GMC were carried out in a timely manner. All recommendations were positive and 10 doctors had their revalidation deferred. A deferral does not affect a doctor's licence. It means the doctor is given additional time to provide supporting information required by the RO.
- 1.7 The annual return to NHS England, (AOA) Annual Organisation Audit was submitted on time.

2.0 Purpose of the Paper

- 2.1 The Trust has a statutory duty to support its Responsible Officer in discharging their duties under the Responsible Officer Regulations and it is expected that the Board will oversee compliance by:
 - Monitoring the frequency and quality of medical appraisals in the organisation.
 - Checking there are effective systems in place for monitoring the conduct and performance of their doctors.
 - Confirming the feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors.
 - Ensuring that appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that medical

practitioners have qualifications and experience appropriate to the work performed.

- 2.2 It is a requirement that the Trust Board receives an annual report on r revalidation and approves an annual statement of compliance to NHS England.
- 2.3 NHS England provides guidance on the content of the annual report and this paper follows that format.
- 2.4 The purpose of this report is to update the Board as part of the RO regulations on arrangements within the Trust and performance in achieving compliance with the process.
- 2.5 The Board is asked to
 - **Note** the report
 - **Approve** the statement of compliance at Annex E, confirming that the Trust as a Designated Body complies with the regulations.

3.0 Governance Arrangements

- 3.1 Medical appraisal and revalidation is supported by the medical appraisal and revalidation team. The team has access to GMC Connect to ensure that the list of doctors for whom the Designated Body is responsible is up to date.
- 3.2 All complaints involving medical staff are notified to the Responsible Officer.
- 3.3 The Trust's patient safety team and complaints department provide data on complaints and Datix reports to medical staff to support their appraisals.
- 3.4 A Medical Appraisal & Revalidation Policy is in place and was formally agreed September 2018 through the Trust's policy approval processes.
- 3.5 Regular meetings are held with the GMC Employer Liaison Adviser to discuss local concerns/investigations concerning doctors, GMC cases, deferrals and non-engagement recommendations.

4.0 Medical Appraisal

- 4.1 The medical appraisal & revalidation database is audited on a monthly basis against GMC Connect and ESR to record new starters and leavers and to ensure there is an accurate record of doctors requiring an annual appraisal.
- 4.2 All doctors with a prescribed GMC connection are allocated an appraisal month in which to have an appraisal. This is usually within 12 months of the last appraisal.
- 4.3 Medical appraisal can be postponed or deferred if a doctor is off sick, on maternity leave or has agreed in advance with the RO.

- 4.4 Annual medical appraisal compliance is regularly monitored. 4 month appraisal reminder notification emails are sent to doctors. Any compliancy concerns are escalated to SDU leads and divisional chairs.
- 4.5 An electronic appraisal form was updated for the 1st April 2018 in preparation for the appraisal year. Doctors are encouraged to submit via email or post a hard copy in the internal mail.
- 4.6 An electronic survey based on the GMC colleague feedback form is used for doctors to obtain colleague feedback, and a GMC paper format is used for patient feedback. The medical & Revalidation team collate results and provide reports to doctors.
- 4.7 The quality and consistency of medical appraisal relies heavily on the skills and the professionalism of medical appraisers. There are currently 62 Trust Approved Medical Appraisers. Appraiser training workshops are planned for June and October 2019.

5.0 Quality Assurance

- 5.1 Quality assurance of medical appraisals is undertaken by the Medical Appraisal Lead using the Medical Appraisal Quality Assurance Assessment Tool (MAQAAT), developed by the Revalidation and Appraisal team. This new tool was presented as a poster at the national NHS England conference October 2018 where it was awarded First prize. MAQAAT scores and general comments on quality are fed back to both the individual doctor and the appraiser for learning purposes and overall quality is checked and triangulated by the Quality Assurance Group, made up of senior appraisers and the Revalidation and Appraisal team. A copy of the MAQAAT tool and a record of quality assurance can be found in Appendix A.
- 5.2 Feedback reports are generated for each appraiser. The reports are sent to the appraiser at year-end for discussion at their own appraisal. Appraisal feedback report can be found in Appendix B.
- 5.3 The medical appraisal & revalidation team track the appraisal process and remind doctors of timescales.
- 5.4 The medical appraisal and revalidation team attend regular NHS England RO & Medical Appraisal Leads Network Meetings to keep up to date with NHS England and the GMC activity.

6.0 Access, security and confidentiality

- 6.1 There is no Patient Identifiable Data in the appraisal records. Each doctor has a legacy paper file and an e-folder, maintained in a secure medical staffing drive.

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6.2 With the changes to the General Data Protection Regulation (GDPR) in May 2018, the medical appraisal & revalidation team have reviewed the use of surveys and personal information.

7.0 Revalidation Recommendations

7.1 All revalidation recommendations are reviewed by the Revalidation Referral Group (RRG) chaired by the Responsible officer Dr Kenny and attended by Divisional Chairs, Medical Education Director and Associate Medical Director.

7.2 Revalidation recommendations made between the 1st April 2018 – 31st March 2019: (revalidation dates are determined by a doctors GMC registration date)

- Number of positive recommendations: 80
- Number of deferred recommendations: 10
(There are several reasons that the RO may defer a revalidation recommendation 1) there is incomplete information on which to base a recommendation to revalidate or 2) the doctor is participating in an ongoing local governance process.

8.0 Recruitment and Engagement, Background Checks

8.1 The Trust follows the NHS Employment Check Standards produced by NHS Employers for all recruitment of permanent staff, fixed term contracts temporary locum staff, students, trainees and trust bank staff.

8.2 In addition to a standard employment reference, a transfer of information from previous employers is obtained for all new appointments and external practice declaration is recorded in the appraisal paperwork.

8.3 GMC connect provides a connection history and establishes a doctors movement within the medical field.

9.0 Monitoring Performance

9.1 All doctors are professionally accountable to the Medical Director.

9.2 Monitoring performance is undertaken by Job planning, management of complaints via Datix and a medical HR casework tracker.

9.3 Significant events are recorded as part of the annual medical appraisal. Discussions are about how events have led to a specific change in practice or demonstrate learning.

10.0 Responding to Concerns and Remediation

10.1 All medical Conduct, Capability, Ill health is managed by the medical HR team. The Appeals Policies and Procedures for Practitioners – Maintaining

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High Professional Standards (MHPS) outlines the process for dealing with serious concerns about a doctor's performance including conduct, capability and health issues. A case tracker is held within Medical HR.

11.0 Risk and Issues

- 11.1 The medical appraisal and revalidation process is maintained by many paper-heavy manual processes which require constant vigilance to maintain and we need to procure an electronic appraisal management system to reduce the risk of future failure. A business case has been submitted and approved, however financial approval is on hold. The management system will store appraisal evidence for the Responsible Officer to form the basis of a revalidation recommendation to the GMC and streamline the process for doctors. A system will provide patients and the organisation with assurances of clarity, standardisation and efficiency of the medical appraisal and revalidation processes.

12.0 Future Developments

- 12.1 On delivery of an electronic Revalidation Management System, there will be a period of implementation and training for all doctors to use the system.
- 12.2 Consider ways in which the Trust can provide clinical data for doctors that feeds into the annual medical appraisal.

13.0 Recommendations

- 13.1 The board are asked to agree to this report.
- 13.2 The board are asked to delegate approval for the CEO to sign the 'Statement of compliance' Annex E confirming that the organisation, as a designated body, is in compliance with the regulations.

Annex E - Statement of Compliance

Designated Body Statement of Compliance

The board of Buckinghamshire Healthcare NHS Trust has carried out and submitted an annual organisational audit (AOA) of its compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a Responsible Officer;

Comments: **Dr T Kenny**

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

Comments: **Yes. An accurate record is maintained by the Medical Appraisal & Revalidation Team on an excel database, regularly checked and monitored against the GMC Connect listing and Trust starters/leavers reports.**

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

Comments: **Yes. We maintain a Trust Approved Medical Appraiser list for appraisees to select a suitable appraiser from. The Medical Appraiser list is regularly updated and available on the intranet.**

4. Medical appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent);

Comments: **Yes. Appraisers are required to undertake training. We have a Quality Assurance Group to monitor and audit appraisal standards.**

5. All licensed medical practitioners¹ either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

Comments: **Yes. We closely monitor annual medical appraisal completion and are committed to continually improving and developing our systems to ensure potential non-engagement is dealt with quickly and effectively.**

¹ Doctors with a prescribed connection to the designated body on the date of reporting.

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners¹, which includes [but is not limited to] monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues, ensuring that information about these is provided for doctors to include at their appraisal;

Comments: **Yes. We have a system for monitoring the conduct and performance of our licensed medical practitioners. We have developed a process to provide doctors with information about complaints/DATIX for appraisal input.**

7. There is a process established for responding to concerns about any licensed medical practitioners¹ fitness to practise;

Comments: **Yes. Any concerns regarding fitness to practise are dealt with under our Maintaining High Professional Standards policies and procedures. A case tracker is held within Medical HR to monitor case progress.**

8. There is a process for obtaining and sharing information of note about any licensed medical practitioners' fitness to practise between this organisation's Responsible Officer and other Responsible Officers (or persons with appropriate governance responsibility) in other places where licensed medical practitioners work;

Comments: **Yes. A transfer of information is requested by this Trust to other organisations on appointment of new doctors. Doctors are required to notify any other employers and make a probity declaration in their annual appraisal. We also require an external practice form to be completed with the annual appraisal, requiring other employers to notify any fitness to practise concerns.**

9. The appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that all licenced medical practitioners² have qualifications and experience appropriate to the work performed; and

Comments: **Yes. We have rigorous pre-employment checks for licensed medical practitioners.**

10. A development plan is in place that addresses any identified weaknesses or gaps in compliance to the regulations.

² Doctors with a prescribed connection to the designated body on the date of reporting

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Comments: **Yes. I confirm we have a Medical Appraisal and Revalidation Work Plan in place.**

Signed on behalf of the designated body

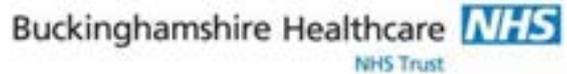
Name: Neil Macdonald

Signed: _____

Chief Executive

Date

Agenda item 16.1
 Enclosure no: TB2019/079



PUBLIC BOARD MEETING Wednesday, 31 July 2019

Details of the Paper

Title	Equality, Diversity and Inclusion (ED&I) annual report
Responsible Director	Bridget O'Kelly
Purpose of the paper	To update Trust Board on developments in Equality, Diversity and Inclusion during 2018-19, including the Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES)
Action / decision required (e.g., approve, support, endorse)	The Board is asked to: <ul style="list-style-type: none"> • Approve the data for submission for the workforce Data Equality Standard (WDES) and the Workforce Race Equality Standard (WRES) and approve for publication • Approve the Public Sector Equality Duty Reports prior to publication • Approve the EDS2 Gradings and approve for publication • Approve the Trust Equality Objectives for 2019 to 2023 and approve for publication

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

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

ANNUAL OBJECTIVE

Attracting and retaining high calibre and engaged people

Please summarise the potential benefit or value arising from this paper:
 Information & Assurance

RISK

Are there any specific risks associated with this paper? If so, please summarise here.	Non-Financial risk: There is a risk to us delivering all corporate objectives if we don't attract and retain high calibre and engaged people
	Financial risk: None

LINK TO CARE QUALITY COMMISSION ESSENTIAL STANDARDS OF SAFETY AND QUALITY

Which CQC standard/s does this paper relate to?	Regulation 18: staffing Regulation 19: Fit and proper person employed CQC Well led framework
---	--

Author of paper: Christine Hughes

Presenter of Paper: Bridget O'Kelly

Other committees / groups where this paper / item has been considered: ED&I Steering Group and EMC

Date of Paper: 18 July 2019

Agenda item 16.1
Enclosure no: TB2019/079

Agenda item 16.1
Enclosure no: TB2019/079

Equality, Diversity & Inclusion: 2018-19 annual report

1. Executive Summary

- 1.1. This report provides an update on Equality, Diversity and Inclusion (ED&I) activity in the Trust for 2018-19, specifically in relation to our statutory duties.

There has been a significant amount of work across the organisation in the last 12 months. The Director of Workforce & OD has re-established an Equality, Diversity & Inclusion Steering Board. The Board has overseen the work set out in the Workforce Race Equality Standard 2018 action plan.

This Board is also supporting the creation of four staff networks: Black, Asian, Minority Ethnic (BAME), Disability, LGBTQ+ (Lesbian, Gay, Bisexual, Transgender, Queer) and Spirituality. The BAME network has grown quickly and now has over 100 members. It is leading work across the organisation to improve the experiences of BAME staff, including a reciprocal mentoring scheme for senior and BAME staff. The other networks are in earlier stages of development.

- 1.2. As an NHS Trust and public sector body, we have a number of requirements to meet. As such, the Board is asked to note and approve for publication the following sets of data and reports:

- The data for submission for the Workforce Data Equality Standard (WDES) and the Workforce Race Equality Standard (WRES)
- The Public Sector Equality Duty (PSED) Reports
- The Equality Delivery System 2 (EDS2) grading
- The Trust Equality Objectives for 2019 to 2023 and approve for publication

These reports flag areas where the experiences of staff with protected characteristics are worse than those without. There are differences in a number of key areas. E.g. recruitment, formal employee relations and bullying & harassment.

The detail of each of these requirements is set out below and the reports are included as appendices.

- 1.3. We have used information from these different sources of information (EDS2, WDES, WRES, PSED and Staff Survey report) to inform the proposed four Equality Objectives, which have been endorsed by the ED&I steering group.

These high-level objectives have been developed so that they support the delivery of and run alongside the corporate objectives, in particular the programme to “develop teams, talent & an inclusive workforce”.

Specific outcomes, milestones and key performance metrics will be set in the next two months as we formulate the action plans for WDES and WRES.

Agenda item 16.1
Enclosure no: TB2019/079

2. Detail

2.1 Disability and the Workforce Disability Equality Standard (WDES)

Progress in the past twelve months:

In January 2019, we held a Disability networking event. The aim was to share knowledge about the different aspects of disability and publicise the support we offer to staff with disabilities and those who care for people with disabilities.

In March, we held the first meeting of the BHT Ability Network for staff with disabilities and allies. This group is now meeting bi-monthly.

The WDES

The NHS launched the WDES in April 2019; all NHS organisations are required to publish a standard data set from the previous financial year. Trusts are measured against ten specific workforce related indicators and benchmarked via a national reporting template. Trusts are then required to write and publish an action plan.

A summary sheet of our key WDES 2019 data is included at Appendix 1; a full copy of the WDES data submission is available on request.

The data gathered for the Trust WDES shows the following:

- A non-disabled candidate is 1.22 times more likely to be appointed from shortlisting than a person with a disability.
- 3% of staff have formally declared a disability which is recorded on the Electronic Staff Record (ESR); in comparison, 16% of staff who responded to the NHS National Staff Survey declared that they had a disability. It is also worth noting that the national census data shows that the percentage of the population in Buckinghamshire that declare a disability is c14%.

Next steps

The ED&I Steering Group and BHT Ability group will work together to draw up an action plan. This will come for approval to Trust Board in September 2019 prior to publication.

A key piece of work is for us to understand the reasons that staff do not declare a disability and from that work encourage increased declaration rates

Recommendation

The Board is asked to approve the WDES data for publication.

2.2 Race and the Workforce Race Equality Standard (WRES)

Progress in the past twelve months:

In October 2018, we launched the BAME staff network. The network meets monthly and now has over 100 members. Its current focus is recruitment, particularly into senior roles.

Agenda item 16.1
Enclosure no: TB2019/079

The chair of the network has set up a reciprocal mentoring scheme for senior managers and BAME colleagues. There are now 13 partnerships in place. In October, we held events to celebrate Black History Month. These included a film week and a network event celebrating different cultures and food.

WRES

The NHS established the Workforce Race Equality Standard (WRES) in 2015. A summary sheet of our key WRES 2019 data is included at Appendix 2; a full copy of the WRES data submission is available on request. A copy of our current WRES Action Plan can be found in Appendix 3.

Areas to note from our 2018/19 data

- White staff are 1.57 times more likely to access non-mandatory training and education than BAME staff; this is a significant change since the 2018 WRES when White staff were 0.71 times as likely to access this.
- There is a small improvement in the ratio for BAME staff being appointed from shortlisting in comparison with white staff; this ratio for 2019 is 2.38 compared to 2.44 in 2018. This is a small improvement, but above the target we set for this year of a figure below 2.2.
- Further analysis (not reported on the WRES template) shows that white applicants are 1.85 times more likely to be appointed from interview than a BAME applicant. The data also shows a significant number of both BAME and white candidates who are shortlisted but then pull out before interview.
- BAME staff are 1.50 times more likely to enter formal disciplinary procedures; this compares to an improvement from 3.5 times in 16/17, to a figure of 1.36¹ times in 17/18. Whilst a small improvement was made, this was still below our target of 1.4 times at the end of 18/19.
- A breakdown of ethnicity of our workforce by AfC (Agenda for Change) band will be published as part of the WRES data set. This data is also included in the information for the public sector equality duty. It shows that the percentage of BAME staff reduces significantly in senior AFC bands. (This information is set out in Appendix 16 of this report – Public Sector Equality Duty.)

Next steps

The ED&I Steering Group and BHT Ability group will work together to draw up an action plan. This will come for approval to Trust Board in September 2019 prior to publication.

Recommendation

The Board is asked to approve the WRES data for publication.

2.3 Public Sector Equality Duty (PSED)

Under the statutory requirements of the Public Sector Equality Duty (PSED) the Trust is expected to publish sufficient information to demonstrate compliance with the Equality Act 2010. For the general duty as set out in the PSED we need to show how we are having due regard to the need to:

¹ The figure for 2018 has changed from 1.52 (previously published figure) to 1.36 following changes to the technical guidance.

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- Eliminate unlawful discrimination, harassment, victimisation and any other conduct prohibited by the Equality Act 2010
- Advance equality of opportunity between people who share a protected characteristic and people who do not share it
- Foster good relations between people who share a protected characteristic and people who do not share it.

There are 10 reports covering information relating to staff and patients for the financial year 2018-19. These must be published annually to comply with our statutory duty. A summary of the key findings is set out in Appendix 4. The full reports are available on request.

Recommendation

The Board is asked to approve the PSED reports for publication.

2.4 Equality Delivery System 2 (EDS2) and the Trust Equality Objectives for 2019-23

EDS2 is a national tool designed by the NHS to help NHS organisations to review and improve their delivery of services and performance as an employer for people with protected characteristics. Its use is mandated by NHSI and the CQC to inform the Trust Equality Objectives, in conjunction with the other information (from WRES, WDES and PSED).

The EDS2 is not a self-assessment; panels of patients and staff are asked to assess the Trust's performance in a number of areas. Two assessments – one by patients reviewing services, and one by staff reviewing their experiences - were carried out during April and May 2019. A summary of the outcome is set out in Appendix 5. The numbers of participants at the panels were small; however, the findings align with information from other sources – i.e. WDES, WRES and PSED and Staff Survey reports. A copy of the EDS2 Grading Sheet is on available on request.

Patient assessment and proposed actions

The patient grading results for 2019 remained similar to those recorded in 2016 with the exception of goal 2.2 (People are informed and supported to be as involved as they wish to be in decisions) which decreased to Developing. The panel felt, specifically under this goal that patients are still not fully aware of schemes like “choose and book” and often feel pressurised by their GPs as to where they should be treated.

The panel proposed that the Trust needs to try and engage with patients in certain hard to reach communities such as travellers, ethnic minority groups, impoverished local areas to ensure all residents and potential patients to BHT know about services being offered not only at hospital sites but within the community to help support them and prevent health issues.

Staff Assessment and proposed actions

The staff grading results saw a decline in grading in 4 specific goals (3.1, 3.5, 3.6 and 4.3). Three of these goals fall under goal 3 (Empowered, engaged and well supported staff). The panel reflected that the Trust has embraced equality, diversity and inclusion for staff since 2016 and great examples were highlighted by staff. However, the grading panel felt objectives needed to be agreed in order to address some inconsistency within the Trust relating to certain issues, in particular bullying and harassment by patients, carers, families/friends of patients.

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The panel flagged bullying and harassment as a key area for work; they reported that Trust processes could be too long and that as a result many incidents are not reported or escalated as the Trust would like.

Recommendation

The Board is asked to approve the EDS2 data for publication.

2.5 Trust Equality Objectives

Every four years public bodies are required to publish Equality Objectives. The Trust must now review its Equality Objectives and publish its objectives for 2019 to 2023.

We have used information from the different sources of information described above: EDS2, WDES, WRES, PSED and Staff Survey reports – to develop four equality objectives, which have been endorsed by the ED&I steering group.

These high-level objectives have been developed so that they support the delivery of and run alongside the corporate objectives. Specific outcomes, milestones and key performance metrics will be set in the next two months as we formulate the action plans for WDES and WRES.

Equality Objective	
1	Staff – reduce inequalities for staff with protected characteristics at BHT
2	
3	Patient experience
4	

Christine Hughes
ED&I Lead

Appendix 1 – WDES – Indicators**Summary of findings – WDES 2019**

	METRIC	Ratio (where applicable)	Disabled staff %age	Non disabled %age
1.	Percentage of staff in AFC pay bands or medical and dental subgroups and very senior managers (VSM) (including executive board members) compared with the percentage of staff in the overall workforce.		3%	85%
2.	Relative likelihood of Disabled staff compared to non-disabled staff being appointed from shortlisting across all posts. This refers to both external and internal posts.	1.22		
3.	Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.	0 (there were no cases involving staff who had declared a disability)		
4a	Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from patients/service users, their relatives or other members of the public, managers or colleagues		31.3%	25.8%
4b	Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.		45%	47.3%
5.	Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.		87.1%	88.4%
6.	Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.		23.5%	19.1%
7.	Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.		40.9%	46.8%
8.	Percentage of Disabled staff saying that their employer has made adequate		79.8%	

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	adjustment(s) to enable them to carry out their work.			
9a	The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation.		6.8	7.1
9b	Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? Yes or No	Yes		
10	Percentage difference between the organisation's board voting membership and its organisation's overall workforce, disaggregated: By voting membership of the board By Executive membership of the board		-3%	

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Appendix 2 – WRES Indicators 2019

Progress of WRES Indicators, 2-9 from 2017 to 2019	2017 Data	2018 Data	2019 Data	Target 2019 outcome from 2018 action plan (if applicable)	Comments
Indicator 2 – Relative Likelihood of staff being appointed from shortlisting across all posts	2.41	2.44	2.38	2.2 or less	Improvement but target not met
Indicator 3 - The relative likelihood of BME staff entering formal disciplinary process compared to that of white staff	3.5	1.52 (1.36 ²)	1.5	1.4 or less	Improvement but target not met
Indicator 4 - Relative Likelihood of White Staff accessing non mandatory training and education in comparison to BME Staff	0.44	0.78	1.57		There has been a deterioration for BAME staff this year, and we will ask members of the BAME staff network to inform actions going forward
Indicator 5 - percentage of BAME staff experiencing harassment, bullying or abuse from patients, relatives or the public in the past twelve months	26.92%	28.4%	26.3%		This shows a decrease in 2019, following an increase in 2018, in comparison to 2017
Indicator 6 - percentage of BAME staff experiencing bullying, harassment or abuse from staff in the last 12 months	23.57%	21.2%	22.9%		This figure has increased following a considerable fall in 2018
Indicator 7 - percentage of BAME staff believing that the Trust offers equal opportunity for career progression	80.7%	78.3%	80.9%		This shows a considerable increase over the 2018 data.
Indicator 8 – Percentage of BAME Staff who in the past	12.19%	11.1%	10.8%		There has been a

² Due to the Technical Guidance having been changed, the figure for 2018 has changed from 1.52 (previously published figure) to 1.36

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12 months have personally experienced discrimination at work from their Manager/team leader or other colleague					sustained decrease in this figure since 2017
Indicator 9 – Percentage difference between the organisation's Board voting membership and its overall workforce	-7.4%	-9.5%	-10.5%		There has been a deterioration in this figure since 2017

Appendix 3

WRES Action Plan 2018 – 19 update

Action	Action Owner	Success Criteria	Target Date	Update on Actions to date
Set up BAME Network to support BAME employees and WRES related actions and ensure then meets quarterly	E,D&I Lead and Leadership Projects lead	Network established with Chair/Co-Chair and Secretary in post and annual rolling programme of events in place	30-Sep-18	Launch of Network held on 27/9/18, follow up held on 23/1/18. Meetings have been held bi-monthly. Total membership around 100 staff. Current focus is the recruitment of BAME individuals into senior roles within the Trust
The BAME Network has asked that the Trust implements the practice of a BAME representative being on every recruitment panel for posts at 8A and above	Head of Recruitment	Reduction in ratio for Indicator 2 - from 2.44 to 2.2 or less	31-Mar-19	This will be implemented from July 2019 onwards.
Ensure that Recruitment Training is put in place with a lived experience video	Leadership Projects Lead and Head of Recruitment		31-Mar-19	Recruitment Training introduced in April 2019, 59 Leaders are now trained.

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Review the PSED data in conjunction with the WRES data to draw out a detailed analysis of the issues around Disciplinary, Grievance and Dignity and Respect at Work	Senior HR Business Partner	Reductions in Indicators 3,6 and 8 as detailed elsewhere	31-Mar-19	In line with best practice, a Triage process for disciplinary cases is to be introduced in August 2019
Work with the BAME Network to flesh out ways that the approach to disciplinary processes could be improved for BAME staff and then start a Task and Finish Group within that Network to establish ways of continuing the improvement on WRES Indicator 3 and ensure that these initiatives are implemented (Disciplinary Processes)	E,D&I Lead and Leadership Projects Lead	Reduction in ratio for Indicator 3 from 1.52 to 1.4 or less	31-Mar-19	In line with best practice, a Triage process for disciplinary cases is to be introduced in August 2019
Establish an Employee Relations Task and Finish Group to analyse and review experience of BAME staff in relation to the Grievance and Dignity and Respect At Work Policies	Assistant Director of HR	Indicator 6 - reduction from 21.17% to 19% or below Indicator 8 reduction from 12.19% to 11% or below for BAME Staff	31-Mar-19	Senior HR Business Partner and E,D&I Lead to attend the next BAME network meeting to inform the action plan and then facilitate amendment of the action plan to include these actions

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Initiate a programme of Reciprocal Mentoring the Trust	Leadership Projects Lead		31-Dec-18	A number of Reciprocal Mentoring relationships have been set up and are ongoing.
Publicise E,D&I related activity using Swanlive	E,D&I Lead in conjunction with Communications Team	Page established which can be accessed by a range of contributors and is regularly updated with current news items. Broader awareness of E, D&I issues amongst trust staff. Set a minimum number of hits on this page to determine success	31-Jan-19	There has been regular communication regarding E,D&I activity on Swanlive
Develop and deliver cultural awareness training for Medical and other staff	Medical Appraisal and Validation Lead	Arrange at least five sessions to be held during 2019 Sessions arranged and publicised	31 March 2019	Three sessions have already been held and two further are planned for 2019. These sessions have capacity for up to fifteen attendees. Sessions continue to be publicised.
Promote and celebrate Events such as Black History Month, National Inclusion Week, Human Rights, Equality, Diversity and Inclusion Week	E,D&I Lead to co-ordinate programme with volunteers taking the lead on specific events	Wider awareness across the Trust of specific protected characteristics and greater motivation by individuals across the trust to initiate relevant events. BAME staff saying that they feel they have equal respect to White staff	Ongoing	Events to celebrate Black History Month in October were held - including a weekly film night and an event celebrating different cultures and food. Human Rights, Equality and Diversity Week was celebrated with information about the different protected characteristics. Other events, such as International Women's Day were

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				celebrated with 'Lived experience' pieces on Swanlive
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Appendix 4

Summary of PSED Key Findings

Report	Protected characteristic	Key finding
Workforce profiles	Ethnicity	<ul style="list-style-type: none"> 25% of employees in Band 6 are of a BAME background (22% in 2018 WRES), and this drops to 16% (15% in 2018 WRES) at Band 7. At Band 8B, 25% of employees are of a BAME background (18% in 2018) and this drops to 8% at Band 8C (9% in 2018 WRES). 15% of staff at Band 9 are of a BAME background and this drops to 0% at Very Senior Manager level.
	Disability	<ul style="list-style-type: none"> As noted in the WDES section above, there is a significant difference in the percentage of staff who have declared a disability in 2018 Staff Survey (16% of respondents) compared to the data held on ESR (the electronic staff record) (3% of staff).
	Gender	<ul style="list-style-type: none"> The Gender breakdown as of 31 March 2019 was 81% Female and 19% Male. In the previous financial year, the gender breakdown was 78% female and 22% male. There has been a small, but significant increase in women in senior leadership roles in the Trust. At Band 9, there has been an increase from 6 women to 8 between 2018 and 2019. In Bands 8A-8D there has been an increase from 229 in 2018, to 235 in 2019.
	Sexual orientation	<ul style="list-style-type: none"> Only 1% of staff reported themselves to be Gay or Lesbian, again we will be carrying out some focussed work to encourage higher declaration rates. 17% of staff who were asked this question chose not to declare their sexuality. We will put actions in place to address this in the coming year
	Religion & belief	<ul style="list-style-type: none"> Our 2018-19 data shows a 1% increase in Atheism, 6% increase in undefined, a 5% increase in Christianity and a 1% increase in Hinduism in comparison to 2017-18.
Employee Relations	Disability	<ul style="list-style-type: none"> 15% of staff who took out a Grievance had declared a disability.
	Ethnicity	<ul style="list-style-type: none"> 47% of formal disciplinary cases involved someone of a non-white background 33% of staff who made complaints under Dignity and Respect at Work, had declared their ethnicity as White.
	Gender and age	<ul style="list-style-type: none"> Flexible Working - 91% of flexible working requests were made by female staff and the age

		group most likely to make such are request was aged between 35-44
Bullying and Harassment	Ethnicity	<ul style="list-style-type: none"> • Fewer BAME staff experienced harassment and bullying from the public in 2018, 26% as opposed to 28% in 2017. Our 2018 figure compares favourably with a national figure of 28% of BAME staff in similar Trusts. However, such behaviours perpetrated by staff increased to 23% in 2019 from 21% in 2018.
	Disability	<ul style="list-style-type: none"> • As demonstrated in the WDES, 31.3% of staff who declared a disability had experienced bullying by patients and the public; nationally this compares to a national average figure of 34.1%. This is an action that is likely to need addressing in our action plan for 2019-20
Patient Engagement and patient involvement		<ul style="list-style-type: none"> • In contrast to our results for 2017/18 where the majority of participants were older, this year in large part due to a county wide engagement programme for Better Births the majority of participants were between 25 and 34. One of our aims identified in our 18/19 report was to engage with younger people. This was largely achieved through a promoting the engagement via social media. • Patient involvement traditionally attracts more female participants, however this year's results have been skewed by our engagement on Better Births which targeted women who were pregnant or had had a child in the last year. • It is positive to see that the views of people received through our various engagement and involvement opportunities, represent a broad range of ethnic minority groups. Locally, in the population of Buckinghamshire, 81.1% are from a white British ethnic group, this is reflected in our breakdown as most respondents are from a white British ethnic group. However further work needs to take place during 2019/20 to encourage minority groups to engage with Buckinghamshire Healthcare NHS Trust.

Appendix 5

Equality Delivery System 2 (EDS2) and setting of the Trust Equality Objectives for 2019-23

EDS2 Patient Grading Summary

9 patients met to grade the first two goals for the Equality Delivery system:

- Goal 1 – Better health outcomes for all
- Goal 2 – Improved patient access and experience

The table report below outlines the grades agreed and comments made surrounding the decisions made. A copy of the EDS2 Grading Summary can be found attached in Appendix 6.

Patients have highlighted and suggested ways of tackling shortcomings by the Trust throughout this document. Each highlighted section represents comments given by the panel to assist addressing of the shortcomings. All are listed below:

Goal	Patient Panel Suggestion	Grade	Link to Corporate Objective
1 – Better health outcomes for all 1.1 Services are commissioned, procured, designed and delivered to meet the health needs of local communities	It was acknowledged that the Trust needed to try and engage with patients in certain hard to reach communities such as travellers, ethnic minority groups, impoverished local areas to ensure all residents and potential patients to BHT know about services being offered not only at hospital sites but within the community to help support them and prevent some health issues.	Developing	Link to Inequalities objective – building community partnerships to enable us to support hard to reach groups
1 – Better health outcomes for all 1.1 Services are commissioned, procured, designed and delivered to meet the health needs of local communities	The grading group was advised that a “Welcome Pack” was currently being developed which would be sent/given to each patient. The content of the pack was currently being discussed but the grading panel wanted it to include; Welcome letter, information about patient experience surveys and how to fill them in including a discharge survey, (Please help us improve our services. How to get more engaged with the Trust etc.), hospital and ward opening times, information on parking fees and concessions, food (different menu choices, laundry service, Pastoral care (what available, where and when), translation	Developing	Link to Culture objective – listening to our patients

	services (who to contact, how to arrange etc.) what to bring with you and information about discharge (what to expect, when, how etc.).		
1 – Better health outcomes for all 1.2 Individual people’s health needs are assessed and met in appropriate and effective ways	It was suggested that we involve our vast volunteer network to encourage inpatients to take the friends and family test giving them the vital information of why taking part in the survey is so important to the Trust. It was also suggested that volunteers should be treated like staff and included on being able to give feedback through the staff survey and various staff networks.	Achieving	Link to Culture objective – listening to our patients and Enabling Making it easier to get things done
2. Improved patient and access and experience 2.2 People are informed and supported to be as involved as they wish to be in decisions about their care	Information about choices that patients have should be better advertised around the Trust.	Developing	Link to Inequalities objective – build community partnerships to enable us to support hard to reach groups

EDS2 Staff Grading Panel

10 members of staff met to grade the third and fourth goals for the Equality Delivery system:

- Goal 3 – Empowered, engaged and well-supported staff
- Goal 4 – Inclusive leadership at all levels

The table below outlines the grades agreed and comments made by the panel. It also includes results from the 2018 NHS staff survey where appropriate. Prior to the grading, the group also discussed how the Trust could increase the number of staff who respond to the NHS staff survey.

Goal	Staff Panel Suggestion	Grading	Link to Corporate Objective
Staff survey - Staff still believe that the staff survey is not 100% anonymous. The Trust needs to explain the coding system used on the staff survey and simply and clearly explain to staff that	<ul style="list-style-type: none"> • “Survey cafes” should be opened. Quiet areas throughout the Trust where PC’s are set up for staff to complete the survey online. Somewhere that is quiet but has access to tea/coffee and a biscuit • Staff should be given the time to fill out a staff survey. Maybe this could be done as protected time within a staff/department 	N/A	Making BHT a great place to work

<p>there will be no retribution for any responses made within the staff survey. This message also needs to explain the importance of gathering the information obtained through this survey and how the Trust will use the information gathered to develop support services for staff</p>	<p>meeting at the beginning of the meeting. Surveys would be given out and all staff asked to fill one out prior to the meeting taking place or a PC being left open for a week for staff to sit and fill out a staff survey without being called away to do their day job</p> <ul style="list-style-type: none"> On Audit days, protected learning days, completing the staff survey could be part of the agenda/meeting/learning 		
<p>Empowered, engaged and well-supported staff</p> <p>3.4 When at work, staff are free from abuse, harassment, bullying and violence from any source</p>	<p>As highlighted within the main report, the Trust needs to focus and create an equality objective which focuses on Bullying and Harassment within the workplace. The Trust needs to ask itself:</p> <ul style="list-style-type: none"> How can we make this process easier for staff to report bullying and/or harassment without prejudice? What would staff like to see put in place to make this easier? – Workshop/s Is conflict resolution training going to the right audience? Are staff aware of services available to them to support them in times of stress? 	Undeveloped	<p>Making BHT a great place to work</p> <p>Develop teams, talent and an inclusive workforce</p>
<p>Empowered, engaged and well-supported staff</p> <p>3.5 Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives</p>	<p>The panel discussed the Flexible working policy, how it works on the ground and if not, how it can be adapted.</p>	Undeveloped	<p>Making BHT a great place to work</p> <p>Develop teams, talent and an inclusive workforce</p>

Both of these issues, 3.4 and 3.5 scored very low in the EDS2 scoring. Both link into the Workforce – improve retention by making BHT a great place to work. The following goals have all seen a decline in ratings which again is linked to our workforce corporate objectives:

- Fair NHS recruitment and selection processes lead to a more representative workforce at all levels (3.1)
- Staff report positive experiences of their membership of the workforce (3.6)
- Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination (4.3)

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Safe & compassionate care,
every time

Buckinghamshire Healthcare **NHS**
NHS Trust

TRUST BOARD MEETING Wednesday 31 July 2019

Details of the Paper

Title	Annual Report - Freedom To Speak Up April 1 st 2018 to 31 st March 2019
Responsible Director	Bridget O'Kelly – Director of Workforce and Organisational Development
Purpose of the paper	To provide the Trust Board with an annual report, reflecting key areas of work and progress over the past year with regards to the Freedom to Speak Up agenda.
Action / decision required (e.g., approve, support, endorse)	The Board is asked to note the content of the report.

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

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

ANNUAL OBJECTIVE

Attracting and retaining high calibre and engaged people
Strategic priorities. Quality and People

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

This report helps to headline positive progress whilst outlining remaining challenges in our journey to build a positive speaking up culture. This is important for patient and staff safety when preventing errors and learning from concerns raised.

RISK

Are there any specific risks associated with this paper? If so, please summarise here.	<p>Non-Financial risk:</p> <ul style="list-style-type: none"> There is a risk to us delivering all corporate objectives if we don't attract and retain high calibre and engaged people <p>Financial risk:</p> <p>Poor cultures of speaking up in organisations affect recruitment and retention so potentially there is risk if we don't do this well. A positive speaking up culture helps save resources of multiple types, including financial.</p>
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LINK TO CARE QUALITY COMMISSION ESSENTIAL STANDARDS OF SAFETY AND QUALITY

Which CQC standard/s does this paper relate to?	CQC Well led framework Freedom To Speak Up is included as part of the inspection framework.
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Author of paper: Tracey Underhill Freedom To Speak Up Guardian.

Presenter of Paper: Tracey Underhill Freedom To Speak Up Guardian.

Other committees / groups where this paper / item has been considered: EMC and SWC

Date of Paper: 18 July 2019

Freedom to Speak Up – Annual Report 2018/19

1. Purpose

- To provide Trust Board with an annual summary and overview with key headlines for the year 1st April 2018 to 31st March 2019.
- For assurance and information.

2. Executive Summary

Key areas to highlight improvements are:

National staff results

- National Staff survey results show a 4% increase in staff saying they would feel secure in raising concerns about unsafe clinical practice. We have now achieved our sector score of 70% which we have not done previously and will continue to strive to exceed it.
- We are also showing a 4% increase in staff saying they are confident that the organisation would address their concern. However, there is more work to do in this area with our overall score is just 1% below our sector score of 58% which we continue to aim to improve.

The negative scores on both of these questions year on year have halved.

4% increases in any one year of the national staff survey results is seen to be significant and exceed usual expectations.

- In 2017/2018, Women, Children & Sexual Health Division showed only 38% of the staff in the response sample said they were aware of the FTSUG role which was the lowest score for this question. The most recent results show them now in the top position of all the clinical divisions with a significant improvement to 73%
- Similarly, Integrated Elderly & Community Care Division has demonstrated a significant improvement in awareness of how to locate contact details of the FTSUG. This was 41% last year and has improved to 63%

Casework

- Q1 and Q2 year on year saw a 177% increase in numbers of cases received by the Freedom to Speak Up Guardian (FTSUG) and no specific themes.
- Q 3 year on year has shown the highest number of cases but it is for different reasons, so we await to see this year if this becomes a pattern. 2017/18 the cause was winter pressures related, 2018 /19 it was due to national “Speaking up Month” which is October.
- The total number of cases has increased from 46 last year to 74 this year. This is a positive increase of 61%.
- With specific call activity (see section 5) this equates to 96 concerns and learning opportunities that we might not otherwise have been made aware of.
- This past year has seen the number of people raising concerns directly with the FTSUG break through a 100 with a total of 116 staff. This increased from 70 the previous year. This is a positive achievement for the second year and indicates progress towards building a positive speaking up culture.

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Building a climate of respect

- Building a Climate of Respect was launched in December 2018, this is a new campaign to raise awareness of our zero tolerance to bullying and harassment and poor behaviours. Encouraging people to call it out. This campaign was developed as a result of listening and learning from staff speaking up. A seven minute video was produced and cascaded across the organisation. Led with clear messaging from our CEO and supported by the Director of Workforce and Organisational Development, our Union Chair representative and the FTSUG, the film highlights the importance and value of respecting each other. [Link to BACR Video](#)
- In addition, a supporting resource guide has been developed with a range of reports, evidence, toolkits, books and references and signposts for further support. Both can be accessed by staff outside work if needed. This continues to develop with added resources. [Online BACR Resource Guide](#)
- The national staff survey has shown that we have very positive results for staff' awareness of our Dignity and Respect at Work policy with the overall score being 93% and all divisions showing above 90%. It is also positive news to see that the 94% of the staff in the response sample say they do know how to report bullying, harassment, violence or victimisation.
- However, there is work still to do with the overall score of 71% of staff saying they would feel secure raising concerns about these behaviours and only 59% feeling confident their concerns would be addressed

The launch of the Building a Climate of Respect campaign was after the staff survey was undertaken so will not have had impact on this years set of results for the relevant questions. It is hoped that this will help to further improve this score for next year.

- Our Divisions of Integrated Medicine, Women, Children & Sexual Health and Surgery and Critical Care appear to be demonstrating a positive reduction of 8%, 8% and 14% respectively year on year in the number of staff who have experienced either bullying, harassment, victimisation, violence or abuse of a physical nature from patients over the previous 12 months. The results show there is still work to do in this patient facing area, particularly in Integrated Medicine but it is still good news that the Trust score is showing a positive reduction of 12% overall.
- With regards to the same question but relating to colleagues, the Divisions of Integrated Medicine and Surgery and Critical Care are also showing a strong decrease of 11% and 9% respectively, whilst Specialist Services and Corporate Areas have demonstrated a slight increase.

Other activities

- "Concerning Conversations" is a new one year programme of workshops will launch on May 14th planned and developed across Q4, See Appendix 1.
- Trust-wide Lessons Learned sessions were delivered in July 2018 with another scheduled for this coming August.
- Multiple activities have been undertaken throughout the year to help promote and raise awareness including, numerous presentations, corporate and doctor inductions, national "Speaking up Month" including a theme for the final of the Trust "Bake Off", locally developed speak up wordsearches, various stands and appearances at various sites for promotional work.

Agenda item: 16.1

Enclosure no: TB2019/080

3. Background

The Freedom to Speak Up Guardian is a mandated role across all NHS provider Trusts in England and provides a safe place for staff to raise concerns when they feel unable to do so via their manager or usual reporting line. At BHT, the role has been in place for just two years and so these growth patterns should be seen as positive development. Increased awareness of the role, access, activity and demonstrable progress; as outlined above, helps to give us assurance that our journey is progressing in the right direction. Just five years ago, our national staff survey results for the questions shown in the first two bullets in Section 2.0 were very poor and were in the bottom five of our overall national staff survey results.

The importance of a positive speaking out culture cannot be overemphasised. The tragedy of what can happen when staff do fear speaking out and when there is no safe place for them to do so, is evidenced by the serious failings that occurred at Mid Staffs and Gosport. These remain stark reminders and sources of invaluable learning, which serve to fuel our ongoing commitment as an organisation to the "Freedom To Speak Up".

4. National update

The National Guardian, Dr.Henrietta Hughes is supported by the National Guardian Office (NGO) which is an independent body with the remit to lead culture change in the NHS so that speaking up becomes business as usual. The NGO is sponsored by the CQC, NHS England and NHS Improvement.

BHT welcomed Dr Henrietta Hughes to BHT on May 23rd as part of the programme of visits to Trusts across the Country. We were delighted to have her present and share with her some of our work.

The NGO published its Annual Report for 2017/18 in autumn 2018 see [NGO Annual Report 2018](#) Since our last annual report the NGO has published further case reviews relevant to this period [Nottinghamshire Healthcare NHS Foundation Trust](#) and [Royal Cornwall Hospitals NHS Trust](#)

As a result of learning from this report, the FTSUG highlighted the need for our Director of Workforce and Organisational Development to

- Provide assurance that BHT has a current fit for purpose policy which covers personal conflict of interests - this has been provided.
- Clarify that any settlement agreements would meet the most recent criteria and guidance as ours are handled via external legal advisors.

The FTSUG has met with HR Best Practice Team to discuss the above findings and the learning from The Royal Cornwall NHS Trust around the report finding that there was a grievance culture.

The NGO has been supporting the implementation of FTSUGs across primary care and is working with Vanguards and arms-length bodies and private healthcare providers. A national conference was held in March and the NGO has declared October will again be national "Speaking Up" month for 2019.

Agenda item: 16.1

Enclosure no: TB2019/080

5. Local Update and progress

Table 1 shows a quarter on quarter, year on year comparison on numbers of cases / concerns received from staff by the FTSUG.

Table 1

Quarter	2017/2018 Inaugural Year	2018 / 2019
Q1 – Cases	3 (<i>Start up quarter</i>)	20
Q2 – Cases	10	16
Totals for Q1 and Q2	13	36
This represents a 177% increase in numbers of cases across Q1 and Q2 comparing 2017 to 2018		
Q3 – Cases	20	22
Q4 - Cases	13	16
Total year end Cases	46 <i>(Representing 70 individuals)</i>	74 <i>(Representing 94 individuals)</i> <i>Plus calls meeting recording criteria (new for 2018/19)</i> <i>Total number of people raising concerns in 2018 – 2019 to FTSUG</i> **** 116 ***

Contact and resolution calls

This is the number of telephone calls to the FTSUG which can be termed as contact and resolution calls. This is new information collected this year representing additional activity not previously accounted for. This is not the total number of calls received, but these are one off calls made by a member of staff for those situations where someone requires a short confidential conversation and may require advice, signposting or reassurance only. These calls are defined by no more than 30 minutes of time, are a specific one off and are self-resolving. These are not logged as cases.

There was a total of 22 contact and resolution calls during the year. (*Not reflecting all calls*)
This equates to 96 concerns raised at year end.

New and General

- The FTSUG has continued to work with wide range of areas/ teams across the Trust where barriers to a positive speaking up culture have been identified. These are not meetings specific to case work but additional sessions where either pro active managers or team members have asked for support if concerned they have barriers to speaking up, need help to better understand options to address concerns they may already be trying to tackle or have issues relating to poor behaviours.
- A Trust Board seminar has been held regarding the national guidance for Freedom to Speak Up for NHS Trust Boards on roles and responsibilities.

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- The FTSUG is now signposted within the process flow chart for the medical examiner process for anyone who may wish to speak up but does not feel otherwise safe to do so. Helping to provide every opportunity to maximise the learning from hospital deaths.
This builds on inclusion of the FTSUG role in safeguarding and doctors raising concerns flowcharts and processes and a number of staff policies.
- Concerning Conversations - is a new 12 month bespoke programme of participative workshops developed in-house based on learning from concerns over the past two years. FTSUG, Tracey Underhill and an experienced external colleague, Peter Walmsley are offering monthly workshops aimed at managers and aspiring managers. The offer is to help build skills, knowledge and awareness of how to build a positive speaking up culture in their teams. Like Building a Climate of Respect in year one, this has been a positive product of concerns raised at the end of year two. See Appendix 1.
- Collaborative working to further embed this agenda has been undertaken in maternity, with a resulting scheduled year long programme of drop in sessions. As well as this joint working with the professional midwifery advocate (PMA), the role of the FTSUG has been promoted through her local training for midwifery staff. Staff survey results as highlighted in the executive summary show the evidence of the difference this has already made in awareness. We have begun to see positive improvement in numbers of midwives speaking up. This professional group had previously been virtually absent from the range of professional groups, which is also reflected nationally.
- The FTSUG was interviewed as part of the CQC Well Led Inspection
- National data has been reported to the NGO on time throughout the year
- A broader range of bands are now represented in the data which is encouraging and evidence of some of the previously unseen roles, e.g junior doctors and night staff

6. Learning and resulting actions

Below are just a few examples to demonstrate the range of actions and learning that staff who have raised concerns over the past year have helped us improve.

Building a Climate of Respect – a Trust Wide campaign to strengthen messages of zero tolerance and bring reinforcement that poor behaviours will not be tolerated at BHT.

Development of a video and an online resource guide providing a range of information and supporting advice for managers and those who are feeling bullied.

*Planning in Q4 for the development and launch of **Concerning Conversations** which has launched on May 14th 2019. A bespoke participative 2.5 hour workshop aimed at upskilling managers and those aspiring to such positions to understand how we can better build a positive speaking up culture and deal with concerns well, early on. Developed based on the learning from concerns raised over the past two years*

One clinical area has implemented a revised local junior doctor induction, revised DFM meetings to facilitate more efficient decision making for patients, re introduced a junior doctor local ward based forum, implemented a new remit into the team to help better support junior doctors

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<p><i>A wide range of poor behaviours which includes perceived bullying and harassment have been raised and addressed with a variety of different methods in a variety of areas and some have to be addressed formally. In the majority of situations people are unaware of the impact of their behaviours on others and once aware, do make efforts to improve.</i></p> <p><i>Actions and methods to address vary taking into account the situation and wishes of the individual who is raising the concern.</i></p> <p><i>Learning from these are also feeding into the development of concerning conversations.</i></p> <p><i>Clear messaging has been consistent throughout the year and will continue – “At BHT we have zero tolerance and we expect our staff to work in accordance with our CARE values to each other, which includes respect”.</i></p>	<p><i>Development of a service strategy and team building.</i></p> <p><i>As a result of one concern about issues with behaviours, good engagement with the senior management team which welcomed input, help and support, enabled a wider set of underlying issues to be addressed. Through collaborative working with the FTSUG who engaged with the OD team work was undertaken with the service team to deliver a strategy. The whole team had a chance to input into it and felt ownership of it.</i></p> <p><i>The underlying team issues have much improved and staff are happier with resulting service improvement as a benefit for patients.</i></p>
<p><i>1 independent investigation has resulted from a concern raised</i></p> <p><i>HR have willingly agreed to undertake quality checks of 2 separate formal HR processes, resulting in concerns being addressed.</i></p>	
<p><i>Over the past two year period, a total of 10 grievances have been averted by people raising concerns with alternative options and actions discussed. This has resulted in them taking a less formal route to resolution. Significant cost and personal distress can also be saved.</i></p>	
<p><i>Poor culture in a service area determined by management style and approach following a change has resulted in an action plan being developed. This will involve a supportive and developmental offering to help all involved to have an opportunity to contribute in designing resolutions. This will help build a strong vision for that team and service.</i></p> <p><i>The impact of this culture has affected team morale, retention, service delivery and created a difficulty for people to speak up locally. This was raised to the FTSUG and the matter was escalated to ensure senior assistance with resolution which has been readily offered. Good progress is being made.</i></p>	
<p><i>As result of a theft of a valuable personal belonging, we have implemented some additional lines into letters that go out to doctors and other staff who may be taking up accommodation onsite. We are now making it clear that they need to make sure their belongings are insured. This has been something that has come to light specifically for those doctors and staff from overseas who may be unfamiliar with English systems</i></p>	<p><i>Consideration needs to be given to actions that help those services that are less well seen and yet are absolutely essential / critical to front line care feel they have a stronger profile.</i></p>

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7. Summary.

This has been another busy but productive year which demonstrates the progress we are making in our journey to a positive speaking up culture. The national staff survey results show improvement on a significant level and other evidence of improvements comes from the variety of sources outlined above.

As hoped this year has been another year of growth, however, our focus going forward needs to be on strengthening our ability to deal with concerns well at source, and locally and at the early stages. The introduction of “Concerning Conversations” aims to support that task along with continuing collaboration with areas across the Trust to help embed and further support sustainability. We have made some good progress but there is more to do.

Appendix 1

Concerning Conversations...

Receiving a concern from a member of your team may be hard to hear but however small it might seem *it could save a life! It will help us improve.*

Treating information as a gift helps improve learning and understanding; it helps us to share our different perspectives and experiences and deliver better patient care.

Please come and join us for this interactive workshop

Aimed at:
 Anyone with line management responsibilities e.g. managers, supervisors, team leaders and those aspiring to these roles.

We'll help you to:
 Create an environment where honest, open and frank conversations can take place: See beyond the "person with a concern" and get right to the **heart of the issue** in a collaborative and mutually respectful way.
 A mix of case studies, activities and discussion, as well as a range of hints, tips and techniques will help you to handle concerns effectively and create a positive speaking up culture.

We'll cover:

- The benefits for all of enabling staff to speak up safely - Freedom To Speak Up
- Barriers to listening, selective hearing and effective follow-up
- The impact of behaviours and styles of management on enabling speaking up
- Starting a conversation with "the end in mind"
- "Building a Climate of Respect", bullying, harassment and poor behaviours
- Identifying areas for improvement and personal development.

To book your place and for dates and venues click on the NLMS icon on your desktop and follow the links to course 434 'Concerning conversations'.
 For more information email Peter Walmsley via p.walmsley@nhs.net or Tracey.Underhill@nhs.net (FTSUG) – Freedom To Speak Up Guardian

Safe & compassionate care,
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Agenda item: 16.3
Enclosure no: TB2019/082

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Buckinghamshire Healthcare **NHS**
NHS Trust

TRUST BOARD MEETING DATE 31/07/2019

Details of the Paper

Title	Staff Survey Update
Responsible Director	Bridget O'Kelly, Director of Workforce and OD
Purpose of the paper	To provides a summary update to the Board on our 2018 staff survey results and the plans to improve the areas identified as priorities over the next 12 months
Action / decision required (e.g., approve, support, endorse)	The Board is asked to note this update

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

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

ANNUAL OBJECTIVE

Attracting and retaining high calibre and engaged people

Please summarise the potential benefit or value arising from this paper:
Information & Assurance

RISK

Are there any specific risks associated with this paper? If so, please summarise here.	Non-Financial risk: <ul style="list-style-type: none"> There is a risk to us delivering all corporate objectives if we don't attract and retain high calibre and engaged people
	Financial risk: None

LINK TO CARE QUALITY COMMISSION ESSENTIAL STANDARDS OF SAFETY AND QUALITY

Which CQC standard/s does this paper relate to?	Regulation 18: staffing Regulation 19: Fit and proper person employed CQC Well led framework <i>(if you need advice on completing this box please contact the Director for Governance)</i>
---	---

Author of paper: Maria Early/Amir Khaki

Presenter of Paper: Amir Khaki

Other committees / groups where this paper / item has been considered: HR & WKforce, EMC

Date of Paper: 19/07/2019

Agenda item: 16.3
Enclosure no: TB2019/082

2018 Staff Survey Results

Purpose

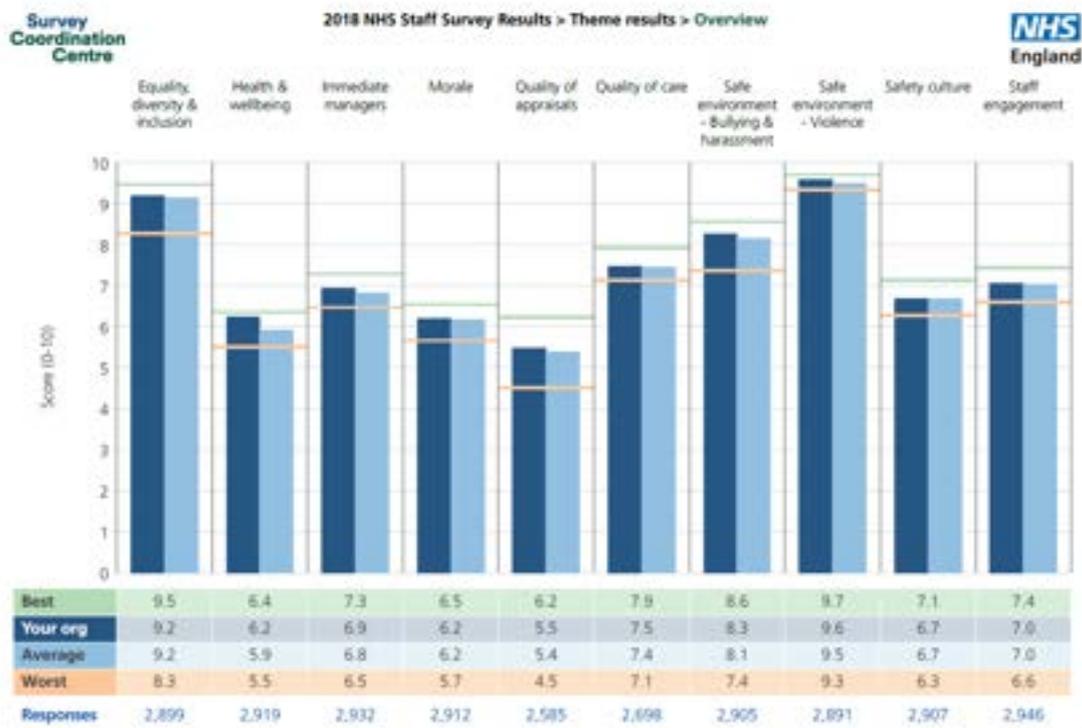
This paper provides a summary update to the Board on our 2018 staff survey results and the plans in place to improve the areas identified as priorities over the next 12 months.

BHT Results

All staff within the Trust were invited to participate in the survey and we achieved a 51% response rate which compares favourably with the national average response rate for combined acute and community trusts in England of 41%. We are one of 43 Trusts in this benchmarking group.

The Board may be aware there were significant changes to the national reporting structure this year. The previously scored 32 key findings have been replaced with 10 themes, and these are all scored on a scale of 0 -10. The ten themes summarise groups of questions relating to the staff experience. For all themes, higher scores indicate more positive results. The Trust's results are positive; with 6 themes scoring above the national average and 4 themes average with the national average. There were two statistically significant improvements in the themes; staff engagement and safety culture and no statistical deteriorations were recorded. It is also worth noting that of the 82 comparable questions analysed in the survey only 3 of the questions deteriorated, 21 improved and 58 have remained more or less the same. The table below shows an overview of the results for each theme.

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 Enclosure no: TB2019/082



Priority Areas

We have analysed our results and consulted our Feedback and Engagement Group, the HR & Workforce Meeting and staff side. Three areas have been identified as priorities:

- Tackling the levels of harassment, bullying and abuse (HBA) in particular from managers and colleagues
- Tackling work related stress and the balance between staff’s commitment to their job versus the pressure they feel to come to work when unwell
- Identifying where and why staff feel there aren’t adequate supplies and materials for them to do their job properly.

We are currently working with the HR Business Partners and divisional boards, sharing the organisational results, analysing their data and helping divisions make sense of their divisional results. Each of the divisions is tasked with implementing actions at a local level to tackle these 3 priority areas as well as their local priority areas and to integrate their actions into existing programmes of work and their people/workforce plans.

At an organisation level we have identified a number of areas to help drive improvements and will continue to work on this in the coming weeks and months and an update is provided in the final section of this update. However, in addition we wanted to draw the Board’s attention to two additional pieces of analysis which have been commissioned from Quality Health this year; a thematic analysis of the narrative feedback staff have provided and a piece of analysis to support our retention programme. These are summarised below:

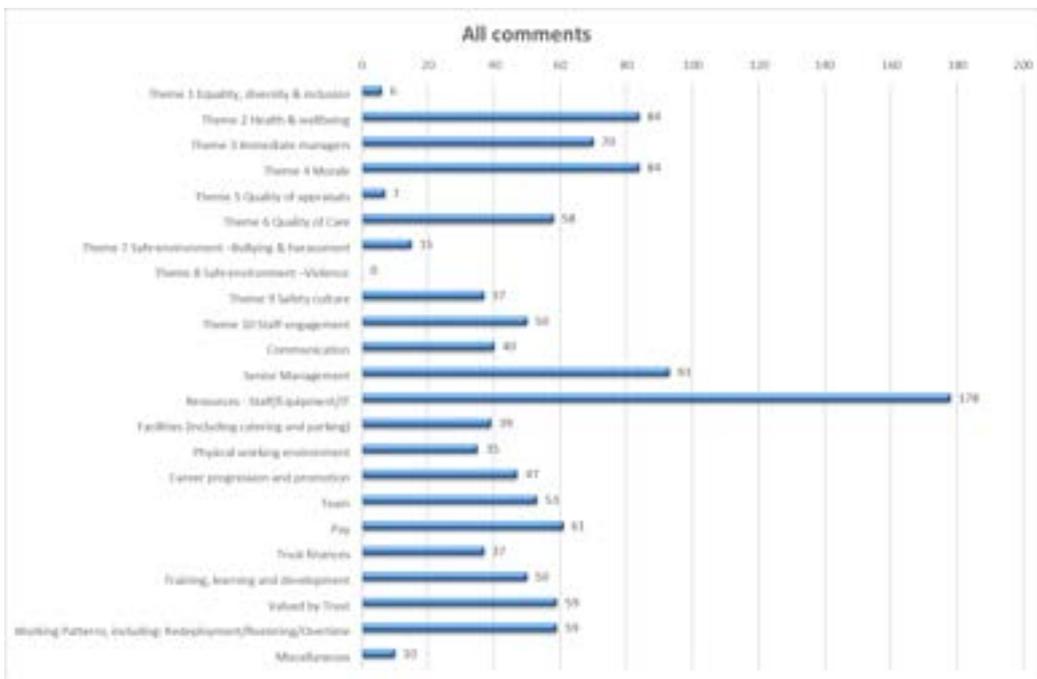
Agenda item: 16.3
 Enclosure no: TB2019/082

Thematic Analysis of narrative

We have recently received a thematic analysis of the narrative feedback in the survey. Of the 2954 staff that responded to the survey, 623 of them provided narrative feedback and this feedback was broken down into 1172 separate points.

It is clear from the report that the main theme is a continued concern over resources including staffing levels and many respondents spoke about how they felt that there were not enough staff in the organisation and how low staffing levels were having a negative impact on patient safety, and their own or their team’s work pressures and/or stress. Comments around immediate colleagues and teams were the most positive. Staff talked about how they felt supported by their immediate colleagues/team and this is encouraging.

It is also important to note this is the first year we have provide narrative feedback at a divisional level; the summary and detailed reports have been shared with the divisional management teams to help inform their local action planning. The report is broken down into themes and this is summarised below.



Quality Health has also carried out (at our request) an analysis of the comments by tone, classifying them as either positive, negative, mixed or neutral/suggestion. The chart below illustrates the tone of comments attributed to each theme.

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 Enclosure no: TB2019/082



Retention Analysis

This year we also commissioned a report from Quality Health (QH) specifically around which of the 10 staff survey themes most strongly correlated with the new Morale theme, and question 23c “As soon as I can find another job, I will leave this organisation” which we use to measure turnover intention. We asked QH to do this work to see if there were differences in what drives morale or turnover for nurses and non-nursing staff so that we could help support the work of the Nurse Retention Direct Support Programme.

Unsurprisingly, the report showed that both morale and turnover are most correlated with overall staff engagement; however it shows that the next highest drivers are Immediate Managers, and Health & Wellbeing. This means that focussing our energy and attention on these areas will have the biggest positive impact on Morale and retention overall. The results did not differ for nurses or non-nurses – so the same things are driving their retention as for everyone else.

Organisational actions to support Priority Areas

Please refer to Appendix 1.

Recommendations

The Board is asked to note this update

Agenda item:

Enclosure no:

Appendix 1: Organisational actions to support Priority Areas

- Identifying where and why staff feel there aren't adequate supplies and materials for them to do their job properly.

Priority Area	Action	Lead	Timescale	KPI
g work related stress and the balance between staff's commitment to their job versus the pressure they feel to come to work when unwell	We are currently trialling with two teams a potential new training intervention Psychological Capital team training – Psychological Capital is a person's cognitive resources which allows them to remain positive in the face of adversity, plan ahead and meet their goals, and hold an overall positive 'can do' mindset'. Once the trial has concluded we will evaluate the programme and if it provides the support around staff engagement and stress reduction we will look to roll this out further across BHT	Carley Brown	July 2019	TBC
	The OD team has seen an increase in the number of requests to support teams with listening events and team days (many of whom seem to have a disconnect between managers and staff) which they are supporting. However, to help share the workload the OD team is planning to work with the HRBPs to upskill them so they can support this increase in requests	Carley Brown	July 2019	
	reviewing the heat maps and those departments that are the worse in their divisions for the 3 priority areas will be supported by the OD and HRBPs to identify bite sized training or programmes such as Understanding Stress and Building Resilience (USBR) to help support staff in these areas	Karon Hart	July 2019	
	continuing with our Go-Engage Pioneer programme for this year. There are currently 5 teams on this 6 month programme and we will introduce 8 more in September	Carley Brown	Sept 2019	
All three priority areas	incorporating these 3 priorities areas into existing leadership and management development programmes	Carley Brown	May 2019	
	identifying leads from within our Feedback and Engagement Group to lead in these 3 priority areas identified	Amir Khaki	July 2019	
g the levels of harassment, bullying and abuse (HBA) in particular from managers and colleagues	SUG is currently launching a new training programme "Concerning Conversations" which is linked to raising concerns and building a positive speaking up culture and is aimed at supporting managers.	Tracey Underhill	May 2019	Program launched

Agenda item: 16.4
Enclosure no: TB2019/082

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PUBLIC TRUST BOARD MEETING 31st July 2019

Details of the Paper

Title	Trust Quality Account 2018/2019				
Responsible Director	Carolyn Morrice				
Purpose of the paper	To provide the Public Trust Board with a copy of the final published Quality Account for the FY2018/2019				
Action / decision required (e.g., approve, support, endorse)	For information				
IMPLICATIONS AND ISSUES TO WHICH THE PAPER RELATES (PLEASE MARK IN BOLD)					
<i>Patient Quality</i>	<i>Financial Performance</i>	<i>Operational Performance</i>	<i>Strategy</i>	<i>Workforce performance</i>	<i>New or elevated risk</i>
<i>Legal</i>	Regulatory/ Compliance	Public Engagement /Reputation	<i>Equality & Diversity</i>	<i>Partnership Working</i>	<i>Information Technology / Property Services</i>
ANNUAL OBJECTIVE					
Which Strategic Objective/s does this paper link to?					
It is a statutory requirement to publish a Trust Quality Account					
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.	<i>Non-Financial Risk:</i> None				
	<i>Financial Risk:</i> None				
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: Joanna Atkins Associate Chief Nurse Mandy Chetland Head of Clinical Quality					
Presenter of Paper: Carolyn Morrice					
Other committees / groups where this paper / item has been considered: EMC, Quality Committee					
Date of Paper: 16/07/2019					

Quality account 2018-2019



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Introduction

The Quality Account is an annual account to the public about the quality of services that we provide and deliver and our plans for improvement. The requirement to produce a Quality Account is outlined in the NHS Act 2009 and in the terms set out in the collective Quality Accounts Regulations 2010 and the Amendments Regulations 2017.

The Quality Account incorporates all the requirements of the Quality Account Regulations and 2018/19 reporting requirements as set out by NHS Improvement. The Quality Account specifically aims to improve public accountability for the quality of care that is contained within the Trust's overall annual report.

Our quality improvements are reported in 3 categories:

- Implementing a culture of safety
- Listening to our patient voice
- Developing a learning organisation

This report also includes feedback from our stakeholders on how well they think we are doing. The publication of this document is one of the ways in which we are able to share our evidence on the quality of care we provide to our patients.

A guide to the structure of this report

This Quality Account summarises performance and improvements against the quality priorities and objectives which were set for 2018/19 and outlines the quality priorities and objectives which have been set for 2019/20.

- Part 1** Statement on quality from the Chair and Chief Executive Officer and speciality achievements for 2018/19
- Part 2** Priorities for improvement and statements of assurance from the Board
- Part 3** Further aspects on quality improvement

Your Feedback

If you have any comments or suggestions on this Quality Account, we would welcome your feedback. Please contact: Mrs Carolyn Morrice, Chief Nurse, through our Patient Experience Team's advice and liaison service on: email: bht.pals@nhs.net

Trust Profile

Buckinghamshire Healthcare NHS Trust is a major provider of integrated hospital and community services for people living in Buckinghamshire and surrounding counties, providing care to over half a million patients every year. In addition we provide specialist spinal services at our world renowned National Spinal Injuries Centre for patients across England and internationally. The Trust is also the regional centre for burns and plastics services.

Our aim is to provide safe and compassionate care, every time to our patients. Our highly trained doctors, nurses, midwives, health visitors, therapists, healthcare scientists and other support staff deliver this care.

We deliver our services from a network of facilities including:

- A range of community settings - health centres, schools and patients' own homes
- Three community hospitals in Amersham, Buckingham and Chalfont & Gerrard's Cross.
- Two community hubs at Thame and Marlow.
- Two acute hospitals located in the two most densely populated areas of Buckinghamshire – High Wycombe and Stoke Mandeville, Aylesbury.
- Florence Nightingale Hospice based on the Stoke Mandeville site, Aylesbury.

Over 6,000 members of staff provide care to approximately half a million people, including the dispersed population of Buckinghamshire and the surrounding areas of Thame (Oxfordshire), Tring (Hertfordshire) and Leighton Buzzard (Bedfordshire). We are recognised nationally for our spinal rehabilitation services, urology and skin cancer services. We are also a regional specialist centre for burns care, plastic surgery, stroke, cardiac services and dermatology.

The acute hospitals

- Stoke Mandeville Hospital, Mandeville Road, Aylesbury HP21 8AL
- Wycombe Hospital, Queen Alexandra Road, High Wycombe, HP11 2TT.

Our main community facilities

- Amersham Hospital, Whielden Street, Amersham HP7 0JD
- Buckingham Hospital, High Street, Buckingham MK18 1NU
- Chalfont Gerrard's Cross Hospital, Hampden Road, Chalfont St Peter SL9 9SX
- Marlow Hospital, Victoria Road, Marlow SL8 5SX
- Thame Community Hospital, East Street, Thame OX9 3JT
- Florence Nightingale Hospice, Stoke Mandeville Hospital, Mandeville Road, Aylesbury HP21 8AL
- Rayners Hedge Rehabilitation Unit, Croft Road, Aylesbury, Buckinghamshire HP21 7RD.
- Camborne Centre, Jansel Square, Bedgrove, Aylesbury HP21 7ET

Our Trust headquarters are at Stoke Mandeville Hospital

Visit our website for more details on our services www.buckshealthcare.nhs.uk

PART ONE

Statement on Quality from the Chair and Chief Executive

We have continued make good progress during 2018/19 in spite of the ever-increasing demand on our services and continued financial pressure. We have a team of highly skilled professionals who deliver outstanding care in areas such as cancer and stroke, colorectal surgery (we are the highest performing Trust in the country by volume and outcomes) and spinal injuries and our family nurse partnership delivers the best outcomes supporting first time young mums and families across the county. We are particularly proud that the Trust is now seen as a national exemplar for the work being undertaken by our medical examiners, which is key in helping us to learn from deaths.

Over the next decade, the population of Buckinghamshire is predicted to grow by approximately 40,000. There will be a growth in children and older people but fewer people of working age. Whilst people are living for longer, they may not be in good health with more and more people being diagnosed with obesity, diabetes and dementia.

Working closely with our Integrated Care System partners (which include GPs, the Council, Ambulance Service, Commissioners and Mental Health services) we are committed to ensuring that we address these challenges supporting the people of Buckinghamshire to lead happy and health lives, receiving outstanding care when and where they need it.

To achieve this, we have set new corporate objectives for the next two years:

Improving our culture by:

- Listening to and involving our patients
- Making it easier to get things done
- Encouraging and supporting our staff to make small changes that make a big difference
- Using a systematic method to implement long-lasting improvements
- Learning from each other and our experiences

Introducing new models of care:

- Developing new models of care and staffing to make sure we have the right people, with the right skills working together to deliver outstanding patient care
- Making the Trust a great place to work
- Developing talent and ensuring we have inclusive workforce that celebrates equality and diversity

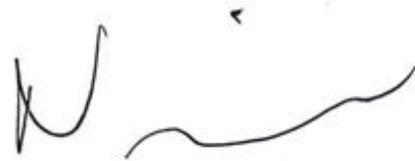
Addressing health inequalities and clinical variation by:

- Building community partnerships which help us to support hard to reach groups such as the homeless
- Getting it right first time to improve the experience for our patients
- Making the best use of our buildings and resources
- More effective use of digital technology

We would like to thank and praise all the staff, board members and volunteers who have worked so hard to support our patients and service users over the past year. We are very fortunate to have such a dedicated and skilled team and we are proud of everything they have achieved. Our thanks also go to our partners, key stakeholders and local communities for your continued support and encouragement.



Hattie Llewelyn-Davies, Chair



Neil Macdonald, Chief Executive

Divisional achievements for 2018/19

Division of Surgery and Critical Care

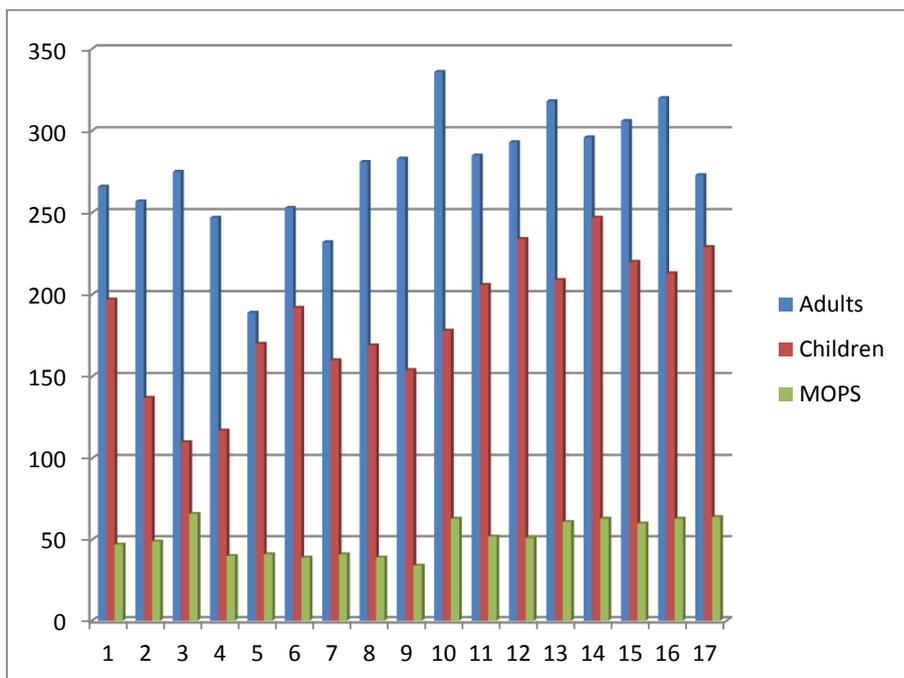
Improved patient experience in Surgical and Plastics Emergency Ambulatory Care (SPEAC)

SPEAC provides a consultant-led daily ambulatory emergency clinic for both plastic surgery and general surgery services. This allows for first class diagnostics and early treatment of emergencies in a safe and welcoming environment.

The new system has been running since October 2017, and the demand for the service continues to increase – reflecting population growth as well as the growing need for this service from the emergency department, Minor Injury Units and GPs.

Below is a table demonstrating the work-load for plastic surgery trauma in the last 17 months for both adults and children alongside (Major) the minor case operating procedures undertaken (MOPs).

In the last three years, we have seen an increase from 400 patients per month to 580 patients per month, not including the adult burns which account for an additional 60 patients per month.



Ophthalmology Vanguard mobile theatre

The Trust has installed temporary operating theatres at Stoke Mandeville to help its ophthalmology team tackle a backlog of patients requiring cataract surgery.

Phacoemulsification with Intraocular Lens (IOL) Implantation (commonly known as cataract surgery) is the most common procedure carried out within the NHS. With a growing and ageing population there is a national backlog of patients waiting for treatment and the Royal College of Ophthalmologists predict numbers will increase by 25% in the next 10 years. The Trust recorded a 24% increase in the number of procedures carried out from April 2017-March 2018 in comparison with the same period the previous year.

This initiative, led by consultant ophthalmologists, with support from Buckinghamshire Clinical Commissioning Group, allowed the Trust to rent a Vanguard theatre service (temporary theatre) for a three month period to help clear the backlog of patients requiring cataract surgery. Uniquely, the surgery was provided by the Trust's own consultant ophthalmologists, who agreed to provide extra operating sessions in what would normally be non-clinical time.



Patient feedback (16 January 2019):

“Stoke Mandeville Ophthalmology Department are to be congratulated for their can do/proactive initiative in the provision of the mobile Vanguard unit to tackle the cataract surgery backlog. I attended on 16 January and found the whole process was well organised, efficient and above all, very sympathetic and patient orientated. Particular praise is due to Dorcia who coordinated the process in a wonderfully efficient and friendly manner. She put

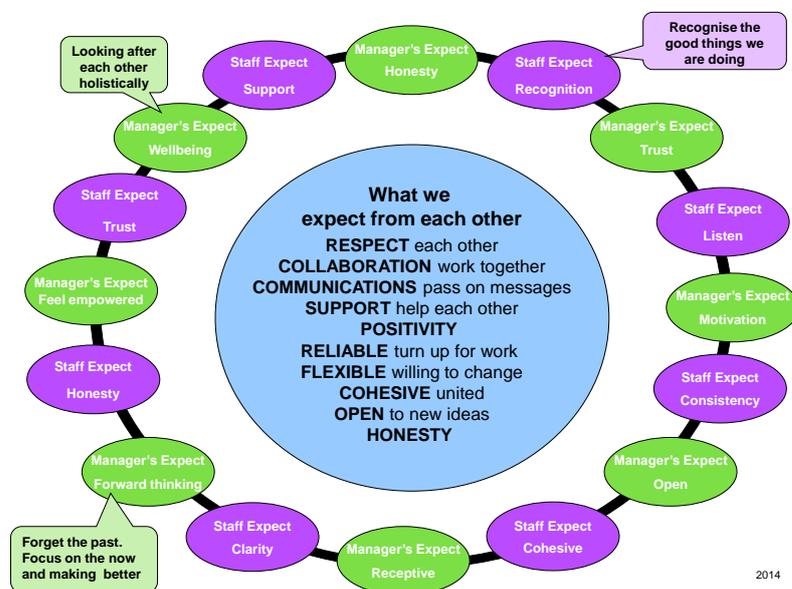
patients at their ease - instantly endearing her to all of us. She is a star and a shining example of what patient care can and should be.”

Theatres cultural improvement programme



We have successfully undertaken a focused piece of work within theatres to proactively address safety standards and change a fragile low trust, low morale culture into a sustainable high trust, high morale, solution-focused culture.

A theatre leadership team has been created with a shared voice and vision alongside a theatre values and behaviour charter which has been collectively agreed and implemented. Motivated and empowered team leaders are now more willing to courageously challenge and uphold performance standards and there is an upsurge of accountability, respect and pride.



Staff now report feeling heard, understood and valued. Feedback revealed that mid-level leaders are now working closely with staff to find solutions to long standing problems.

Anaesthesia Clinical Services Accreditation (ACSA)

Anaesthesia Clinical Services Accreditation (ACSA) is a voluntary scheme run by the Royal College of Anaesthetists for the NHS and independent sector organisations, offering quality improvement through peer review.

The ACSA standards are considered 'above and beyond' the Guidelines for Provision of Anaesthetic Services (GPAS) that the Quality Care Commission (CQC) uses as its benchmark. The overall aim is to improve and standardise the provision of anaesthetic services across the UK.

The scheme is recognised by the Care Quality Commission (CQC) and the Healthcare Quality Improvement Partnership (HQIP) and there are some 27 accredited anaesthetic departments in the UK though none, so far, in the Thames Valley area.

The ACSA standards cover the whole of anaesthesia throughout the peri-operative period including pre-operative assessment, peri-operative care, post-operative care and discharge and follow-up, where appropriate, for all surgical specialities provided by Buckinghamshire Healthcare NHS Trust (BHT).

We signed up for the ACSA scheme in 2016 and received our review visit by ACSA committee representatives September 2018. We have received informal feedback from the review team, as well as a draft report, and await the final formal report and accreditation.

Informal feedback highlighted some minor work to be done on policies and infrastructure, 80% of which has already been completed. It also highlighted areas of outstanding performance, some of which will be presented to the ACSA Committee for inclusion in future ACSA standards (medical examiners, excellence reporting, speak-up boards and theatre quality and safety meetings).

The reviewers also praised the overall culture of safety and quality across the whole Trust, the level of managerial support, the involvement of and support of specialty and associate specialist (SAS) anaesthetists and the pre-operative assessment service.

Medical Support Workers (MSW) – their role in venous thromboembolism (VTE) prevention

The newly created Medical Support Worker (MSW) role was generated within General Surgery to assist in supporting the junior doctors with the increasing burden of administrative, non-clinical tasks. For example:

- Updating patient location details
- Looking up blood test results and scans
- Checking antibiotic review dates
- Checking VTE compliance
- Checking sepsis and MRSA stickers
- Entering blood & scan results into handover notes
- Performing and helping senior surgeons with their audits
- Collecting and checking data
- Working on the comorbidity coding forms and discharge summaries

Since the introduction of the MSW role on the surgical floor, there have been no serious incidents declared in general surgery patients since April 2018 for VTE. The compliance with VTE prophylaxis clinical guidelines has been greatly improved with the support of the MSWs.

The role has been very well received by the trainees and the consultants and there are now eight MSWs across all of Surgery, Plastics, T & O and Urology.

Integrated Elderly and Community Care (IECC)

CIRCLE (Correlate Intelligence Responsibly, Circulate Learning Effectively)



This year the division has designed and is embedding a unique shared governance model, to support staff across specialities to be involved in improving the care they deliver.

Each month a CIRCLE report is circulated to every member of staff. The report contains key information on all aspects of clinical governance and learning from incidents, complaints, excellence reporting, learning from deaths, clinical audits completed and outstanding, good news stories and key performance indicators relating to quality that are aligned with Trust and divisional objectives and what is important to staff.

It is expected that each team will review where they are and choose a topic to focus on for that month. The most important part of this is all team members are involved in reviewing relevant data to them, planning how they could make improvements and understand the infrastructure in place to support them to make decisions and improvements that matter to them and their patients.

CIRCLE is about leading from the frontline through shared governance, having access to a comprehensive report on a monthly basis where the information is clear and data is presented in a way staff can relate to daily clinical practice, enabling staff to feel involved, informed and engaged with the Trust quality agenda.

Community Hubs and Community Assessment and Treatment Service

Development of Thame and Marlow Community Hubs has continued through 2018/19 with the following achievements:

- Provided the Community Assessment and Treatment Service (CATS) including a frailty assessment service where geriatricians, nurses, therapists and GPs provide expert

assessment, undertake tests and agree a treatment plan to help frail older people to stay at home and avoid an A&E visit or hospital admission.

- Introduced a pathway for the ambulance service to consider CATS as an alternative to taking an older person to A&E
- Provided additional diagnostic facilities such as 'one-stop' blood tests and x-rays
- Following the success of the 'Cancer Care Closer to Home' outreach site at Marlow Community Hub, where over 250 patients received line care, pre-chemotherapy assessments and certain oral and subcutaneous cancer treatments during the first year, the service is now also running out of Thame Community Hub.
- Falls specialist led clinics have been run out of both Hubs and a 'Better Balance' strength and balance class out of Marlow Community Hub
- Developed links with Specialist Nurses such as Nutrition Specialist Nurse

Provision of outpatient clinics continues to grow.

The Community Assessment and Treatment Service (CATS) operates from 9am to 5pm at Marlow on Mondays, Wednesdays and Fridays and Thame on Tuesdays and Thursdays. There is a Geriatrician on site in the mornings and a GP in the afternoon.

Quality of service is measured through a Patient Experience Questionnaire. 99.6% of patients who complete the surveys rate the service as good or excellent. 95.9% are likely or extremely likely to recommend the service to friends and family.

97.8% of patients seen in CATS return to their usual place of residence with 2.2% requiring transfer to either the Cardiac and Stroke Receiving Unit or A&E.

A 6 month audit showed that just 3% of patients assessed in CATS present to A&E within 28 days of attendance.

Community Hubs have been shortlisted as finalists for a Health Service Journal (HSJ) award in the category of Improving Value in the Care of Older Patients

Following on from the success of the 'Caf' type forums in 2018 we have consulted with a number of people using inpatient facilities and decided to launch monthly forums called 'Big Conversation Cafes' from April 2019. These will be advertised within Thame and Marlow and we will be inviting people to come and talk about 'big stuff' like nutrition, falls worries, power of attorney and stress levels. Feedback will be collected at each session. If we identify someone who needs a clinical assessment we can refer to CATS.

The Dementia Specialist Nurse

The Dementia Specialist Nurse demonstrates a high level of expertise and skill in understanding the needs of people living with memory problems and/or dementia, their families and carers.

The service is visible within acute hospital services and provides much-needed support to frontline clinicians to enable them to better support the patients in their care.

The key areas of focus in the work of the Dementia Specialist Nurse are:

- To ensure BHT services are meeting the needs of people living with memory problems and/or dementia.
- To help patients access to acute healthcare services for people living with memory problems and/or dementia.
- To help obtain reasonable adjustments to support the often complex care needs of this group of patients and to avoid preventable harm or untimely deaths within this vulnerable group.
- To adopt a consultative and advocacy role to facilitate inter-agency and inter-professional communication in primary care and mainstream services.
- To provide opportunities for learning to all hospital staff. This takes the form of regular monthly dementia awareness sessions and ad-hoc on-demand sessions tailored to specific clinical areas and professional groups.

BHT aims to screen every patient over the age of 75 years to allow early recognition of potential cognitive problems; enabling timely treatment and/or sign-posting to appropriate agencies.

Some of the comments received over the last year:

- “A familiar face makes all the difference! But, please pass my thanks on to the rest of the team.”
- “Thank you so much for all your support good wishes.”
- “Thank you for all your help and support.”
- “Thank you so much for all your help and, in particular, your support over the last ten weeks; it has been invaluable. Once again we are indebted to you ”

Podiatry integrated service

Podiatry is an integrated countywide service delivering care in various locations such as, in-patient wards, outpatient clinics, GP surgeries, health centres and patient homes. The Booking Hub at Brookside Clinic, Aylesbury is the single point of access for the county where all referrals are received, registered and triaged. The team is made up of 26 podiatrists and 6 podiatry assistants who treat a case load of 13,300 patients with approximately 575 new referrals and 2,840 attended treatments each month.

The service objectives are:

- Provide optimal healing times for foot wounds to minimise foot and lower leg amputation and avoid hospital admission.
- Improve quality of life through pain relief & optimal foot function via prescription of insole/ orthotics/ footwear.
- Prevent further deterioration of chronic foot deformities & maintain mobility/ independence.
- Prevent infection and pain by performing partial/ total nail operations, 440 operations annually.
- Risk-rate all our patients to predict their likelihood of ulceration/ amputation.

Quality and outcomes are measured by the use of:

- Manchester Oxford Foot questionnaire implemented in Musculoskeletal (MSK) and Rheumatology clinics.
- Submission to the National Diabetes Foot Audit to benchmark BHT Podiatry Service against national outcomes for non-elective amputation rates.
- Root Cause Analysis techniques are used to identify gaps in service operating procedures and to provide safer patient care.
- The 'Putting Feet First' inpatient diabetic screening team managed to screen and risk-rate an impressive 1,691 patients in 2018 of which 232 patient had active wound.

Photo on following page is of some members of the Amersham team who provide High-Risk and Rheumatology care.



In 2018, 537 questionnaires were sent out for a patient engagement event in the south of Buckinghamshire with 41% completed questionnaires returned. The overwhelming majority of respondents felt the podiatry service provides a good or excellent service (95%).

Therapy and Nurse Led Unit (TNLU)

The Therapy and Nurse Led Unit was established in December 2018. It is based at Stoke Mandeville Hospital and sees patients aged 18 and over. However, the majority of the patients are over 65 years of age.

The Friends and Family Test (FFT) will continue to be used to monitor patient experience, alongside the 'Perfect Ward' and safety audits to establish the safety and effectiveness of TNLU. Current scoring shows a high level of patient satisfaction with the service.

The vision for TNLU is to provide an efficient rehabilitation care pathway for patients reducing their need for care in the community.

Ward 9 acute medicine for older people (MFOP) inpatient ward

The ward consists of 22 inpatient beds for the elderly, led by an acute geriatrician working with the multidisciplinary team (MDT). The MDT consists of doctors, nurses, pharmacists, dieticians, social workers and therapists. The team also has a nurse consultant for older people. Together they work to deliver individual patient focussed care at all times.

The MDT has expertise in managing the older adult with frailty. The team undertakes early assessments for the acutely unwell frail elderly population in Buckinghamshire. The aim is to

support discharge and prevent readmission by providing high quality clinical and preventative care to improve the health of elderly adults with multiple conditions and complex needs.

Community Head Injury Service (CHIS)

The Community Head Injury Service (CHIS) provides core inter-disciplinary community brain injury rehabilitation, specialist brain injury vocational rehabilitation and specialist family services for people with acquired brain injury and their family and friends.

CHIS is based at the Camborne Centre, Aylesbury, providing services at the centre, in the home, in the workplace and other community settings (voluntary, leisure and service - eg Job Centre).

Achievements / developments in 2018/19 include the following:

- Contribution to establishment of new Thames Valley Acquired Brain Injury Forum
- Piloting a medical assessment clinic with consultant ortho-geriatrician
- Pilot of pre-vocational training module in conjunction with Headway staff at Bedford
- Development of draft job search tool kit
- Development of prompt sheet for employers and clients covering reasonable adjustments for aphasia
- Inclusion of client helper in last 'Managing Life and Fatigue Group'
- Information on Educational and Cognitive Groups has been reviewed and updated in light of increasing referrals of people with forms of acquired brain injury other than head injury
- CHIS staff involved in setting up disability awareness event and setting up disability network for BHT staff
- Completion and evaluation first run of new sex and sexuality after brain injury group
- Contribution to development of patient materials on use of technology in health care as part of Allied Health Professional Technology Networking Group

CHIS staff with Headway were 'Highly Commended' in British Medical Associated Patient Information Awards 2018 for their Booklet on Sex and Sexuality.

Elderly Consultant Physician of the Day (ECPOD)

From 4 March 2019, the role of ECPOD was introduced, covered by a consultant geriatrician.

The ECPOD assists the Physician of the Day (POD) in seeing patients aged 78 and over who were admitted the previous day and overnight. The ECPOD will also provide medical advice

to the Therapy and Nurse Led Unit if required, contribute to the supervision of junior doctors and will share learning regarding frailty trustwide.

The service quality will be measured by recording and analysing the following information.

- Number of patients on post-take ward round
- Number of patients on post-take ward round who are over 78
- Number of over 78 year olds seen by ECPOD
- Number of discharges made by ECPOD
- Number of community service referrals made by ECPOD
- Number of inappropriate tests/treatment avoided by ECPOD
- Number of treatment escalation plans (TEPS) completed
- Number of DNARs (do not actively resuscitate) put in place when required
- Feedback from acute staff
- Feedback from geriatricians
- Feedback from junior doctors.

Occupational Therapy (OT)

Occupational Therapists (OTs) are on all acute sites, community hubs and community hospitals enabling patients to maximise their functional abilities in Acute Medicine, Trauma and Orthopaedics, Hand Therapy, Rheumatology and Burns, Stroke rehabilitation, Neurological Rehabilitation, Cardiology, Accident and Emergency, Community Acute Rehabilitation, Community Assessment and Treatment, and in the Rapid Response and Intermediate care localities.

Achievements so far:

- Continued to gain a high score (nationally derived) for OT intervention for outcomes in Stroke treatment
- Collaboration with Wexham Park Hospital to streamline discharge plans for Buckinghamshire patients
- Enabled patients with Parkinson's in their home by having a timely, responsive OT outreach service reducing the number of patients requiring hospitalisation
- Hand Therapy held a conference and invited Derby Hospital renowned in hand therapy to support and to advise and gained very positive feedback regarding our service

- Continue to work very successfully alongside our nurse colleagues, shortening overall length of stay, enabling effective discharge and supporting the nurses to encourage patients to do what they can independently.

Going forward:

- Continue to work alongside our nurse colleagues to maximise the community hospital experience
- Work with acute and community colleagues together streamlining processes and reducing any duplication
- Work with social care colleagues on projects to benefit the integrated care system, for example, regarding equipment provision and care handling

Queens Nurses - Community Nursing

In June 2018 four District Nurses were awarded the Queens Nurse status for demonstrating a high level of commitment to patient care and nursing practice. Applicants must have worked in the community setting for at least 5 years and need to complete a significant piece of written work as part of the application process to demonstrate how the nurse meets both the ethos of the Queens Nursing Institute (QNI) and their overarching approach to nursing. Testimonials are obtained from patients, and from each nurse's manager.

The QNI provides a supportive network of community nurses who link via regional meetings and the annual conference. It offers formal recognition of commitment to improving nursing care in the community.

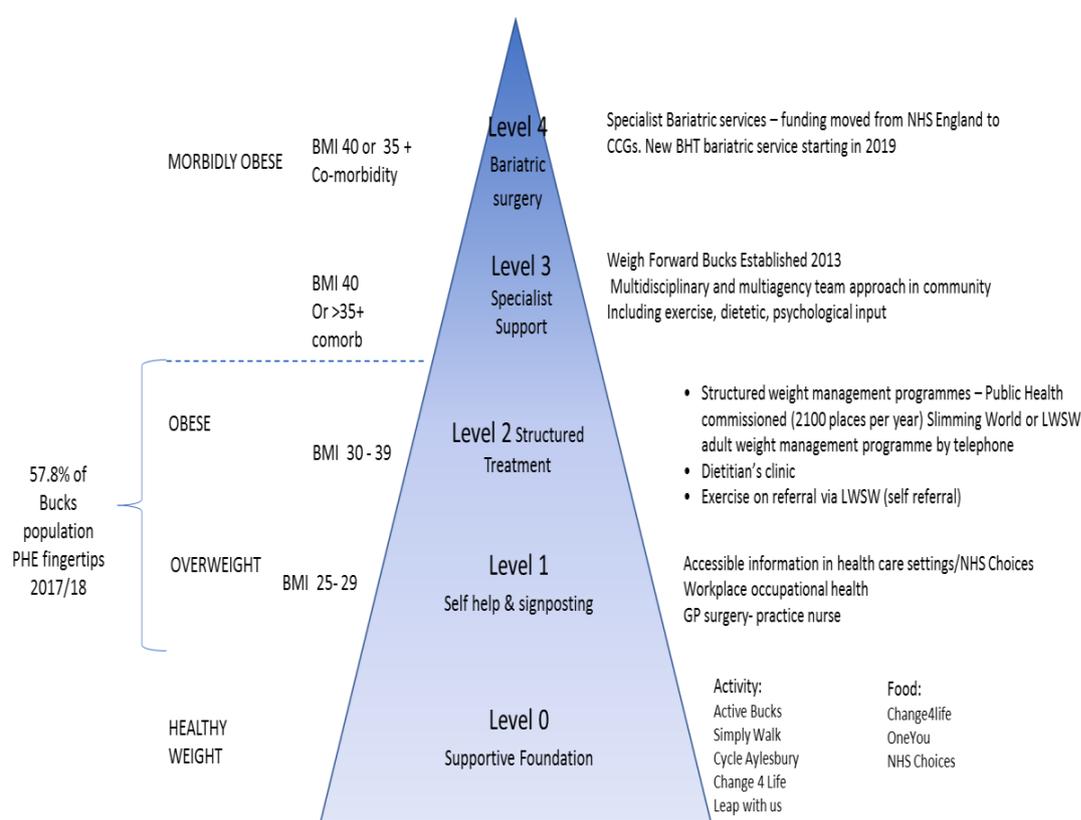


There is access to developmental programmes and this year Helen Mehra, lead nurse community nursing and transformation, was the Trust's first attendee on the QNI Executive Leadership Programme. This course is designed to bring about transformational change enhancing efficiency and productivity in a challenging financial climate.

‘Weigh’ Forward Bucks

Weight Forward Bucks is a collaboration between Buckinghamshire Healthcare NHS Trust and Oxford Health NHS Trust. It is a specialist Tier 3 weight management service run by the department of Nutrition and Dietetics that offers:

- A year long programme of 16 group sessions, and two one to one sessions
- 7 groups per year, with a maximum of 14 people per group
- 98 places available per year, with no waiting list currently
- Daytime and evening sessions, in the north and south of the county, groups start at three points during the year (January/February, April/May, September/October)



Our clients’ weight difficulties are often complex and multifactorial and they have all tried other weight loss approaches in the past without lasting success. Despite this, we have achieved the following:

- Attendance – almost 60% of participants completed the course
- Weight loss – 43% lost at least 5kg by the end of the course

- BMI - 65% of patients had a BMI decrease of more than 1 point
- Quality of Life – 52% of patients whose Quality of Life information we obtained reported improved Quality of Life
- Feedback – 91% of those who provided feedback said that they would recommend the programme to others

Palliative Care

Based at Florence Nightingale Hospice, the palliative care service consists of inpatient beds, community specialist nurses that cover both the north and the south of the county working closely with our community colleagues. A day hospice offering support and review for patients, a bereavement listening team of volunteers, lymphoedema specialist nurse, 24/7 carers for the north of the county and the hospital and in-reach palliative care team covering Stoke Mandeville, Wycombe and Amersham hospitals.

The team support palliative and end of life care patients and their loved ones.

Quality is measured by satisfaction surveys. These always return positive responses across all palliative care services.

Achievements in 2018/19 are:

- Launch of 'Purple Rose' initiative to support end of life patients to be recognised and to ensure appropriate plans are put in place to meet individual needs.
- New end of life care plans, advance care plans and treatment escalation forms being rolled out across the Trust



Wheelchair Service

The Wheelchair Service is based at Amersham Hospital.

The service assesses adults and children of all ages who meet the criteria for the service, and have a Buckinghamshire General Practitioner. The team undertakes assessments in a clinic, or at home. Clinics are held at the Halton Multiple Sclerosis (MS) centre, schools and the National Society for Epilepsy (NSE) centre.

The service has introduced new clinics particularly for children so that they are seen quickly.

Patient experience questionnaires are used to monitor the quality of the service and make changes to improve the service and make more effective.

Speech and Language Therapy (Adults and Acute Paediatrics)

Speech and Language Therapists (SLTs) work on the wards, in outpatients and out in the community in hubs, care homes, people's homes, community centres and outpatient facilities.

SLTs sees patients who have had a stroke, or who have Motor Neurone Disease, Multiple Sclerosis, Dementia, Parkinson's disease, voice disorders, head and neck cancer and patients on the Spinal Unit and in intensive care as well as the neonatal unit.

Achievements this year include:

- The Stroke SLT Team achieved an 'A' rating in SSNAP (Sentinel Stroke National Audit Programme)
- The SLT team worked with Scannappeal to fund a new endoscopy scope and set up a FEES (Fiberoptic Endoscopic Evaluation of Swallowing) service at Stoke Mandeville Hospital
- IDDSI (International Dysphagia Diet Standardisation Initiative) was introduced across the organisation
- Training and activities were organised for International Swallowing Awareness Day
- Carer training was organised on the Stroke Unit
- Excellent patient feedback was received regarding the Joint Voice Clinic

Next year we are working with therapists across the region to improve the SLT Service to people with head and neck cancer diagnoses.

Integrated Medicine

Emergency Department (ED)

Friends and Family Test (FFT)

ED has been piloting software (Envoy) to analyse FFT data. The second month of full data is now available and this pilot is scheduled to run for six months.

The pilot offers the opportunity to analyse real time data by theme, sentiment and mood. The Envoy platform provides unlimited access to information in an easy to understand format.

As a result of the Envoy FFT Pilot, ED has a clearer picture about the feedback from patients. Benefits seen since the pilot began are:

- An increase in ED's FFT response rate from an average of 8% to over 27% in December 2018
- Live voice messages are relayed to staff as patient stories and used to encourage staff and drive improvements in the department
- Live patient feedback is immediately reviewed and acted on by the governance lead and matron in ED
- Access to daily FFT data showing at a glance the words and phrases patients are using the most and the context in which they appear
- Design and run bespoke surveys and analysing data instantly to show the team where the areas for attention are
- Identify areas for improvement based on last year's winter feedback and triangulating it with this year's data

Top themes reported in December 2018 feedback

Top 10 Themes			
+ Positive		- Negative	
1. Staff attitude	442	1. Staff attitude	53
2. Implementation of care	236	2. Environment	47
3. Waiting time	174	3. Waiting time	42
4. Environment	129	4. Clinical Treatment	40
5. Clinical Treatment	107	5. Communication	32
6. Admission	104	6. Implementation of care	29
7. Communication	93	7. Patient Mood/Feeling	20
8. Patient Mood/Feeling	60	8. Admission	18
9. Staffing levels	26	9. Staffing levels	14
10. Catering	9	10. Catering	2

ED data can be themed to show immediate feedback information about specific issues data from December 2018 has provided the following:

- Staff attitude was the most positive recorded feedback and it was also the most negative aspect of the feedback as well
- The length of time waited was both the third most recorded compliment and the third most recorded concern.
- Patient mood suggests the majority of visitors to ED report positive mood whilst in the department.

The Pilot is due to finish in May 2019.

Comfort Packs

Following an initiative started by a local Brownie pack, where packs were put together and delivered to the ED department last summer as part of a brownie badge, the department liked the idea so much they have continued to provide packs for patients who were not expecting to stay in. The packs contain wipes, tissues, comb, toothbrush and toothpaste.



ED Intranet project

ED identified the need for a way to share information between team members. A way to communicate, share learning, give easy access to information, provide an audit trail for all communication, make information sharing interesting, make the senior management team approachable and most importantly make this information available to the team from home and via mobile devices.

After research it was agreed to launch an Intranet (private network) which was launched in January 2019.

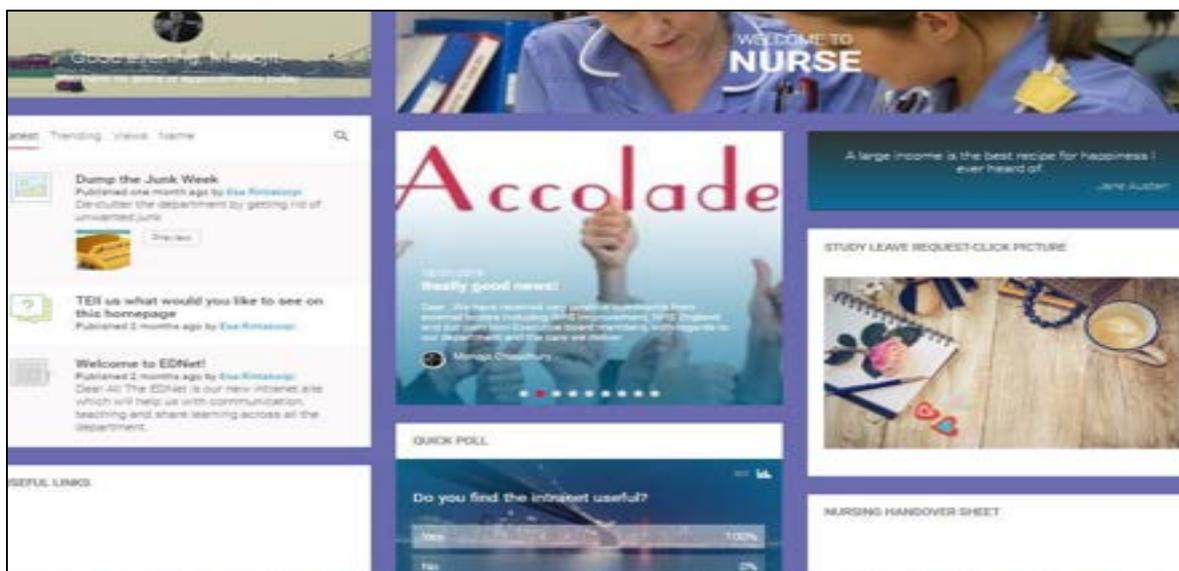
The new intranet has received very positive feedback and engagement from every team member since its launch. Its content is growing on a daily basis.

Features of the intranet

- Countdown to important events
- Share important information using banners
- Gives the team the ability to directly feedback to senior team and provide audit trail for actions taken
- Ask interactive questions
- Share patient feedback
- Get a snapshot of how people are feeling at work through quick polls

- Share learning
- Encourage people to write blogs
- Encourage people to read interesting topics beyond medicine
- Give staff interesting ECGs, radiology and journal links to read to keep up-to-date
- Dedicated pages for different groups of team members
- Dedicated governance page
- Policies and guidelines in one place and access from home and mobile device as well
- Dedicated mental health page with access to important information, all the forms and policies linked to mental health
- Recording of handover sheet electronically





Emergency Department Buddies

A daily presence of buddies and volunteers help provide food and refreshment to our patients. They talk to patients and explain what to expect when in the department. They receive great feedback and are integral to the smooth running of the department and the patient experience.



Sepsis

The department has a sepsis nurse who works with all members of staff to improve the uptake of sepsis screening and treatment. Monthly audits are undertaken and the results shared widely with ED staff. 'Sepsis Stars' are awarded to those members of staff who have shown 'excellence' in recognising and treating patients with sepsis.

Results for April 2019 can be seen below, the best results on record as yet.

- Paediatrics – 100% screened for sepsis
- Adults – 86% screened for sepsis
- Total 90% screened

The audit also detailed those patients who were not screened or treated as per the guidance pathway and provided the following action plan:

- Audit to continue and include 30% paediatrics as representative of population
- Remind all triage trained nurses to ensure **all** majors patients are triaged on the triage form and screened for sepsis
- Continued discussion with consultants regarding doctors administering intravenous antibiotics when nurses are unable
- Continue to highlight importance of alert card prescription use for haematology/oncology patients
- Sepsis added to all ED mandatory study days using real life examples to learn from
- Date/time has been added to non-compliance to see if there is a theme for time of day
- Continue to promote Sepsis Stars for excellence in sepsis recognition and treatment
- Positive reinforcement as this is the highest compliance percentage for sepsis screening!

Cardiology

Research success

The UKGRIS (UK GRACE Risk Score Intervention Study) trial is progressing well with 35 sites open and new sites in setup. By implementing this study within BHT, the GRACE scoring system has been introduced which is a risk assessment of people who have been diagnosed with NSTEMI (type of cardiac anomaly) or unstable angina, and is important for determining early management plans. This allows the benefits of treatment to be balanced against the risks of treatment-related adverse events. Failure to categorise future risk can lead to people being given inappropriate treatment. A GRACE score is completed for all appropriate patients admitted through the Cardiac and Stroke Receiving Unit which means care is being delivered in accordance with NICE guidance.



Cardiac rehabilitation and the integrated community and inpatient heart failure service

The Heart Failure service has integrated with the Cardiac Rehabilitation Team to enable us to offer an integrated pathway to our patients. Following the publication of the National Audit of Cardiac Rehabilitation Quality and Outcomes Report 2018 we were delighted to be told that our cardiac rehabilitation programme has met all 7 minimum standards and can be listed as a certified programme. The programme will retain this status for a further year.

Improving patient experience of discharge

There is national evidence and guidance supported by the Department of Health and NHS Institute of Innovation and Improvement on the discharge process.

DFMs (Daily Facilitated Meetings) have been introduced to ward 2a to support 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.

Stroke

Innovation

Following the successful implementation of Neurologic Music Therapy (NMT), the stroke unit is now working with Rosetta Life to bring Stroke Odysseys to Wycombe. Stroke Odysseys is

designed to produce and embed an interdisciplinary arts intervention for stroke survivors that combine movement, song making, storytelling and performance.

They have a remarkable partnership with Garsington Opera that enables them to deliver session work in hospitals and communities and to deliver an annual performance project that will not only provide entertainment for staff and patients, but engage all patients in a participatory process that changes their perceptions of their disability, improves confidence about life after stroke and celebrates movement and voice.

University accredited Stroke Course

Developing staff is a high priority for the Trust, and February saw the start of the BHT Stroke Unit's first university accredited stroke course, delivered in conjunction with Buckinghamshire New University. This 15 week course was open to the multi-disciplinary team and attended by both registered (working at academic level 6&7) and non-registered staff. All staff who have participated have enjoyed the experience and learning and are bringing this back into their daily work to support patient care.

Patient experience

Stroke is a catastrophic event and many of our patients in hospital can be low in mood. There is a flourishing relationship between the stroke unit and the on-site nursery. The children enjoyed visiting the wards to sing Christmas carols so much that they returned to deliver valentines cards for patients – including one to be sent on to a previous patient who they had sung with at Christmas.



Women, Children and Sexual Health Services

Paediatrics

The Paediatric Respiratory Nurse Specialist and the School Nursing Service joined the “Asthma Bus” initiative providing health education focusing on asthma self-management. The Asthma Bus visited three schools in Buckinghamshire and was open to children and young people and teachers of the school.

The number of Day Surgery operations carried out at Wycombe Hospital has increased enabling children and their families to recover in the Children’s Day Unit. Positive verbal and written feedback has been received from families following their operations at the hospital.

A burns and plastics nurse-led service providing post op wound checks, removal of sutures and follow-up is now available in Wycombe Hospital offering care to children closer to home.

An eating disorder service has been developed jointly with Child and Adolescent Mental Health Services, the Emergency Department team and paediatricians. This offers early diagnosis, early intervention and paediatric senior support to young people in the community to avoid hospital admissions.

Two new consultant paediatricians have joined the team, with two more being recruited in 2019 enabling all children admitted to be seen within 14 hours of admission in line with the national standards for paediatrics. The additional consultants will improve decision making, reduce delays in admissions and discharges and provide additional support for our trainee doctors. Additional outpatient clinics will be created for nephrology and epilepsy sub-specialities.

Following feedback from families, the parents’ lounge on the children’s day unit in Wycombe has been refurbished.

Following a listening event with families with children with complex needs, the following changes have been made so far:

- Where possible children with complex needs will be given a side room to ensure privacy and dignity during their stay.
- Promoting optimal rest/sleep overnight by reducing noise disturbance by ensuring medications are prescribed at set times and all bins in clinical areas are soft close.

Neonatal Unit

Occupational therapy and physiotherapy are now included as part of the multidisciplinary team, assessing and treating preterm babies whilst they are in the neonatal unit, following them up in the community and supporting families with on-going developmental care.

Following a peer review visit, the changes listed below have been made:

- A weekly chaplaincy service is available providing pastoral care for families who babies are staying in our neonatal unit
- Parents now have lockers available to store belongings securely

“Prematuri-Tea Party” in aid of World Prematurity Day. Families of premature babies who had been on NNU over the last year were invited to attend to talk through their experiences. Following feedback from this day, NNU have set up a monthly mother and baby group for families with premature babies, both in Wycombe and Aylesbury Childrens’ Centres, which will be supported by the neonatal community team.

Maternity

In outpatient gynaecology we have made changes to our early pregnancy services in response to feedback from users including improved access to appointments and a separate entrance in order to ensure women are seen in the most appropriate timeframe and have a positive experience. We have also introduced a menopause pathway.

The safety and experience of women and families who use our maternity service is of paramount importance.

Perinatal mortality rates have continued to reduce. In 2018/19 the extended perinatal mortality rate was 4.14 per 1,000 for the Trust compared to a national average of 5.84 per 1,000.

Approximately 5,000 babies a year are born at the Trust, and we ensure that all women have one to one care in active labour wherever they choose to give birth, whether this is at home, Wycombe Birth Centre, Aylesbury Birth Centre or Stoke Mandeville labour ward. Through service and clinical changes, we have reduced the number of babies requiring admission to the neonatal unit, thereby reducing the number of mothers and babies separated after birth and increasing breast feeding rates.

Specialist consultant-led antenatal clinics have been implemented for women at risk of pre-term birth, twins (or more), or who have had previous late pregnancy loss. These clinics

complement our specialist medical clinics that include diabetes and perinatal mental health pathway.

Women's experiences of care continue to improve particularly in the following aspects of care:

- Partners can stay as long as they want
- Women receive help and advice about feeding their baby
- Women felt their concerns were taken seriously

Engaging with women has been a high priority this year and we have undertaken surveys and engagement workshops so that women's preferences can be designed into the way we deliver midwifery services over the next two years, particularly regarding Better Births and Continuity of Care.

Buckinghamshire Sexual Health and Wellbeing Service (bSHaW)

2018/19 has seen continued development of the integrated sexual health service based at the Brookside Clinic, Aylesbury and the Shaw Clinic, Wycombe.

We have continued to adjust the mix of pre-booked appointment and walk in and wait clinics to ensure service users have a choice of clinic and can be seen within 48 hours of contacting the service. Telephone consultations are offered to reduce the need for some service users to attend clinic.

All national programmes focused on sexual health prevention/promotion have been adopted at an early stage by the bSHaW service, most recently the provision of HPV (human papilloma virus) vaccination to men who have sex with men.

We work with the providers of our website to ensure the information displayed is accurately, reflects current service provision and provides relevant health promotion information.

The multidisciplinary team has been enhanced by the investment in two new dedicated health advisers supporting improvements in partner notification and motivational interviewing for behaviour change.

The service has continued to participate in national research being successful in securing additional places for the 'Impact' trial focused on preventing the transmission of HIV. We are one of a small number of clinics nationally accepted to participate in the Lustrum trial to evaluate the effectiveness of offering patients diagnosed with chlamydia the opportunity when collecting their treatment to also access treatment for their partners(s).

We are proud of our patient feedback which is consistently positive. Feedback forms are available in clinic; two formal patient surveys are carried out every year. In autumn 2018 we focused on young people, results are displayed in clinic including plans to make service improvement in response to the feedback.

Positive feedback

- I was reassured and comforted by a lovely lady who was so bubbly and friendly. Best service I have received
- The doctor and nurse were so kind and respectful. They listened to everything I said and I was so well looked after. A student medic sat in on my appointment but I was asked first if this was okay and at every stage they kept checking if it was still fine for her to be there. I had such a lovely experience with the staff, I cannot praise them enough
- I was made to feel dignified and respected by the receptionists as I walked in they were lovely and very respectful of my privacy
- Friendly staff who explained everything clearly. Very clear, helpful, answer questions and give you information
- The health advisor was very kind and clear throughout the consultation

Suggestions for improvement:

- The only thing I can suggest is sometimes there are long waiting times but it's only because it's busy and the staff take the time to look after each patient
- Give clients an idea of their waiting time
- Make appointments easier to get
- I was treated with respect, however, as a non-binary person I was often misgendered

What have we done?

- We have ordered digital information boards to update all service users on waiting times
- We have already made it easier to book appointments and have a walk in clinic daily
- We will continue to work with all staff to improve communication skills and awareness of diversity
- We have held a workshop on transgender health for all staff

Children and young people

Improvements in the Neonatal Unit therapy pathway: As part of BLISS (a charity for babies born premature or sick) recommendations for Allied Health Professionals within Neonatal

Units. Occupational therapy, and physiotherapy are now included as part of the multidisciplinary team, assessing and treating pre-term neonates whilst they are in the Neonatal Unit. Follow up is offered in the community, as is supporting families with on-going developmental care, with the aim of improving outcomes.

‘Autistic Spectrum Disorder’ single point of access

This offers collaborative working with CAMHS, and has enabled a neuro-developmental single point of access, which was launched at the end of January 2019. This is to improve the child’s pathway/journey and clinical outcomes.

Health Visiting

The service achieved UNICEF’s Baby Friendly Initiative (BFI) stage 2 accreditation. The assessment assured that staff are equipped with the knowledge and skills to implement the ‘Baby Friendly’ standards. This helps promote breastfeeding, and support mothers with the feeding of their babies.

Speech and Language Therapy redesign

The Service Improvement team is working with the Speech and Language Therapy Service (SLT), to redefined their referral criteria/pathway and this has now been launched. This means that each school will have a named link SLT.

Family Nurse Partnership (FNP)

The annual review was a success in terms of celebrating the FNP achievements in 2018, with friends of FNP and clients from across the county in attendance. Father Christmas visited, and families received graduation certificates in recognition of their hard work and commitment to be the best possible Mum and Dad, through completing the FNP programme.

Specialist Services

National Spinal Injuries Centre (NSIC)



CARF - Committee for Accreditation of Rehabilitation Facilities

In May 2018, NSIC was visited by three CARF inspectors from the United States. The inspectors are everyday clinicians who provide care to people with spinal cord injury.

The CARF team looked at all aspects of service provision, patient experience, staff training, our business and governance systems, and how we communicate with stakeholders

(referrers / major trauma centres, SCI charities and users). A very positive feedback session was held on the second afternoon. These were some of the highlights:

- NSIC's Goal Planning and Key Worker programme was praised as a "real strength". The CARF team congratulated NSIC for an "extraordinarily in-depth programme".
- NSIC's Workforce Strategy was seen as "progressive" with some of the year-on-year improvements in nurse recruitment and retention described as "impressive", especially in the midst of a national nursing crisis.
- NSIC's fund-raising achievements were highly praised as "extraordinary and a tremendous help".

Overall, the inspectors gave their view that NSIC does a "really remarkable job" and thanked the team for being tremendously accessible and helpful and speaking to them with authenticity and transparency.

The inspectors went through a series of recommendations and consultations which will be included in their final report. NSIC will work through this after the outcome of the inspection has been formally confirmed. The National Spinal injuries centre has earned a further three year accreditation.

Patient Experience at the National Spinal Injuries Centre

The National Spinal Injuries Centre (NSIC) at Stoke Mandeville Hospital aspires to provide the best, patient-centred, effective and evidence based care to enable people with a spinal cord injury to reach their life goals. Listening to and involving patients is central to this. In July and August 2018 the NSIC, with the support of the engagement and involvement team, conducted a programme of events and other listening opportunities for patients.

The involvement and engagement team gathered the views of 57 NSIC patients using a mixed methodology; including two patient workshops, one for inpatients, one for outpatients, telephone and face to face interviews and a survey to patients who wished to attend the workshops but were unable to. This has led to shared development recommendations for improving patients' experience of the NSIC.



Cancer Services

Buckinghamshire 5 year Cancer Strategy was developed jointly by Buckinghamshire Healthcare NHS Trust, Buckinghamshire Clinical Commission Group, Public Health, General Practitioners, Macmillan and Cancer Research UK. The focus of the strategy is on key work streams covering prevention, screening, early diagnosis, flows and pathways, living with and beyond cancer, and end of life. The 5 year plan is now in its second year, and the strategy group meets on a quarterly basis.

Delivery of the plan is supported by Thames Valley Cancer Alliance and Macmillan who provide funding for the Cancer Pathway Improvement manager and Consultant Nurse who are both now in post.

Moving on with confidence

- The patient is assessed before starting the group using the cancer experience survey and HADS (Hospital Anxiety and Depression scale)
- There is a formal patient evaluation after each group
- Patients are invited back after 3 months for to score again to see if the coping strategies have been sustained
- Feedback is presented to cancer education information and support service steering group

For the latest survey results, patients were asked to rate their care on a scale of zero (very poor) to 10 (very good). BHT respondents gave an average rating of 8.7 in 2016 improving to 8.8 in 2017. Scores for comparable Trusts ranged between 8.5 and 8.8 in 2017.

Oncology

Thame community hub cancer clinic opened in March 2018

In March 2018 the Cancer Care and Haematology team developed a clinic on Wednesday mornings at Thame Community Hub. This clinic mirrors the pilot site launched at Marlow in August 2017 and follows positive patient and staff feedback. The clinic provides anti-cancer treatment (SACT) and supportive care closer to a patient's home, in an appropriate outpatient setting. In line with national guidance, this clinic is suitable for patients living within the local area who may be receiving SACT either orally, by sub cutaneous injection or who require central line care. This is a nurse-led service which is an extension of the existing cancer care and haematology unit's outpatient services.

Working in partnership with Macmillan Cancer Support, funding was secured to allow the team to further develop this model of delivery. In early February 2019, the Macmillan SACT Outreach Team designed an Oral Oncology Clinic run by nurses at Stoke Mandeville Hospital. This clinic benefits approximately six patients every week. Many people who live in Aylesbury and the surrounding areas can now have a quieter patient experience, compared to attending the busy hospital day case unit.

The SACT Outreach team is also mobilising a third site at Amersham Hospital which will commence in June 2019 and enable a greater proportion of patients from both Stoke Mandeville and Wycombe Hospitals to receive treatment closer to home.



Pathology

The Pathology team at the Trust has a mission to provide every patient with the best possible, high quality efficient service using the latest techniques available.

Cellular Pathology recently underwent their surveillance visit inspection from the United Kingdom Accreditation Service (UKAS), who are the sole national accreditation body for the

UK. The initial results were very positive. This means that patients will continue to benefit from the excellent, high quality service that cellular pathology provides. It also means that the efforts and hard work that staff have put into the department to ensure quality systems are working effectively has been recognised by UKAS.



Pharmacy

Significant strides have been made in quality and patient experience of Pharmacy and Medicines during 2018/19. Some of the highlights include:

Pharmacy@Bucks, a subsidiary pharmacy has taken over providing outpatient prescription services to both the Stoke Mandeville (April 2018) and Wycombe (April 2019) sites. This has shown a 60% reduction in waiting time for patients, with most waiting less than 15 minutes. Permanent pharmacists and support staff ensure that patients will also get a consistent and knowledgeable team to help them with their medicines related queries.

Developments have allowed a dedicated team to focus on known discharges, ensuring that discharge medications are ready earlier in the day. Using the mobile application 'Perfect Ward', pharmacy can consistently help wards review the safety and appropriateness of their medicines, practices and knowledge.

Cross system working has led to the creation of the 'Medicines Resource Centre', that will provide a medicines advice system for Trust and community patients, reducing duplication of effort. Other roles for this group include managing medicines choices ensuring quality, safety and value with input from prescribers in hospital and general practices.

Looking forward to 2019/20 the Trust is in the process of implementing an 'Electronic Prescribing and Medicines Administration' (EPMA) system. This system will provide doctors,

nurses and other healthcare professionals real time information on medicines, support with prescribing, allergy awareness and improved discharge documentation.

Radiology

The Radiology team continues to ensure it is making the best use of imaging to improve outcomes for our patients and the local community through effective use of imaging and image guided intervention. Successes over the last year include:

- Approval for replacement MRI scanners at Wycombe Hospital and an additional MRI scanner at Stoke Mandeville Hospital.
- Approval for the replacement programme for dental units. The units at Amersham Hospital are installed and in use and the units at Stoke Mandeville Hospital are in the process of being installed.
- Meeting the ongoing increase in demand for complex imaging with radiologist reporting, waiting list initiatives and outsourcing.
- Recent successful radiologist recruitment for paediatrics and breast imaging.

Patient Feedback:

For the last year the radiology department has been running a patient experience feedback project. The questions posed to adult patients change week by week and cover everything from cleanliness of the department to the friendliness of staff, efficiency and whether the patient was seen on time.

The results from the project are collated into a monthly report and published in the radiology monthly team brief so all staff are aware of patient feedback.

Improvements made as a direct result of this feedback are:

- The layout of the waiting room at Stoke Mandeville Hospital was changed for easier mobility.
- A sturdier chair was placed in the disabled changing room at Stoke Mandeville Hospital
- Facilities in the disabled toilet at Wycombe Hospital have been upgraded

Research and Innovation

2018/2019 has been an exciting year for research and innovation. We have grown the number of research studies (199 studies) that are open and the number of innovations we are supporting.

We are growing the number of partnerships with universities and with industry to increase opportunities for growth.

In 2018/19 nearly 6,000 patients consented to be part of research studies.

The partnership between the Trust, Bucks New University, Buckinghamshire Clinical Commissioning Group, and the Council for Bucks Life Sciences now has a delivery vehicle called Bucks Health and Social Care Ventures. There are currently 5 SMEs (small medium enterprises) on cohort 1 of the accelerator programme and cohort 2 will be launched in the summer.

The team has been building a social media presence to communicate to the community and to build awareness amongst colleagues and external partners and we have also built a new web page that will go live in April 2019.

Bethan Peach who is a retired medical researcher has joined the Patient Research Ambassador team as a volunteer to help promote NHS health research from a patient's point of view. Bethan said, "Engaging patients in clinical research can provide the NHS with a most powerful resource, and enables the patients themselves to help direct future health decisions."

Impact from some of our research and innovation

- CLOTS trial led to decompression socks being used. During the trial an estimated 10 lives per year were saved. This is now standard care in the Trust
- STAR study gives a single dose of stereotactic radiotherapy (SRT) to the eye of patients with age related macular degeneration. Our 2 patients were having repeated 4 weekly eye injections for many months prior to the SRT. Following the SRT the number of injections they have received has reduced significantly. The patients are very happy and there are cost savings to the Trust.
- DIAMONDS compares currently used standard lasers with the newer micro pulse laser in patients with diabetic macular oedema. The study centre has provided a micro pulse laser for the duration of the study which now gives us two options for patient treatment.

- BVMP was a trial to assess improved binocular visual function in young patients undergoing cataract surgery. Depending on the outcome of randomisation, we were able to offer a bifocal lens unavailable on the NHS.
- INJECT was a Phase IV study looking at the effectiveness of Ocriplasmin/Jetrea in patients with vitreo-macular traction. As a result of the study the Trust stopped using it. It was a very expensive drug.

Data on number of studies open

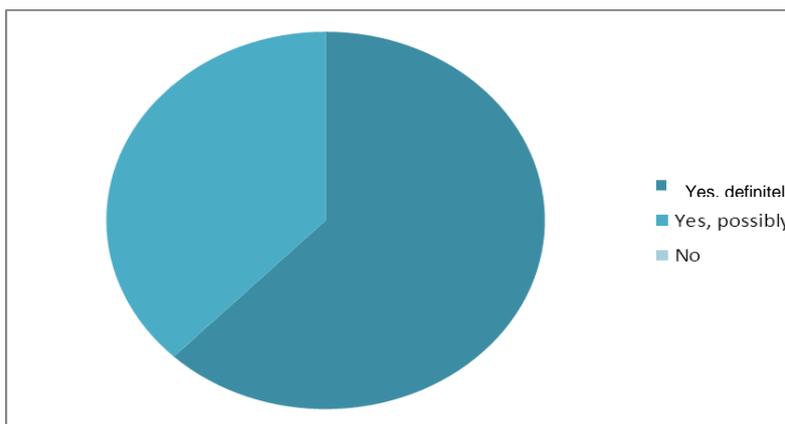
Study type	Number of active studies
Academic/student	3
Commercial non-portfolio	2
Commercial portfolio	36
Non-commercial non-portfolio	20
Non-commercial portfolio	138
Total	199

Specialty	Number of studies open
A&E	4
All patient areas	4
Cardiology	30
Community	7
Critical care	10
Dermatology	3
Diabetes	7
Gastro	14
Neurology (excluding Stroke)	5
Obstetrics & Gynaecology	17
Oncology & Haematology	44
Ophthalmology	8
Orthopaedics	1
Paediatrics	9
Pharmacy	4
Plastics & Burns	3
Radiology	2

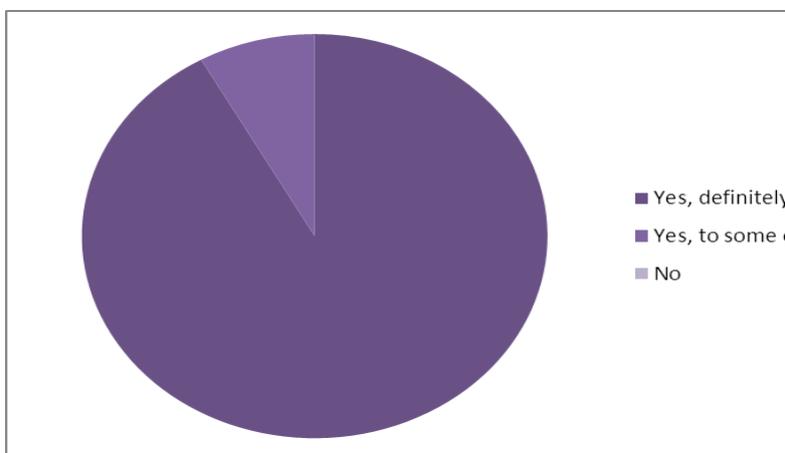
Respiratory	4
Rheumatology	6
Spinal	10
Stroke	7
Total	199

Research and innovation – Patient Feedback

Has your experience in research made you more likely to be involved again?



Do you feel that your participation in research was valued?



92% of our patients say research has been a positive experience



The team had a stand at the Bucks County Show this year which led to people registering on our Contact for Consent for research database along with a new Patient Research Ambassador.

Looking forward

2019/2020 is already set to be an exciting with the opening of the Research and Innovation facility which includes an Innovation Centre for SMEs to work with us. There are exciting collaborations coming together now for the new year which we look forward to reporting back next year.

Patient stories

Anna's research story

Can you tell me a bit about yourself?

I worked in banking & accounts and retired in 2008. Up until recently we had a narrow boat which kept us active and busy. Now I enjoy keep fit, walking and gardening. A few months ago I found my energy levels getting low and my skin or eyes were sometimes yellow. My GP sent me for blood tests which caused huge concern.

What type of study are you taking part in?

The UK Autoimmune Hepatitis Cohort (AIH-UK) observational study. It's where the immune system develops a fault and starts to attack parts of the body, in my

case the liver. This is a rare disease which only affects around 10,000 people in the UK.

How did you find out about the study?

My consultant, Dr Maggs, asked if I would like to take part when I was in clinic then Ruth Penn, the research nurse, met me at Stoke Mandeville when I had my biopsy.

Why did you decide to take part?

Being a fairly rare disease I felt strongly I should participate, especially as there was a strong possibility it could be genetic and my children and grandchildren could be affected.

What do you have to do?

I have regular blood tests to monitor my treatment and an extra one is sometimes donated to the study. When I had my liver biopsy an extra bit of sample was also taken for the study. I'm followed up for 2 years and have to fill in questionnaires about how I'm feeling on some visits.

What would you say are the benefits to you?

The benefits to me are that I'm being closely monitored. Any questions I have are fully explained by research nurse Ruth, which is very reassuring.

What would you say to anyone else thinking about taking part in research?

Do not hesitate. You feel you are helping the research identify new test and treatments for the benefit of others.



Hilary's research story

What does informed consent mean?

Prior to taking part in research it is essential that a person freely gives informed consent. The potential participant must be given the information to make a voluntary decision about whether to take part or not, this includes the purpose of the research, what's involved for them and understanding the risks and benefits. The research professionals taking consent must also be trained and qualified to take it.

What do you have to do?

"I have to inject myself every two weeks. They give us a diary to fill in with dates and times you do it. I started off coming to see the team monthly at first for four months and it's gradually reduced to every six months now. The drug's now been licensed in the UK and the trial's stopping early, I only have two more visits left."

What would you say are the benefits to you?

"I'm participating in something that will benefit others and I'm monitored. When I did have a problem I could contact the team and come in. It's been reassuring."

What would you say to anyone thinking about taking part in research?

"Definitely people should take part. It's for the benefit of everyone else in the future isn't it?"



Hilary in clinic with Nicola Bowers, Senior Cardiac Research Nurse

Ian's cardiac research story

Can you tell me a bit about yourself?

My name is Ian and I'm 69. I'm a keen naturalist with a particular interest in owls. I do a lot of bird watching and I have to be a keen gardener as I have a big garden.

What type of study are you taking part in?

It's called Orion3 which is looking at medicines which lower the levels of bad cholesterol (LDL) in high risk cardiac patients. I will be part of it for four years.

Why did you decide to take part?

Because my cholesterol was too high and this was an opportunity to do something about it.

What do you have to do?

I have to turn up for my study visits, do blood samples and injections.

What would you say are the benefits to you?

The treatment has massively reduced my cholesterol level.

How did you find out about the study?

I was invited by the cardiac research team.

What would you say to anyone else thinking about taking part in research?

From the trial I am participating in I can't see any down sides.



PART TWO

Priorities for improvement and Statements of Assurance from the Board

Quality of performance against our priorities set out in 2018/19

During the last year we have focused on driving forward quality improvement in areas that were identified as part of the organisation's corporate objectives. In addition to these quality priorities we worked collaboratively to improve the overall patient experience.

We had twelve quality priorities in our Quality Improvement Programme. Each priority had an executive lead and delivery lead assigned to them with responsibility for delivering their projects, supporting the staff involved and reporting progress on a monthly basis to the Quality and Patient Safety Group and on a quarterly basis to the Quality and Clinical Governance Committee.

The twelve quality priorities were aligned to the organisation's three corporate objectives outlined below:

- Implementing a culture of safety
- Listening to our patient voice
- Developing a learning organisation

The following information provides an overview of performance against quality targets during 2018/19.

We recognise that not all of our quality and safety improvement priorities for 2018/19 have been achieved in full, however, significant improvements in some areas have been demonstrated and we will continue to work to further improve on these areas.

Results and achievements for the 2018/19 Quality Account priorities

The following section provides detail on what has been achieved in the delivery of the priorities - what went well and what has been identified as requiring further improvement.

Overarching results for Quality corporate objective

Quality priority	Status
Implement a culture of safety	
Listen to our patient voice	
Develop a learning organisation	

Key:

- Green** - Quality priority met
- Amber** - Quality priority partially met
- Red** - Quality priority not met

Implement a culture of safety

The key focus was to establish and embed the SAFER (a mnemonic for streamlining patient discharge processes) bundle and a single transfer of care process through the following eight key components:

1: Implementation of the SAFER Bundle (With the exception of Women, Children and Sexual Health Division who have their own national guidelines to follow)

Objective:	<p>Implementation of the SAFER Bundle</p> <ul style="list-style-type: none"> • 100% of patients will have an estimated date of discharge within 24 hours of admission • 35% of transport booked by 4pm for patients having a transfer of care the next day • 50% of eligible patients will be discharged from
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	inpatient ward before midday
Status:	partially met 
<p>Improvements achieved:</p> <ul style="list-style-type: none"> • 52% of transport booked by 4pm for patients having a transfer of care the next day • All inpatient wards across the divisions have shown a marked improvement in the percentage of transport booked by 4pm for patients being transferred the following day and have exceeded the Trust target of 35%. 	
<p>Further improvements identified:</p> <ul style="list-style-type: none"> • 38% of patients have an estimated date of discharge within 24 hours of admission (data extracted from Medway). • 20% of eligible patients will be discharged from inpatient ward before midday • Ensure we are able to capture the data required • Improve the number of patients being discharged from an inpatient ward 	

2: Establish and embed a single Transfer of Care process

Objective:	60% reduction in avoidable delayed transfer of care 60% reduction in transfer of care to community services without fully completed documentation.
Status:	Following an extensive internal review of how to measure this outcome, there was no accurate and appropriate way to capture information directly linked to a single transfer of care process.

3: Implementation of a Clinical Accreditation Scheme (2018 – 2020)

Objective:	Set up systems and processes for identifying and rewarding the maintaining of good quality standards in the delivery and management of patient care.
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	<ul style="list-style-type: none"> • By end of year, 15 areas accredited • Completion of nursing documentation (90% by 30 March 2019)
<p>Status:</p>	<p>Partially met </p>
<p>Improvements achieved:</p> <ul style="list-style-type: none"> • A proposal to design and develop a Clinical Accreditation Programme has been approved to ensure the consistent delivery of safe, high quality patient care. Teams at a local level will lead continuous improvement and the Perfect Ward app will be the tool to deliver Clinical Accreditation across inpatient wards. • By the end of 2018/19 no areas were accredited, however, 3 inpatient wards have consistently performed at 90% and above since Q3 for Quality Rounds (using CQC Key Lines of enquiry) identified through Perfect Ward. These wards will undertake a final deep dive review in order to become fully accredited in early 2019. • On average all inpatient areas across the specialities have achieved between 90 - 100% compliance with the completion of quality round reviews using Perfect Ward. • Quarterly matron-led peer reviews across our inpatient wards have taken place for a second time during 2018/19. • Fifteen ward areas have received a 'deep dive' quality review which included an interview with the ward sister/charge nurse/matron, looking at the leadership and management of the area, communication and feedback from staff working in the area. This is in addition to defined care standards aligned to the Care Quality Commission (CQC) key lines of enquiry. • Six patient assessors have been trained and linked to a specific ward area. They support the wards with quality rounds, bringing a different view to the review. The patient assessors have so far completed one quality round and will, with their link ward, report their findings to the Trust's Patient Experience Group (PEG) meeting. • Documentation compliance for all specialities using Perfect Ward met the 90% target by the end of Quarter 4 (Jan-Mar 2019). • We have also worked with our pharmacy colleagues to support wards with the medicines management part of quality rounds which has shown month on month improvement in compliance. 	

<p>Further improvements identified:</p> <ul style="list-style-type: none"> • Clinical Accreditation steering group to be set up with Chief Nurse and Non-Executive Director sponsor to continue to drive clinical accreditation and provide support to wards / areas to reach accreditation. • Programme of deep dive quality reviews to be established for the year ahead with support from our Buckinghamshire Clinical Commissioning Group colleagues. • Wards to be identified that are ready to receive clinical accreditation. • Awarding the accreditation to be supported by our communications team.

4: Implementation of an e-prescribing system (2018 – 2020)

Objective:	<p>Year 1 – Electronic prescribing system (e-prescribing) set up and piloted in one ward</p> <p>Year 2 - E-prescribing system rolled out across the acute site and reduction in prescribing errors by 50% based on Q1 2018/19 data</p>
Status:	<p>Met </p>
<p>Improvements achieved:</p> <ul style="list-style-type: none"> • Electronic Prescribing and Medicines Administration (EPMA) system is still under development. The first patients should have their medicines electronically recorded in early 2020 with a full roll out across the Trust in Q2 and Q3. • Following a successful funding bid, a system supplier has been selected; project group recruited, requirements for the system agreed, process mapping underway and transformation plan in place. 	
<p>Further improvements identified:</p> <ul style="list-style-type: none"> • Communication and training to be developed to engage and support staff with the process as we get closer to going live. • The first patients should have their medicines electronically recorded in early 2020 and after a period of review and optimisation, the system will rollout across the 	

Trust through Q2 and Q3 of 2020.

5: Implementation of an electronic patient (e-observation) monitoring system (2018 – 2020)

Objective:	Year 1 - e-observation system established and piloted in ten wards Compliance with NEWS 2 recording and escalation 100% Year 2 - e-observation system rolled out across the acute site and occurrence of sepsis reduced in A&E by 50% base on 2017/18 data
Status:	Met 
Improvements achieved: <ul style="list-style-type: none"> • The e-observation (monitoring) system has been fully piloted and we have established the system in 10 wards • We have improved recognition and response to acute patient deterioration and sepsis across the Trust • There has been a successful procurement and implementation of Careflow Vitals electronic patient observation system that will be used across all inpatient wards • NEWS2 is used in all acute areas of the Trust including the National Spinal Injuries Centre demonstrating compliance for recording on the system and all clinical staff have been trained in NEWS2 and Careflow Vitals. • ED has a dedicated sepsis nurse • ‘Sepsis Star’ given to staff who demonstrates excellent sepsis practice • Establishment of a regional sepsis survivors support group in collaboration with Oxford Academic Health Science Network • The education and learning team has been working with community care homes to improve recognition of deterioration and sepsis 	
Further improvements identified:	

- Implementation of NEWS 2 in our community hospitals
- Ongoing Careflow Vitals implementation plan for Wycombe and Community hospitals by May 2019
- Introduction of phase 2 of the electronic observations project which enables enhanced nursing assessments to be recorded electronically
- Digitisation of sepsis screening to be introduced
- Data from Careflow Vitals to drive ongoing improvements in care
- Improved handover and workload allocation utilising the introduction of CareFlow Connect communications
- Continue to work with community partners to improve recognition of deterioration and enhance early, appropriate decision making with a view to reducing hospital admissions

6: Implementation of a trustwide automated decontamination programme

Objective:	Develop automated decontamination programme across the Trust.
Status:	Partially met 
Improvements achieved:	
<ul style="list-style-type: none"> • Piloted automated decontamination within the urgent care services at Stoke Mandeville Hospital • Post pilot audit demonstrated improvement • Tender process has begun to broaden the provision of the decontamination programme 	
Further improvements identified:	
<ul style="list-style-type: none"> • Procurement process developed to support a wider automated decontamination service in the Trust 	

7: Reducing gram negative results

<p>Objective:</p>	<p>Reduce gram negative blood stream (GNBSI) infections by 25% of 2017 achievement.</p> <p>Provide a final report that identifies improvements made, changes in practice, policy and processes and any further changes required to maintain and continually improve urinary catheter gram negative bloodstream infections in 2019/20</p>
<p>Status:</p>	<p>Partially met </p> <p>Gram Negative Blood Stream Infections (GNBSI) has been discussed nationally and regionally. Nationally the scale of the challenge has been recognised and time scales and targets have yet to be clarified. The focus locally has been on the value that is added following the completion of an investigation of each case. Findings demonstrated that of 30 assessed, one GNBSI was deemed 'avoidable'.</p> <p>Information on the GNBSI work is now included in the annual report.</p>
<p>Improvements achieved:</p> <ul style="list-style-type: none"> • The focus on GNBSI has been developing nationally and as part of that, in 2018/19 we began a process of completing root cause analysis on all GNBSIs. Due to the number of RCAs completed, of which one was identified as avoidable, the Trust will now focus on an alternative approach to reducing GNBSIs which will include sampling and monitoring of cases post 48 hours from admission. • Local findings have demonstrated that of 30 GNBSIs assessed only one was avoidable. 	
<p>Further improvements identified:</p> <ul style="list-style-type: none"> • There is no obvious direct causal relationship between antibiotic use and gram negative bacteraemias based on the evidence to date. Therefore, no specific 	

actions with regards to antibiotic prescribing/use to aid in the reduction of these infections can be identified over and above embedding good antimicrobial stewardship principles in line with Trust policy and guidelines.

8: Prudent use of antibiotics

Objective:	Prudent use of antibiotics and delivering: 72 hour review of antibiotics for 30 patients, as for Q1, with 90% compliance achieved. 1-2% reduction in total antibiotics consumption / 1000 admissions vs baseline 2-3% reduction on Carbapenem consumption per 1000 admissions vs baseline
Status:	Met 
Improvements achieved: <ul style="list-style-type: none"> • 90% compliance achieved for 72 hour review of antibiotics for 30 patients • 12% reduction in total antibiotics consumption / 1000 admissions • 18% reduction on Carbapenem consumption per 1000 admissions • The prudent use of antibiotics and reduction in consumption has exceeded the 2-3% target set for 2018/19 following a baseline audit. The prudent use of antibiotics, their consumption and review of patients taking antibiotics will continue to be monitored and reported through the Antimicrobial Stewardship Committee and the Infection Prevention and Control Committee, which reports to the Quality and Patient Safety Group. 	
Further improvements identified: <ul style="list-style-type: none"> • No further improvements identified 	

Listen to our patient voice

Our key focus was to work in partnership with patients to improve their experience of discharge from our care, outpatients and A&E. To achieve this goal we aim to be in the top 20% of performing Trusts in the country for overall patient experience by 2020 in line with the Patient and Carer Experience Strategy 2017 to 2020.

Improving the patient experience in response to what patients have told us from surveys, complaints and Friends and Family feedback.

Objective:	Year 1 - Recruit and train volunteer patient representatives to become members of patient forums across the Trust
Status:	Met 
<p>Improvements achieved:</p> <ul style="list-style-type: none"> • Patients /carers who support the Trust’s Patient Led Assessment of the Care Environment (PLACE) have been recruited and trained to join the Trust Patient Experience Group (PEG) on a permanent basis. The PEG group has grown significantly and now comprises of 22 members. • Guidance on developing and supporting the role of patient representatives has been created and distributed. • Guidance for patient representatives has also been created and distributed which includes the following: To act as a ‘critical friend’ to the Trust on the delivery of the patient/carer strategy. To take part in quality assurance activities such as quality rounds, speaking to patients and working with staff on improving patient experience. To provide input and feedback on Trust policies and strategies that impact on patient/carer experience. 	
<p>Further improvements identified:</p> <ul style="list-style-type: none"> • As more patient experience representatives were recruited to support the Trust, it became more apparent that a coaching style of introduction and support should be used rather than formal training and as such the guidance will be reviewed and adapted accordingly. 	

Improving the patient experience

Objective:	<p>Reduce 12 hour and more waiting times in A&E by 40%</p> <p>Improve the turnaround time for TTO (To Take Out) medicines (this will form part of the Single Transfer of Care project)</p> <p>Reduce the number of cancellations in the outpatient department by 40%</p>
Status:	<p>Partially met </p>
<p>Improvements achieved:</p> <ul style="list-style-type: none"> • 68% reduction in patients waiting for more than 12 hours in A&E • 30% improvement in turnaround time for TTO medication 	
<p>Improvements achieved:</p> <ul style="list-style-type: none"> • The Trust is continuing to implement processes to reduce outpatient cancellations. Although we have not seen a reduction of 40% set out for 2017/18 there are robust plans in place to ensure a significant reduction by 2019/2020. 	

Develop a learning organisation

Our key focus was to ensure the organisation learns when patients deteriorate or die within our care. To achieve this goal we aimed to create a Learning Organisation Framework based on serious incidents, deaths and avoidable harm. We already have a 'Freedom to Speak Up' Guardian to enable staff to raise concerns implemented as part of a national programme following the Francis Inquiry into 'Mid Staffordshire NHS Foundation Trust'.

Objective:	<p>Implement a training and development programme that provides staff at all levels the understanding of quality improvement and the tools to reduce the occurrence of avoidable harm</p>
Status:	<p>Met </p>

Improvements achieved:

- In order to build skills in Quality Improvement (QI) we have adopted the NHSI Quality, Service Improvement and Redesign (QSIR) training programme, as our QI methodology of choice.
- QSIR provides a complete collection of quality, service improvement and redesign tools, theories and techniques that can be applied to a wide variety of situations.
- Training has been implemented during the last year and is available as either a 1 day 'Fundamentals' or 1 day 'Practitioner' course. These are run across the Buckinghamshire, Oxfordshire and Berkshire (BOB) STP, where shared experiences across all areas promote learning and support integration.
- There are 47 practitioners and 64 staff who have attended fundamentals training.
- Five members of staff have achieved graduate status and can now teach the course and within BHT.
- A network of QSIR practitioners has been formed and meetings are held quarterly to provide support and coaching to the practitioners.
- The BHT leadership team has incorporated quality service improvement and human factors into the new Senior Leaders Programme (SLP). A half-day session on human factors is available to both clinical and non-clinical senior leaders from across the Integrated Care System (ICS).

Further improvements identified:

- As part of our QSIR approach, a monthly fundamentals day will take place from April 2019.
- Drop in monthly clinics are planned where staff can seek advice and support with QI tools and techniques for their projects.
- Training will continue to build skills within the Trust.

The BHT Way

Introduction to the 2019/20 priorities for improvement

Our priorities for improvement are tied to our mission and vision in everything we do which is underpinned by our values and behaviours.

‘The BHT Way’ sets out our ambition to be **one of the safest healthcare systems in the country delivering safe, compassionate care every time for every patient.**



The BHT Way is underpinned by our **CARE** values of collaborate, aspire, respect and enable and throughout 2019/20 we continued to embed these throughout the organisation. We are focussing on the following three strategic priorities designed to ensure we deliver our vision:

- Continue to improve our culture
- Implement new workforce models
- Tackle inequalities and variation

Corporate Objectives

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 3 key areas that will transform our culture, workforce and clinical services.

These are not business as usual and initiatives related to the performance of the Trust will be reported and monitored separately through the Integrated Performance Report.

The following three corporate objectives and related programmes have been agreed:

Corporate objective	Projects	Executive lead	Committee
Continue to improve our culture	BHT Way – always improving: <ul style="list-style-type: none"> - 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 Board Finance
	Clinically-led financial plan	Medical Director	Finance
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	Board
	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: <ul style="list-style-type: none"> • 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	

Corporate objectives and plans link with our three strategic priorities and will be in place for 2 years. Our digital, estates, clinical and commercial strategies are designed to enable the delivery of our objectives. All Board committees, together with EMC, are being structured to oversee the delivery of this plan and associated projects.

Links with operational and clinical teams are built through the delivery of the clinical strategy and business plans. These will be detailed and aligned with the health and social care system and contribute to the delivery of corporate objectives and significant transformation.

In April 2019 our flagship engagement event – the BHT Way – was set aside to launch the corporate objectives. It was used as an opportunity to hear from various individuals and teams who are implementing plans linked to corporate objectives and for leaders and staff to discuss how to make the corporate objectives real in their teams.



As a Trust we will continue to work with divisional structures to embed and monitor plans linked to delivering the corporate objectives and routinely discuss progress and challenges at future BHT Way events.

At a high level, each of the accountable executives, has worked with their teams to develop project initiation documents (PIDs) that outline critical milestones over the 2 years as well as

identify key performance indicators linked to our strategic priorities – quality, people, money. 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.

As a result of the above changes to the way BHT has structured its corporate objectives the Board Assurance Framework is being updated to reflect the new corporate objectives. 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.

Having corporate objectives set for two years provides BHT with an opportunity to focus and prioritise delivery of these changes. It also provides a level of stability and direction to build further plans in the organisation and the system that will support the delivery of our vision to be one of the safest healthcare systems in the UK.

Quality Improvement

BHT is working towards embedding a Quality Improvement (QI) culture so that the creativity, passion and initiative of its entire staff can be harnessed for improving patient care. QI is the use of a systematic method to involve those closest to the quality issue in discovering solutions to a complex problem. It applies a consistent method and tools, engages people (both staff in clinical/corporate teams and patients/service users/families) more deeply in identifying and testing ideas, and uses measurement to see if changes have led to improvement.

A “BHT Way” day last October brought together 180 staff from a broad range of specialties, departments and levels of seniority to collectively think about what a trustwide culture of continuous improvement looks and feels like. Whilst BHT is able to demonstrate many individual examples of excellent quality improvement projects and initiatives, it became clear that we did not yet have a widespread culture of continuous improvement. Feedback from the audience gave several indicators for where to start this journey, building on our current status. Some of them were longer term, requiring investment in terms of time and expertise, but others were ideas the Trust can start to develop.

What would make improvements easier?



In addition, two NHS Trusts rated as outstanding with embedded Quality Improvement cultures were visited (Western Sussex Hospital NHS Foundation Trust and East London NHS Foundation Trust) and a national conference on QI hosted by NHS Improvement attended.

Implementing QI is the cornerstone of the Trust's Corporate Objective for 2019/20 to continue to improve our culture. The change programme is focused on three key elements:-

- Leadership for QI
- Building capacity and capability
- Creating a movement for change

A QI steering group has been formed and a driver diagram outlines agreed actions. Some of the proposals already exist in some form in the Trust but need to be enhanced and developed within the framework and branding of a quality improvement culture. Others will require identified resource to lead the initiative and drive it forward.

Ensuring Board and Executive leadership for QI is fundamental to establishing a culture of continuous improvement and Neil Macdonald the Chief Executive chairs the monthly Improvement Committee where new projects and ideas from clinical teams are approved, supported and monitored.

QSIR Training

One of the essential elements of any QI culture is building capability within the organisation using recognised QI tools and techniques. BHT has a central Quality Improvement team whose purpose has been to support teams to make improvements. Within BHT, we are aiming to build our capability in QI methodology and to achieve this aim the NHSI Quality, Service Improvement and Redesign (QSIR) training programme has been adopted as its quality improvement (QI) methodology of choice. QSIR provides a comprehensive collection

of quality, service improvement and redesign tools, theories and techniques that can be applied to a wide variety of situations.

The training is available as either a 1 day fundamentals or 5 day practitioner course. These are run across the Integrated Care System (ICS), where the shared experiences from across all areas of the health and local authority sector are very valuable in promoting learning and will support integration. A database of all those who have attended QSIR training has been set up and by the end of April 2019, there are 43 practitioners who have completed the training. There are also 45 staff within BHT who have completed the 1 day Fundamentals training. There are 5 QSIR practitioners who have now achieved graduate status enabling them to teach the course.

Training utilising the QSIR methodology has now also been implemented on the leadership pathways, preceptorship cohorts as well as bite size sessions to teams. From April 2019, The Fundamentals training will be provided in-house (although offered to ICS partners as well) on a monthly basis for 20-30 staff each time. The templates for QI tools and techniques will be available for all staff to access on the intranet or a separate repository.

Mandatory declarations and assurances

All NHS Trusts are required in accordance with the statutory regulations to provide prescribed information in their quality accounts. This enables the Trust to inform the reader about the quality of our care and services during 2018/19 according to the national requirements.

The data used in this section of the report has been gathered within the Trust from many different sources or provided to us from the Health and Social Care Information Centre (HSCIC). The information, format and presentation of the information in this part of the Quality Account is as prescribed in the National Health Service (Quality Accounts) Regulations 2010 and Amendment Regulations 2012 / 2017.

Statements of assurance

During 2018/19 Buckinghamshire Healthcare NHS Trust provided and/or sub-contracted seven NHS services. These are:

- Accident and Emergency (A&E)
- Acute Services (A)
- Cancer Services (CR)
- Community Services (CS)
- Diagnostic, Screening and/or Pathology Services (D)
- End of Life Care Services (ELC)
- Patient Transport Services (PT)

Buckinghamshire Healthcare NHS Trust has reviewed all the data available on the quality of care in seven of these NHS services.

The income generated by the NHS services listed represents 94% of the total income generated by Buckinghamshire Healthcare NHS Trust for 2018/2019. The Trust received the other 6% of its income for other aspects of work, for example research and development, education and training, sustainability and transformation funding and other miscellaneous income.

Clinical audit and national confidential enquiries

During April 2018 to March 2019, 46 national clinical audits and national confidential enquiries covered relevant health services provided by Buckinghamshire Healthcare NHS Trust.

During that period Buckinghamshire Healthcare NHS Trust participated in 94% (44/47) national clinical audits and 100% (5/5) national confidential enquiries of the audits and enquiries in which it was eligible to participate.

The national clinical audits and national confidential enquiries that the Trust was eligible to participate in during April 2018 to March 2019 are detailed in the table below.

The table shows which audits the Trust participated in and the percentage of eligible/requested cases submitted.

AUDIT	Applicable overall	Data collection (yes/no)	2018/19 status	% eligible/requested cases submitted or reason for non-participation
CANCER				
Bowel Cancer (NBOCAP)	applicable	yes	Participating	100%
National Lung Cancer Audit	applicable	yes	Participating	100%
National Prostate Cancer Audit	applicable	yes	Participating	100%
Oesophago-gastric Cancer (NOGCA)	applicable	yes	Participating	Data submitted through the Oxford Regional Network
National Audit of Breast Cancer in Older Patients (NABCOP)	applicable	yes	Participating	100%
WOMEN AND CHILDREN				
Diabetes (Paediatric) Audit (NPDA)	applicable	yes	Participating	100%
Maternal, Newborn and Infant Clinical Outcome Review	applicable	yes	Participating	100%
National Maternity and Perinatal Audit (NMPA)	applicable	yes	Participating	100%
National Neonatal Audit Programme (NNAP)	applicable	yes	Participating	100%
National Audit of Seizures and Epilepsies in Children and Young People	applicable	yes	Participating	100%

Feverish Children (Care in Emergency Departments)	applicable	yes	Participating	5 consecutive cases per week
CARDIAC, DIABETES AND VASCULAR				
Myocardial Ischaemia National Audit Project (MINAP)	applicable	yes	Participating	100%
Cardiac Rhythm Management (CRM)	applicable	yes	Participating	100%
National Audit of Cardiac Rehabilitation	applicable	yes	Participating	100%
National Audit of Percutaneous Coronary Interventions (PCI)	applicable	yes	Participating	100%
National Audit of Percutaneous Coronary Interventions (PCI)	applicable	yes	Participating	100%
National Cardiac Arrest Audit (NCAA)	applicable	no	Not participating	Data is collected and reviewed via a monthly local audit
National Heart Failure Audit	applicable	yes	Participating	100%
Inflammatory Bowel Disease (IBD) Programme	applicable	yes	Participating	19 cases in 2017/18
National Diabetes Audit – Adults	applicable	yes	Participating	100%
National Vascular Registry	applicable	yes	Participating	Data submitted by the Regional Vascular Service at Oxford
Rheumatoid and Early Inflammatory Arthritis	applicable	yes	Participating	100%
OLDER PEOPLE				
Falls and Fragility Fractures Audit Programme (FFFAP)	applicable	yes	Participating	100%
National Audit of Dementia	applicable	yes	Participating	100%
Sentinel Stroke National Audit Programme (SSNAP)	applicable	yes	Participating	100%
National Audit of Intermediate Care	applicable	yes	Participating	100%
National Asthma and COPD Audit Programme	applicable	no	Not Participating	Withdrew from audit with Trust agreement
ACUTE				
National Emergency Laparotomy Audit (NELA)	applicable	yes	Participating	100%

National Comparative Audit of Blood Transfusion Programme	applicable	yes	Participating	100%
Case Mix Programme (ICNARC)	applicable	yes	Participating	100%
Elective Surgery (National PROMs Programme)	applicable	yes	Participating	100%
Major Trauma Audit (TARN)	applicable	yes	Participating	100%
National Joint Registry Audit (NJR)	applicable	yes	Participating	93%
National Ophthalmology Audit	applicable	No	Not participating	Registered but awaiting approval and installation of required software
BAUS Urology Audit - Nephrectomy	applicable	yes	Participating	113.6%
BAUS Urology Audit - Cystectomy	applicable	yes	Participating	112%
BAUS Urology Audit – Female Stress Urinary Incontinence (SUI)	applicable	yes	Participating	100%
BAUS Urology Audit – Percutaneous Nephrolithotomy	applicable	yes	Participating	100%
BAUS Urology Audit – Radical Prostatectomy	applicable	yes	Participating	103% for 2015/16/17 combined
Vital Signs in Adults (Care in Emergency Departments)	applicable	yes	Participating	5 consecutive patients per week
VTE Risk in Lower Limb Immobilisation (Care in Emergency Departments)	applicable	yes	Participating	5 consecutive patients per week
Adult Community Acquired Pneumonia	applicable	yes	Participating	100%
National Audit of Care at the End of Life (NACEL)	applicable	yes	Participating	69 cases note reviews submitted
Non- Invasive Ventilation – Adults (BTS)	applicable	Yes	Participating	30/30
Surgical Site Infection Surveillance Service	applicable	Yes	Participating	100%
OTHER				
Learning Disability Mortality Review Programme (LeDeR Programme)	applicable	yes	Participating	All applicable cases (3) submitted
Seven Day Hospital Services	applicable	yes	Participating	100%

National Confidential Enquiry into Patient Outcome and Death	BHT applicability	BHT participation	Participation rate
Acute Heart Failure	Applicable	Participated	9/9 questionnaires submitted
Perioperative Diabetes	Applicable	Participated	9/14 questionnaires submitted
Pulmonary Embolism	Applicable	Participated	4/5 questionnaires submitted
Acute Bowel Obstruction	Applicable	Participating	still collecting data
Long Term Ventilation in under 25s	Applicable	Participating	still collecting data

The reports of 19 national clinical audits were reviewed by the provider in April 2018 to March 2019 and Buckinghamshire NHS Trust has taken the following actions to improve the quality of healthcare provided:

- FFFAP National Hip Fracture Database** – Following review of the data from this audit the Trust has introduced the ‘Golden Patient’ model. This means that when theatre lists are prepared hip fracture patients are treated as a priority and if possible the first patient on the list. This change should mean more patients will receive their surgery within the 36 hour target. Theatre nurses attend the daily trauma meeting to ensure that the list order is correct and also that the correct ‘kits’ are ready for the surgery. This change has led to improved communication and efficiency in theatres.
- Learning Disability Mortality Review Programme (LeDeR) 2017/18** – The results of this audit have been used to inform changes in the process for reviewing deaths involving patients with a learning disability. The Learning Disability nurses work closely with the Trust’s Mortality Review Lead to ensure they are included in all mortality reviews involving people with a learning disability. In this way learning can be identified and shared. The Learning Disability nurses also attend the ICS LeDeR review meeting
- Maternal, Newborn and Infant Clinical Outcome Review Programme 2017-18 - MBRRACE)** – Following review of the MBRRACE report mortality rates are now being closely monitored with a renewed focus on reducing neonatal deaths. Monthly perinatal mortality data collection occurs via the maternity dashboard and trends are discussed at the quarterly multidisciplinary perinatal mortality review panel. Recommendations from the Each Baby Counts report (2017) have been or are being actioned including; implementation of the Perinatal Mortality Review Tool (PMRT) to support local review processes, joint perinatal monthly morbidity and mortality meetings to share learning

amongst the wider maternity and neonatal team; annual audit of the number of placentas sent for perinatal pathology (target 90%); improved adherence to the Trust fetal growth monitoring guideline, which includes customised growth chart, and follows the RCOG recommendations for detection and prevention of babies small for gestational age.

- **NCEPOD Non-invasive Ventilation Study (2017)** – This study was a review of the quality of care provided to patients receiving acute non-invasive ventilation (NIV). The study found a wide variation in both the organisation of acute NIV services and the clinical care provided. Working with the Trust quality improvement team, the respiratory department is developing a pathway for patients receiving NIV which will bring together all the specialities involved. An NIV group has been set up with executive leadership from the Divisional Chair for Surgery and Critical Care. As recommended by NCEPOD, a senior respiratory consultant is the NIV lead for the Trust. The group is working through all the recommendations and hopes to implement changes mid- 2019.

Participation in research

The number of patients receiving NHS services provided or sub contracted by Buckinghamshire Healthcare NHS Trust in 2018/19 that were recruited during that period to participate in research approved by a research ethics committee was 5,561.

Income for quality and innovation

A proportion of the Trust's income in 2018/19 was conditional on achieving quality improvement and innovation goals agreed between Buckinghamshire Healthcare NHS Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation Payment Framework.

Further details of the agreed goals for 2018/19 and for the following 12 months period are available on request by emailing: bht.communications@nhs.net.

Care Quality Commission (CQC)

Buckinghamshire Healthcare NHS Trust is required to register with the Care Quality Commission (“CQC”) under section 10 of the Health and Social Care Act 2008 and its current registration status is ‘Registered’. Buckinghamshire Healthcare NHS Trust is registered with the CQC with no conditions attached to registration.

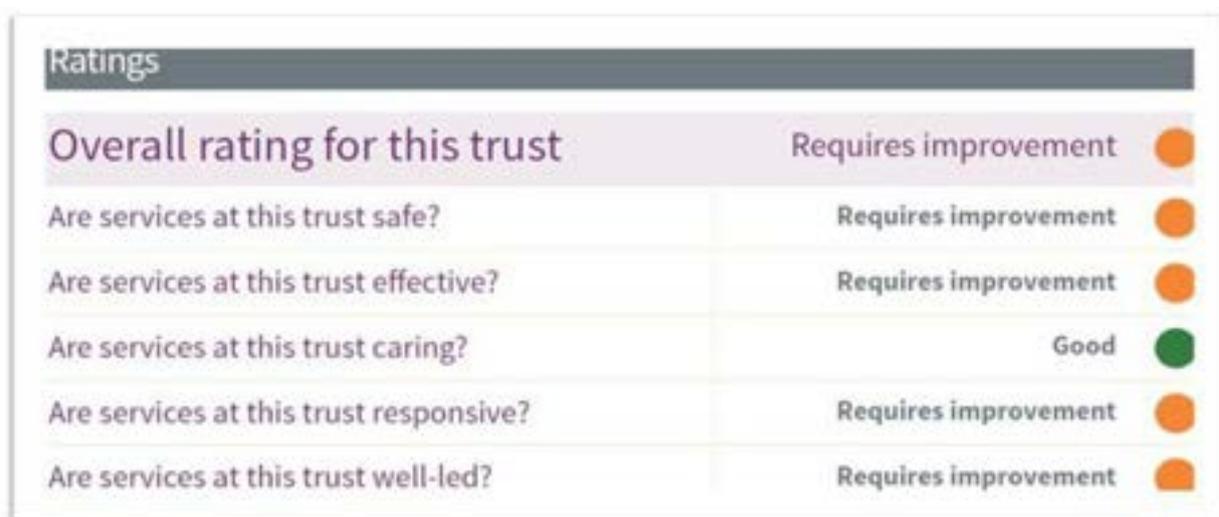
Buckinghamshire Healthcare NHS Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

Buckinghamshire Healthcare NHS Trust underwent an unannounced, focused CQC inspection between 6 -7 September, 2016. The inspection was undertaken using the new CQC framework which assessed whether services are:

- Safe
- Effective
- Caring
- Responsive
- Well-led

The following sites were inspected: Stoke Mandeville Hospital, Wycombe Hospital, and Buckingham Community Hospital.

The overall Trust rating of Requires Improvement has not changed from the comprehensive inspection in 2015. The chart below depicts the Trust’s overall rating.



The following themes for improvement arose from the inspection areas:

- Safe management of medicines
- Pharmacy workforce resourcing
- Embedding end of life care plans for all patients – some variability
- Variation in documentation- medical and nursing
- Infection control- clean equipment in 2 areas

The CQC noted areas of concern, for which it issued compliance notices regarding Regulation 12 – safe care and treatment and Regulation 18 - safe staffing. A compliance action plan has been submitted to the commission by the required deadline and the Trust has already achieved several improvements in respect to these.

A copy of the CQC inspection report can be accessed here

<http://www.cqc.org.uk/provider/RXQ>

In early 2019 the Trust was again inspected by the CQC and the results of this inspection are available at the above internet address.

Data Quality

Buckinghamshire Healthcare NHS Trust submitted records during 2018/19 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data relating to <i>admitted patient care</i> which included the patient's:	The percentage of records in the published data relating to <i>out-patient care</i> which included the patient's:	The percentage of records in the published data relating to <i>accident and emergency care</i> which included the patient's:
Valid NHS Number was 99.7% (National Average 99.4%)	Valid NHS Number was 100% (National Average 99.6 %)	Valid NHS Number was 99.9% (National Average 97.5 %)
General Medical Practice code 100% (National Average 99.9%)	General Medical Practice code 100% (National Average 99.8%)	General Medical Practice code 100% (National Average 99.3%)

Buckinghamshire Healthcare NHS Trust will be taking the following actions to improve data quality:

The Trust will create a Data Quality (DQ) dashboard to monitor five agreed key indicators that reflect local priorities and are directly linked to the organisations areas of risk

Indicators:

- Missing / incomplete clinic outcome codes by specialty / clinician
- NHS number completeness
- Registration of duplicate records
- Duplicate pathways created for the same specialty
- Appointments put on hold weekly

The Trust will expand the existing data quality audit programme to include separate checks on RTT (Referral To Treatment) data. The programme will rotate through the organisation's specialties.

The Trust will create a central list of the data quality checks, how they are reported, who investigates them, corrects the data and if feedback occurs. For example, a data quality team, in the information department, checks for missing NHS numbers, postcodes and GP practices. The corporate application team has a list of data quality tasks that they perform daily. Medical records manage merging of duplicate records. We will then be able to review the training these staff receive to be assured that they are appropriately skilled.

Manage and maintain standard operating procedures (SOPs) trustwide for data collection and validation. This includes statutory returns with sign off by relevant managers in divisions prior to submission.

To develop a data quality strategy aligned to the New ICS Information Strategy 2019-24(Draft).

Promote and reinforce the corporate message that data quality is the responsibility of all.

Ensure the Data Quality Steering Group holds a log of data quality issues and monitors agreed actions and improvements.

The Department of Health Core Quality Indicators

The core quality indicators that are relevant to Buckinghamshire Healthcare NHS Trust are detailed below. They relate to:

- Summary Hospital level Mortality Indicator (SHMI)
- Patient Reported Outcome Measures (PROMS)
- Readmission rate into hospital within 28 days of discharge
- The Trust’s responsiveness to the personal needs of our patients
- Friends and Family Test for staff
- Percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism
- The C. difficile infection rate per 100, 000 bed days
- The number of patient safety incidents reported and the level of harm

Summary Hospital Level Mortality Indicator (SHMI)

The table below details performance against the Summary Hospital level Mortality Indicator (SHMI):

Prescribed Information	Reporting Period	BHT Score	National Average	Highest Score (Best)	Lowest Score (Worst)
The value of the summary hospital-level mortality indicator (SHMI)for the Trust for the reporting period	2017/18	0.972	1.005	0.727	1.247
	2018/19	0.9924	1.0034	0.888	1.1261
The banding of the SHMI for the Trust for the reporting period <ul style="list-style-type: none"> • Band 1 = Worse than expected • Band 2 = As expected • Band 3 = Better than 	2018/19	Band 2	Band 2	Band 3	Band 1

expected					
The percentage of patients deaths with palliative care coded at either diagnosis or specialty level for the Trust for the reporting period	2017/18	44.6%	31.6%	11.5%	59.8%
	2018/19	47.6%	33.6%	Not given by NHS digital	Not given by NHS digital

Buckinghamshire Healthcare NHS Trust considers that this data is as described for the following reasons:

- SHMI makes no adjustment for palliative care and the Trust has palliative care beds within the acute services that are included in the calculations.

Buckinghamshire Healthcare NHS Trust intends to /has taken the following actions to improve this score, and so the quality of its services, by:

- Continuing to improve sepsis care specifically related to screening and “suspicion to needle times”
- Analysing mortality data in the Mortality Review Group and investigating variations.

The Medical Examiner service enables an independent scrutiny of adult inpatient deaths in partnership with families and carers, and identifies opportunities for learning.

Patient Reported Outcome Measures (PROMS):

Patient Reported Outcome Measures (PROMS) measure health gain in patients undergoing hip replacement, knee replacement, varicose vein and groin hernia surgery in England, based on responses before and after surgery. The table below details performance against the Patient Reported Outcome Measures (PROMS):

Prescribed Information	Reporting Period	BHT Score	National Average	Highest Score (Best)	Lowest Score (Worst)
Groin hernia surgery	2016/17	0.118	0.08	0.14	0.06
	2017/18	0.127	0.089	0.198	0.008

Varicose vein surgery	2016/17	0.073	0.099	0.152	0.016
	2017/18	0.035	0.086	0.361	0.002
Hip replacement surgery	2016/17	0.398	0.44	0.53	0.33
	2017/18	0.441	0.458	0.666	0.179
Knee replacement surgery	2016/17	0.28	0.32	0.39	0.24
	2017/18	0.318	0.337	0.506	0.232

Buckinghamshire Healthcare NHS Trust considers that this data is as described for the following reason:

- The Trust has made regular and timely data submissions to NHS Digital and the figures are consistent with those produced by the Trust's internal data systems.

Buckinghamshire Healthcare NHS Trust intends to /has taken the following actions to improve this score, and so the quality of its services, by:

- In 2018/19 we stopped recording PROMS data for varicose veins as we operate on so few now
- Hips and knees – employed an enhanced nurse practitioner for orthopaedics who has been working hard with the whole team to successfully improve the capture of PROMS data both pre and post operatively.
- A new physio standard has been introduced in that all patients post knee replacements are now reviewed two weeks post discharge in a face to face environment
- PROMS data is reviewed and discussed in arthroplasty team meetings and an action plan is in place to support and track improvements

Readmission rates

The table below details performance against the readmission rate into hospital within 28 days of discharge

Prescribed	Reporting	BHT	National	Best	Worse
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Information	Period	Score	Average	Performer	Performer
The percentage of patients aged 0 to 15 readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period	Oct 16 – Sep 17	10.5%	8.7%	2.5%	14.4%
	Oct 17 – Sep 18	11.2%	9.0%	1.0%	17.9%
The percentage of patients aged 16 or over readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period	Oct 16 – Sep 17	6.5%	8.1%	2.4%	16.1%
	Oct 17 – Sep 18	6.8%	8.4%	2.4%	17.1%

Buckinghamshire Healthcare NHS Trust considers that this data is as described for the following reason:

NHS Digital does not provide data on this for the reporting period, so we have provided the latest data from Dr Foster which runs to October 2018.

The Trust intends to /has taken the following actions to improve this score, and so the quality of its services, by:

- Emergency Department review clinics to ensure safety net for patients who are discharged but may need reviewing or follow up that is not available in the community
- Regular communication through social media to sign post the public to most appropriate providers
- Discharge plans for readmitted patients are reviewed in collaboration with the Red Cross and other support agencies
- As part of the winter plan, long stay patient team from Red Cross worked with patients for up to 12 weeks at home
- Deeper analysis of the 0-15 performance will be undertaken to understand the reasons behind the higher than average readmission rate for children

Responsive to the personal needs of patients

The table below contains the indicator values for NHS Outcomes Framework indicator 4.2 - the average weighted score of 5 questions from the inpatient survey relating to responsiveness to inpatients' personal needs. The most recent data on the indicator for responsiveness to inpatients' personal needs is the NHS outcomes framework indicator 4.2 and was released 23 Aug 2018.

Prescribed Information	Reporting Period	BHT Score	National Average	Highest Score (Best)	Lowest Score (Worst)
The data made available to the NHS Trusts of NHS foundation Trusts by NHS Digital with regard to the Trust's responsiveness to the personal needs of its patients during the reporting period.	2016/17	66.8	69.6	86.2	58.9
	2017/18	68.0	68.1	85.23	60.2
	2018/19	64.3	68.6	85	60.5

We have seen a slight drop in our score this year from 68 to 64.3. This score is based on the results from the following questions in the inpatient survey:

	2016	2017	2018	Average	BHT
Care: was involved as much as wanted in decisions	91%	88%	91%	90%	91%
Care: found staff member to discuss concerns with	75%	75%	74%	73%	74%
Care: enough privacy when discussing condition or treatment	95%	93%	95%	94%	95%
Discharge: told side-effects of medication	57%	48%	54%	57%	54%
Discharge: told who to contact if worried	74%	71%	74%	77%	74%

Our performance in four out of six of the questions is above average. However our performance in the questions related to discharge remains below average. Over the last year we have made good progress in improving a number of aspects of our discharge planning,

however areas for improvement in the coming year will focus on ensuring patients are given enough information on the possible effects of medication, and that they are clear on who to contact if they are worried.

We have continued with implementation of the 2017/2020 Patient Experience Strategy which focuses on four key areas:

- Voice of the Child
- Accident and Emergency
- Discharge planning
- Outpatients

In 2018 the Trust took the following actions to improve patient experience in these areas:

Voice of the child

- Young people have been involved in redesigning the Paediatric Decision Unit (Stoke Mandeville Hospital) including additional waiting area space and the creation of a three bedded bay. Rooms were also re-decorated to improve the overall experience for children
- A listening event dedicated to children with complex needs resulted in a review of 'open door' policy and reducing noise at night
- A project capturing views of oncology children via video resulted in introduction of entertainment systems

Accident and Emergency

- Friends and Family Test 47% recommendation rating to 92%
- IT platform to capture patient experience in A&E, includes recording patients speaking about their experiences, launched December 2018
- We have introduced A&E volunteer buddies to support improvement in non-clinical patient care
- A major refurbishment of A&E and Outpatients to improve patient flow and experience has commenced

Discharge planning

- A dedicated pharmacy technician linked to clinical site team being piloted to ensure planned and potential daily discharges have TTO's (To Take Out) completed.
- Introduction of a discharge facilitator for short stay and acute assessment units.

- Introduction of volunteers calling patients that have been recently discharged to support in patient experience of discharge.

Outpatients

- The introduction of SMS messaging for appointment reminders has led to DNA rates being amongst the lowest in the country
- Electronic GP referral system in place with 98% of GP referrals now coming through electronically resulting in a more safe and effective process for patients
- The introduction of a bulk mail system to support an improvement in how we send information and appointments to patients - 59% of all outpatient letters now sent via bulk mail
- Free magazines have been introduced in to our waiting areas and comprise a variety of topics to suit varying interests

Perfect Ward is now established across 63 areas within the Trust and we are pleased to report that we now have patient assessors trained and conducting environmental and patient audits within inpatient wards. This has enabled a wider patient perspective and a direct influence on the quality of care provided in our wards.

2018 inpatient survey

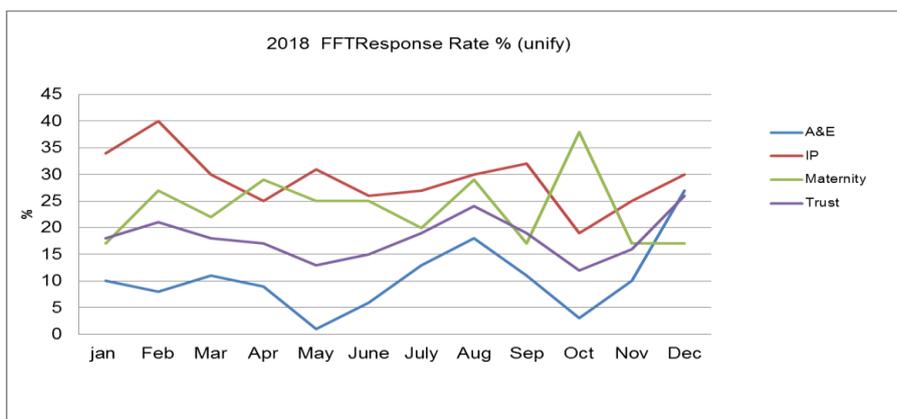
The Trust has significantly improved its performance in the 2018 Picker inpatient survey.

- 12th most improved Trust in England, up from 55th in 2017
- Average positive score ranking 36th out of 77 Trusts commissioned by Picker
- 3 out of 5 of the top scores in survey and 4 out of 5 most improved scores relate to discharge, demonstrating impact of the Trust's focus on improving patient experience in this area
- 99% of patients felt they were treated with dignity and respect, (national average of 98%)
- 86 % rated overall patient experience 7/10 or more (2017 score 84%, national average 85%).

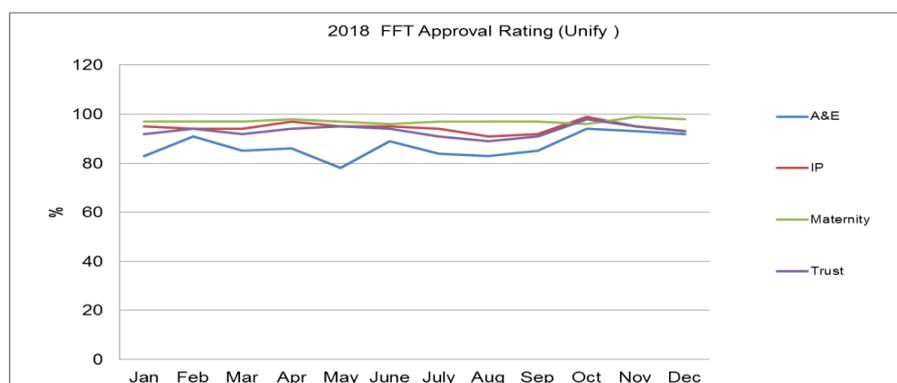
Friends and Family Test (FFT)

In December 2018 the Trust began a pilot of an online FFT platform in accident and emergency, community services and maternity. Early results are very positive for example we saw an increase in response rates from 8% to 27% in accident and emergency.

FFT response rate January-December 2018



FFT approval rating January -December 2018



Friends and Family test for staff

The table below details performance against the Friends and Family Test for staff: Would staff recommend the Trust as a provider of care to their friends and family?

Prescribed Information	Reporting Period	BHT Score	National Average	Highest Score (Best)	Lowest Score (Worst)
The data made available to the National Health Service Trust or NHS foundation Trust by NHS Digital with regard to the percentage of staff employed by, or under contract to, the Trust	2016/17	67%	68%	95%	45%
	2017/18	67%	69%	87%	60%

during the reporting period who would recommend the Trust as a provider of care to their family or friends.	2018/19	70%	70%	90%	49%
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The Buckinghamshire Healthcare NHS Trust considers that this data is as described for the following reason: the figure from the National NHS Staff Surveys 2017 and 2018 is an annual survey which is published by the Department of Health. This annual survey is a poll of NHS Trust staff each year.

Buckinghamshire Healthcare NHS Trust intends to /has taken the following actions to improve this score, and so the quality of its services, by:

- Details of the actions taken are set out in the sections describing the work of the Trust Freedom to Speak Up Guardian and the NHS Staff Survey.

Venous Thromboembolism

The table below details performance against the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism

Prescribed Information	Reporting Period	BHT Score	National Average	Highest Score (Best)	Lowest Score (Worst)
The data made available to the National Health Service Trust or NHS foundation Trust by NHS Digital with regard to the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.	2017/18 Quarter 3	96 %	95%	100%	76%
	2018/19 Quarter 3	95%	96%	100%	55%

Buckinghamshire Healthcare NHS Trust considers that this data is as described for the following reasons:

- The Trust has made regular and timely data submissions to NHS Digital and the figures are consistent with those produced by the Trust internal information systems.

Buckinghamshire Healthcare NHS Trust intends to /has taken the following actions to improve this score, and so the quality of its services, by:

- Ensure compliance with NICE guidance
- Monitor effectiveness of the VTE policy as a priority objective
- Promote patient information and patient engagement re VTE prevention
- Create e-learning package for the Trust
- Standardise the quarterly ward audits and improve the feedback pathways to departments/divisions

Clostridium Difficile infection rate

The table below details performance against the C. difficile infection rate per 100,000 bed days.

Prescribed Information	Reporting Period	BHT Score	National Average	Highest Score (Best)	Lowest Score (Worst)
The data made available to the National Health Service Trust or NHS foundation Trust by NHS Digital with regard to the rate per 100,000 bed days of cases of C.difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period.	2016/17	17.06	13.2	82.7	0
	2017/18	17.47	13.7	91.0	0
	2018/19	18.42	Not Avail*	Not Avail*	Not Avail*

* Data not available at the time the report was written.

Buckinghamshire Healthcare NHS Trust considers that this rate is as described for the following reasons:

The yearly objective for Buckinghamshire Healthcare NHS Trust (BHT) was 31 cases. BHT ended the year with 45 cases. A root cause analysis is undertaken of all cases together with the CCG and the outcome of that work concluded that:

- 28 of the 45 cases were unavoidable
- 17 of the 45 cases were avoidable

Avoidable is defined as follows:

- Lapse/lapses in care identified that has/have directly contributed or there is reasonable correlation with the patient acquiring this episode of C.difficile infection at Buckinghamshire Healthcare NHS Trust.
- For example, if the antibiotics prescribed to the patient in question were not in line with published BHT guidelines and not appropriate for the clinical syndrome/s, then the case will be deemed avoidable.

This analysis demonstrated that there are three main areas to consider:

- The judicious use of antibiotics across the Trust
- A review of cleaning methods and approaches
- Collaborative team working within wards

Buckinghamshire Healthcare NHS Trust intends to /has taken the following actions to improve this score, and so the quality of its services, by:

- Undertaking an extensive piece of work reviewing the use of antibiotics and has achieved a 14.4% reduction in Carbapenem usage (national target of 2% reduction in consumption/1000 admissions) and a 6.7% reduction in total antimicrobial usage (national target 1% reduction in total antimicrobial consumption/1000 admissions).
- Piloting the use of automated decontamination in 2018/19 on the Stoke Mandeville site which resulted in a reduction of C. difficile infections in the following months.
- Embedding the use of the Perfect Ward app which allows staff to jointly audit ward practice, including infection prevention practice.

In the year ahead all three of these areas will continue to be a focus. In addition, the Trust is introducing a Scrutiny Panel review with the Clinical Commissioning Group, Medical Director and Chief Nurse for each new C. difficile infection.

Patient safety incidents

The table below details performance against the number of patient safety incidents reported and the level of harm:

Prescribed Information	Reporting Period	BHT Score	National Average	Highest Rate	Lowest Rate
Rate of patient safety incidents (per 1000 bed days) when benchmarked against medium acute trusts	2017/18	37.63	46.2	111.69	23.47
	2018/19	39.7	44.5	107.4	13.1
Percentage of patient safety incidents resulting in severe harm or death when benchmarked against medium acute trusts	2017/18	0.5%	0.3%	2%	0%
	2018/19	0.2%	0.4%	1.2%	0%

Buckinghamshire Healthcare NHS Trust considers that this number and/or rate is as described for the following reasons:

- The Trust is committed to reducing harm and pro-actively encourages staff to report incidents and near misses and,
- This is evident in the much improved number of incidents uploaded in this time period.

Buckinghamshire Healthcare NHS Trust has taken the following actions to improve this number and/or rate, and so the quality of its services, by:

- Analysing and learning from its mistakes encouraging an open and transparent reporting culture with incident reporting discussed from ward to Board.
- The promotion of near misses as 'good catches' when discussed in meetings and in the Staff Induction Handbook where reporting is aligned to the Trusts' CARE values.
- Promoting feedback from investigations to staff reporting incidents in a timely manner as part of the Quality and Safety Performance Framework and to ensure timely application of duty of candour. Duty of candour fields on the current electronic risk management

system have been revised to enable staff to provide assurance through increased detailed recording on how duty of candour is applied.

- Moving towards a mature patient safety culture which values openness, transparency and quality, the Corporate Patient Safety team continues to facilitate the development of patient safety subject matter expertise amongst the divisional clinical governance leads.
- Scheduling regular meetings with divisional clinical governance leads to build inter divisional relationships for the benefit of joint investigations and shared learning.
- Aspiring to achieve a continual reduction in the proportion of incidents that result in death and severe harm in comparison to the proportion of incidents that are near misses or result in no or minor harm.

Mortality data

During 2018/19, 1,170 of Trust patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

April 2018-March 2019	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Totals
Number of BHT deaths	273	253	302	342	1,170
Number of deaths reviewed by Medical Examiner	273	253	302	342	1170
Deaths subject to case note review (Structured Judgement Review SJR)	41	33	34	41	149
Serious incident investigations	1	2	4	3	10
Deaths more likely than not to have been due to problems in care	0	0	0	0	0
Overall percentage of deaths more likely than not to have	0%	0%	0%	0%	0%

been due to problems in care					
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2017/18

Number of deaths in April 2017-March 2018 reviewed/or investigated after previous reporting period	For those still awaiting review number due to problems more than likely than not to have been due to problems in care	Overall percentage of deaths due to problems more than likely than not to have been due to problems in care
18 ME Reviews 34 SJRs	0	0%

Learning from deaths: improving patient safety and quality of care

Buckinghamshire Healthcare NHS Trust introduced the role of Medical Examiner (ME) in December 2017. The ME service has provided an opportunity to develop a system that provides independent scrutiny of adult inpatient deaths in partnership with families and carers, and identifies opportunities for learning.

The Trust revised mortality review process has a standardised and evidence based Structured Judgement Review (SJR) process for reviewing case records of adult patients. The primary aim is to improve healthcare quality through qualitative and quantitative analysis of mortality data using a standardised, validated approach linked to quality improvement.

End of year results

- A total of 1,170 deaths underwent independent consultant review
- Annual mean selection for structured judgement review (SJR) 12% in line with national expectations
- 88% of cases were identified as having no care problems
- SJR compliance increased to 89%
- A total of 535 compliments, culminating in 34% of excellence reporting

BHT mortality review process

Following the introduction of a Medical Examiner Service, independent screening of all in hospital adult deaths has shown consistent compliance at 100% in comparison to a compliance of 81% in previous years. The ME selects cases for SJR where further learning has been identified, serious incidents (SI) are declared in accordance with the NHS England SI Framework 2015. All SIs are presented to a multi-disciplinary panel with executive and Clinical Commissioning Group (CCG) oversight.

Learning from deaths - SJR findings

SJR findings show no statistical significance in the number of deaths on any given day of the week or day of admission. Learning related to the first 24 hours of admission identified the need to focus on improvements in timely sepsis recognition. This has led to an increase in Q4 Suspicion to Needle Time (STNT) to 81%, and Emergency Department (ED) sepsis screening increased to 87%.

End of life care is evaluated focusing on timely decision making, good communication with relatives and ensuring symptomatic control. The palliative care team have also introduced the purple rose initiative promoting personalised care plans at the end of life.

Patients with a learning disability

The Learning Disabilities Mortality Review (LeDeR) programme is a national programme aimed at making improvements to the lives of people with learning disabilities (LD). All LD deaths undergo national LeDeR reporting with access to the SJR Datix platform. Patients with a learning disability have a reduced life expectancy - this is evidenced in SJR review and nationally recognised. Liaison with primary care has led to the creation of an admission and discharge pathway for LD patients - this was following learning at LeDeR review. Ongoing focus on the care of learning disability patients includes best practice guidance, health passports, communication aids, focused training and education and specialist input from Learning Disability (LD) nurses to guide treatment.

Cardiac arrest reviews

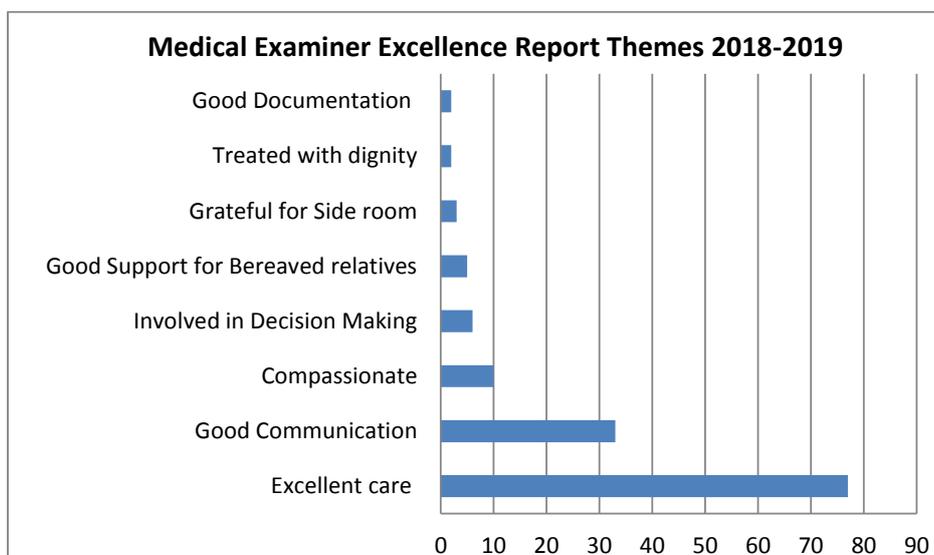
Following multi-disciplinary SJR review it was evidenced that initiation of DNACPR and Treatment Escalation Plans (TEPs) required improvement across the Trust. Training has been provided to consultant groups. A TEP working party has been established with a view to universal adoption of TEP for all adult inpatients within 48 hours of admission.

Relatives Feedback

Feedback from bereaved relatives has been overwhelmingly positive. Compliments received are relayed to ward teams in the form of rapid feedback.

- Over 30% of all compliments were endorsed by the Medical Examiner as cases of excellence
- Theme analysis of excellence reporting includes excellent care, good communication, compassion and involvement in decision making - these themes are disseminated to the divisions for departmental reporting

Relatives’ narratives and patient stories relay a very powerful message and have been used in training and education to support change. Relatives also provide positive feedback on the benefits of discussion with the medical examiner as per the example below.

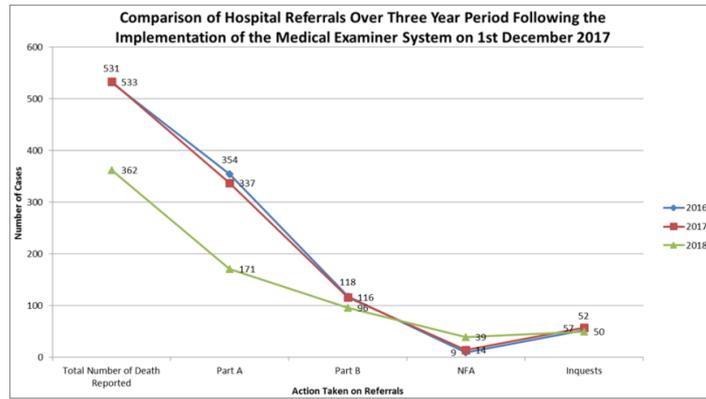


In accordance with national guidance SJR feedback to relatives is via an established pathway and endorsed within BHT mortality review policy.

Improvements and actions

Local partnerships

- Local agreement with the coroner has led to a reduction of 32% in coroner referrals since the launch of the medical examiner service



As an integrated care system, we have worked closely with the local authority, coroner’s office and registrar. Quarterly meetings ensure learning is disseminated beyond BHT and with our regional partners.

Primary care feedback

Over 100 cases of care home admissions have been audited. This data has been presented nationally. Themes relate to end of life care better placed in the community, the importance of frailty assessment and treatment escalation planning in the community. Further presentations are scheduled to promote the role of medical examiner (ME) amongst General Practitioners with the next implementation phase of National ME to the community.



Pictured above: the mortality review team

Information governance

The Trust recognises the importance of managing information and personal information in particular, appropriately and securely. The Senior Information Risk Owner (SIRO) is responsible for ensuring the Board has comprehensive and reliable assurance that appropriate controls are in place and that risks are managed in relation to all information used for operational and financial purposes.

The Data Security Protection Toolkit sets out the National Data Guardian's (NDG) data security standards and demonstrates an organisation is working towards or meeting the NDG standards. The purpose of the assessment is to enable organisations to measure their compliance against the law and central guidance and to see whether information is handled correctly and protected from unauthorised access, loss, damage and destruction. During 2018/19, internal auditors RSM undertook a sample review of the Trust's completed DSP Toolkit assertions to test for completeness and validity of evidence associated with the 10 Data Security Standards.

The Caldicott and Information Governance Committee monitor the performance of the Trust against the requirements of the Data Security and Protection Toolkit. The Trust has self-assessed its performance on information governance requirements using the standards stipulated in NHS Data Security and Protection (DSP) Toolkit. The Trust has satisfactorily met all the mandatory standards for 2018/19 submission. Final end of year submission was at the end of March 2019.

During 2018/2019 there were five reportable data breaches. These breaches were reported to the Information Commissioner which were reviewed, assessed and none were upheld and no further action taken as they felt that appropriate and timely remedial actions were promptly taken by the Trust, which helped to contain the situation and no serious harm or adverse effects ensued.

Implementing the Priority Clinical Standards for Seven Day Hospital Services

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.

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.

The four priority clinical standards are:

- 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

Results from the self-assessment submitted in 2018:

Clinical Standard	Seven day hospital self-assessment – four priority standards	Overall
2	90% of 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 from the time of admission to hospital	97% Standard met
5	Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week: <ul style="list-style-type: none"> • Within 1 hour for critical patients • Within 12 hours for urgent patients 	Standard met
6	Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on site or through formally agreed networked arrangements with clear written protocols. These interventions would typically be: <ul style="list-style-type: none"> • Critical care • Interventional radiology • Interventional endoscopy • Emergency general surgery • Emergency renal replacement therapy 	Standard met
8	All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate).	97%

	Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.	
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Freedom to Speak Up

Results from the National Staff Survey for 2018 have shown improvements termed as “significant” in the following two areas. Increases in results for a single year are more usually expected to be in line with 1% so we are pleased to be able to headline these very positive results.

- Results demonstrate a **4% increase** in staff saying they would feel secure in raising concerns about unsafe clinical practice. This also brings us inline to meet the national score for our relevant similar Trusts of 70% (sector score).
- Furthermore, we have also seen another **4 % increase** in staff saying they are confident that the organisation would address their concern. This brings us to just 1% below the national sector score of 58%.
- These are also important results, making a contribution to our overall safety culture score which also improved from 6.5 last year to 6.7 in the most recent results.

These results help us demonstrate positive progress on the journey to building a positive speaking up culture at BHT. Our ‘Freedom to Speak Up Guardian’ (FTSUG) has now been in post for two years and has seen year on year growth in numbers of staff accessing the service to raise concerns, with numbers of cases last year at 46 now exceeding 70.

Governance arrangements include a Trust policy and procedure and the FTSUG reports regularly through a number of committees including a delegated sub-committee of the Board and to Trust Board directly.

Learning and changes as a result of concerns is shared through a variety of routes which includes reports, committees, Trust Board, presentations and our trustwide lessons learnt programme, in which our FTSUG participates annually. Our “Building a Climate of Respect”

campaign is just one example of action taken to address concerns raised by staff. We launched a video trustwide with clear messaging led by our Chief Executive Officer (CEO) and others, to support all staff in promoting a zero tolerance to poor behaviours, bullying or harassment. We have also developed an extensive online resource guide. These have both been well received and feedback has suggested they have added value in helping staff to feel better able to speak up about behaviour. This has been shared across the regional network of FTSUGS and with the National Guardian Office.

There are multiple ways staff at BHT can raise concerns across the Trust in addition to the FTSUG. Staff can and should use their usual line management reporting routes but we also have a lead executive for speaking up and a designated Non-Executive Director (NED). In addition, there are a variety of systems and processes such as incident reporting and exit interviews that enable staff to raise a concern with a large range of staff in roles such as clinical leads, tutors, safeguarding teams, our director for Medical Education and the Guardian for Safe Working Hours. Executives and other Non-Executives (NEDs) led by our Chair and CEO continue to proactively encourage staff to build a positive speaking up culture across the organisation and are always willing to listen to staff concerns.

PART THREE

Further aspects on quality improvement

Infection control and prevention

GNBSI – Gram Negative Bacteria Site Infection

NHS Improvement ambitions (system wide targets), based on 2017-2018 figures are:

- 25% reduction by 2021
- 50% reduction by 2024

BHT therefore adopted this ‘ambition’ target to be applied internally within the Trust with respect to BHT acquired BSIs

- BHT internal ambition was 10% reduction for 2018-2019 based on 2017-2018 figures

For 2018-2019, based on 2017-2018, the % reductions are:

- E. coli = 6.7%
- Klebsiella = 11.8%
- Pseudomonas = 25%
- **TOTAL = 11.5%**

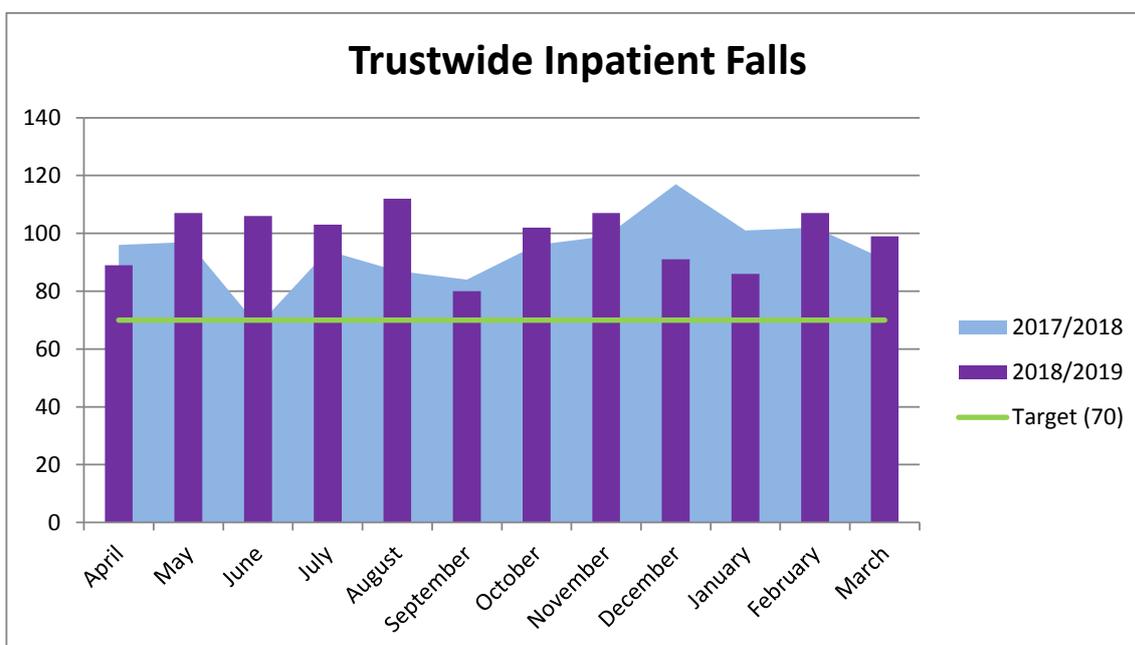
	2017 - 2018	2018 - 2019	TOTAL
E. coli (Total Reported)	45 (231)	42 (252)	87 (483)
Klebsiella (Total Reported)	17 (56)	15 (55)	32 (111)
Pseudomonas (Total Reported)	16 (27)	12 (24)	28 (51)
TOTAL (Total Reported)	78 (314)	69 (331)	147 (645)

Inpatient falls

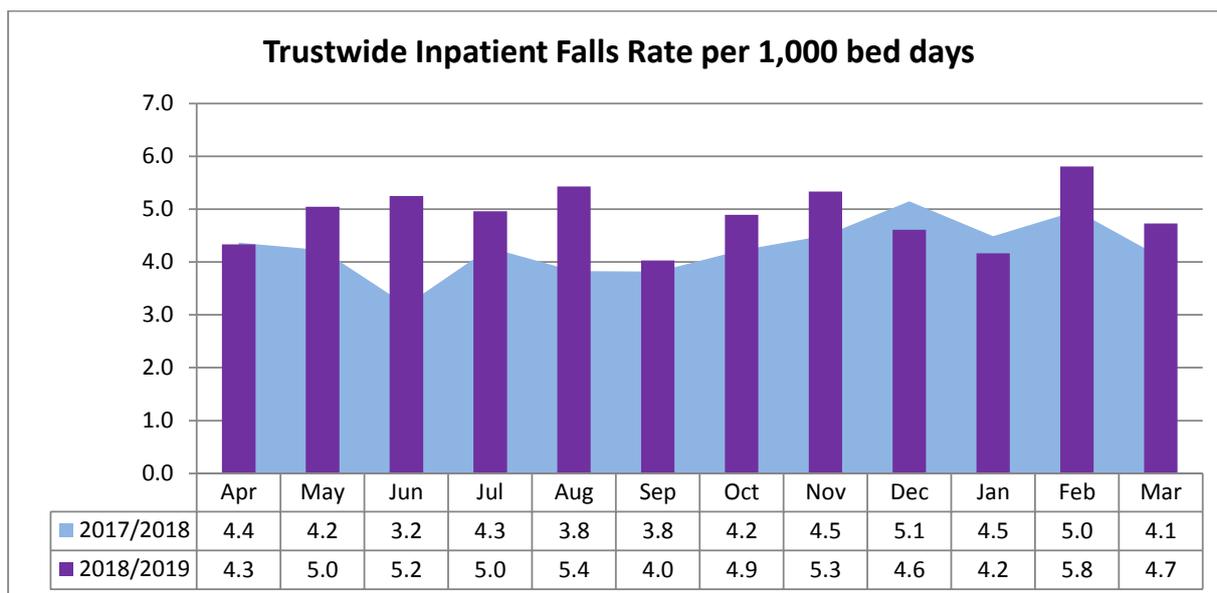
There is a continued strong focus on the reduction on inpatient Falls for the Trust, and a target of no more than 70 falls per month has been set.

Interventions include:

- Focus on ‘stay in the bay’ or ‘stay with me’ to ensure we maximise observation of patients at risk
- Implementation of the Fallsafe bundle
- Completion of risk assessment and appropriate care planning
- Appropriate equipment
- ‘Specialing’ of patients at high risk



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2017/2018	96	97	68	94	87	84	96	99	117	101	102	91	1132
2017/18 Moderate or above harm	0	3	1	1	1	0	2	0	1	1	1	4	15
2018/2019	89	107	106	103	112	80	102	107	91	86	107	99	1189
2018/19 Moderate or above harm	0	1	0	2	1	1	1	1	3	2	3	0	15



Falls with harm

	2017/18	2018/19
Total	1132	1189
No harm	651	709
Low Harm	466	465
Moderate Harm	14	13
Severe Harm	1	1
Death	0	1

In 2018/2019 we have had 13 falls with moderate harm, 1 fall with severe harm and 1 harm which resulted in death.

Pressure ulcers

There continues to be a strong focus on the reduction of Trust acquired pressure ulcers especially due to the rise seen in 2017-18.

During 2018-2019 the target was to reduce category 3 and 4 pressure ulcers by 100% and category 2 by 25% - 30 new recommendations across NHS Trusts for standardisation of reporting.

Total category 3 & 4 pressure ulcers

- 2016-2017 = 5 deemed avoidable
- 2017-2018 = 14 deemed avoidable
- 2018-19 = 9 deemed avoidable

Trust acquired category 2 pressure ulcers

- 2016-2017 = 281
- 2017-2018 = 275
- 2018-2019 = 220

Interventions include:

- New NHSI guidance wanting all pressure ulcers investigated – numbers will rise across Trusts
- Last year 257 patients admitted with category 3 / 4 /deep tissue damage - present on admission to BHT
- 126 of the patients admitted with category 3 or 4 deep tissue damage were admitted for surgery or following a long lie or from external Trust locations – this accounts for 50%
- Levels of harm have to be accurate and not linked to a pressure ulcer category – BHT to revise April 2019
- 2019-20 more emphasis on actions required from all divisions
- New posters for moisture associated skin damage compiled to comply with NHSI guidance
- 342 face to face training sessions on pressure ulcers across BHT – provided by Tissue Viability Nurses and link nurses
- To carry out joint investigations going forward with residential homes and care agencies

Current BHT position for category 3, 4 & deep tissue injury – total numbers:

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2016/2017	3	2	3	4	0	2	2	2	0	1	1	4	24
2017/2018	1	1	5	1	4	4	3	3	6	5	2	5	40
2018/2019	4	1	1	1	2	0	3	2	2	2	5	5	28
2018/19 Deemed avoidable	1	0	1	0	0	0	2	0	1	1	2	1	9
% reduction	0	0	0	0	0	0	0	0	0	0	0	0	↓30%

Current BHT position for category 2

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2016/2017	32	31	20	29	18	15	22	17	28	29	20	20	281
2017/2018	16	31	20	24	20	23	28	16	22	28	20	27	275
2018/2019	29	21	16	19	19	18	11	16	27	13	18	13	220
% reduction	17	17	17	17	17	17	17	17	17	17	17	17	↓20%

Medical device related pressure ulcers (new audit) – also included in above figures

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2018/2019	3	1	1	3	1	0	1	3	5	0	0	0	18

Moisture- associated skin damage (new audit) (MASD)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2018/2019	x	x	x	x	x	x	x	x	x	x	x	x	x

Actions for improvement

- Care rounds discussed in daily safety round with consultant and senior nurse
- New dressings being looked at that are see-through so wound can still be observed
- Tissue Viability community post re-advertised for divisional Tissue Viability Nurse

- All areas now using pressure ulcer care plan
- Mattress selection pathway
- Hybrid mattress trial just completed on St George's ward (NSIC)

Duty of candour

The Trust is committed to high quality healthcare and to observe the requirement to be open, transparent and candid when things go wrong. The duty of candour requires that where a safety incident results in moderate or severe harm, or death, that the Trust disclose this to the patient and/or their family and any other 'relevant person', within 10 working days with an expression of regret, and an explanation of next steps.

NHS organisations have a duty to provide patients and their families with information and support when a reportable incident of this grade has, or may have occurred and provide updates at agreed points until the incident has been fully investigated with actions to support improvements.

Duty of Candour training is now a statutory e-learning module for all staff and uptake of training is monitored and addressed through the education and learning team.

The Trust has a current policy regarding being open and duty of candour and has standardised written information for patients where the duty of candour applies, which includes an outline of what the patient or family should expect. This may be adapted according to a specific incident but includes details of the investigation process and provides contact details of a senior member of staff who will keep the patient/relative informed of progress and who can be contacted with any questions.

The application of duty of candour is always approached with sensitivity with staff mindful that for some patients or families we will need to rebuild their trust in our ability to care for them or their loved one. We do this by asking the patient or family what questions they would like us to answer when investigating an incident which should then, when answered, demonstrate that we are willing to listen and learn where we need to improve.

Safeguarding

Safeguarding adults

The safeguarding adult team is developing closer working links with the hospital social work team, especially in respect of collaborative working to carry out Section 42 enquiries. These are enquiries related to any action that is taken (or instigated) by a local authority (under Section 42 of the Care Act 2014), in response to indications of abuse or neglect in relation to an adult with care and support needs who is at risk and is unable to protect themselves because of those needs.

More robust processes are now being developed with Trust clinical governance leads to ensure that the recommendations and actions from section 42 enquiries are captured and monitored at local level.

For the coming year the safeguarding adult leads plan to build on the developing relationships with hospital social workers to enable earlier help and support for staff around effective discharge and the implementation of Mental Capacity Act (MCA) and Deprivation of Liberty (DoLS) in day-to-day practice. Continuous audit of MCA and DoLS practice will be used to demonstrate improvement or key areas of concern.

The safeguarding adult team works in close partnership with local authority counterparts and will be co-operating in the anticipated forthcoming changes to Buckinghamshire Safeguarding Adults Board (BSAB) and sub-groups. The principles of making safeguarding personal is a key area of focus for BSAB and BHT will be assertively promoting these throughout the coming year.

Safeguarding children

The safeguarding children team continues to work effectively within the local partnership arrangements and is supporting anticipated changes in respect of the multi-agency safeguarding hub (MASH) and exploitation sub group.

Local arrangements in relation to the exploitation of children are currently being enhanced in order to recognise those areas of exploitation other than sexual. It is well recognised that the exploitation of young people can happen in varied ways. Many young people are subject to modern-day slavery as well as gang and drug related exploitation (county lines), which very often extends into their lives as young adults. This is now being acknowledged in

Buckinghamshire and changes in ways of working are now underway; BHT is a key partner in these changes.

The transition of young people into adult services is becoming an area of greater focus within local children's services and this issue is also being recognised in the NHS long term plan. Changes in national and local safeguarding priorities for children will require closer cooperation between children and adult services. The safeguarding structures and arrangement within BHT and the ways of working within the safeguarding team already identify the interface between child and adult services. This will be a key area of focus and improvement for the coming year.

Learning disability liaison

The work of the Learning disability (LD) liaison nurses continues to expand as the number of patients referred to them by Trust staff increase. This is a positive development and indicates growing awareness by BHT staff of the specific needs of people with learning disabilities and the support available.

Future plans for improving staff awareness for specific groups of people with LD will include focused training and support for staff, especially those working in the Emergency Department (ED) in respect of the effective management and support of people with Autistic Spectrum Disorders (ASD). Discussions will be taking place about the prospect of providing means of identifying people with ASD (or indeed with any other communication needs) in ED so as to ensure that their specific needs can be better met. This approach is in line with the principles of making safeguarding personal.

Mental health

BHT safeguarding team works effectively in partnership with colleagues in Oxford Health Foundation Trust (OHFT) including safeguarding equivalents and the BHT Psychiatric In-Reach Liaison Service (PIRLS). BHT also attends the monthly Partnership in Practice (PiP) meetings at the Whiteleaf Centre in Aylesbury and participates in the Crisis Care Concordat.

This is a growing area of development within BHT and the recognition of the parity of esteem for mental health needs alongside those for physical health is being promoted. Whilst it is recognised that more needs to be done in this area of care the achievements of the past year include:

- The development of a Mental Health Act Administration Policy and associated training.

- The establishment of a Mental Health Group which meets quarterly and is attended by Trust staff from all specialities including midwifery, elderly care, children and adult community services as well as colleagues from OHFT.
- Working with colleagues from Public Health to promote suicide prevention awareness which includes sending a member of BHT staff on a City and Guilds training programme.

Training

Safeguarding training is a large part of our strategy (compliance data is below). We have also been working on a comprehensive training needs analysis which is consistent with the requirements of both children's and adult's intercollegiate documents.

The table below sets out the training compliance data for the year ending 31 March 2019 as compared to the same time period in the previous year. Whilst there has been steady improvement in most training types, level 3 Safeguarding children training compliance is becoming an area of concern. Up until March 2019 training compliance at level 3 had been sustained at 90% and above, although gradual decline had been noted at recent meetings of the Trust Safeguarding Committee. This deficit will be addressed by alerting divisional leads and ensuring that additional training events are made available to the relevant staff groups.

We are investigating the drop in Deprivation of Liberty (DoL) training levels and following up into the new financial year to ensure that compliance levels are met.

Safeguarding training compliance BHT			
Training type	Target	31.03.2018	31.03.2019
Child protection level 1	95%	88.23%	91.02 %
Child protection level 2	95%	79.47%	88.38%
Child protection level 3	95%	94.05%	89.88%
Safeguarding Adult Awareness	95%	86.26%	89.83%
MCA	95%	88%	97%
DoLS	95%	90.49%	88.89%
WRAP (Prevent)	95%	97.13	96.86%

As the Care Quality Commission indicates in their position statement on safeguarding training, whilst the level of training is a good indication as to how well the provider responds to safeguarding concerns, it is not the sentinel indicator of good child safeguarding arrangements in an organisation. The organisation needs to demonstrate that they have a 'comprehensive safeguarding system' underpinned by policies, effective risk assessments, and high profile leadership as well as quality assured training and that they know that these are consistently in place. BHT is confident that its safeguarding arrangements and the current structures allow for continuous scrutiny, learning and improvement.

Audit

The BHT safeguarding team has developed a safeguarding audit schedule for the coming year. Progress will be reported to and monitored by the Trust Safeguarding Committee.

Looked after children

The Looked after Children (LAC) team are working in partnership with the Local Authority to improve the timeliness of health assessments in line with statutory guidance. The LAC team sought support from the Trust service improvement team to develop process maps to demonstrate the intricacies involved when arranging the health assessment for a looked after child. This work will identify areas for improvement.

Alongside the process mapping, standard operating procedures have been developed in conjunction with social care and are awaiting final sign off before implementation.

The LAC team are now using RiO (electronic patient record system) to produce reports on the progress of an individual child's LAC health assessments. The reports demonstrate on a month to month basis the number of health assessments that are due and those that have been completed.

All children aged 16-17 leaving care are entitled to receive a summary of their health records so young people leaving care have access to their health information. BHT and Children's Services agreed to distribute health summaries to the 131 children who left care during 2016 and 2017. BHT and Social Care worked together to write to all young people to advise them of their entitlement to a health summary; and to gain their informed consent for the health information to be produced and issued. A follow up letter was sent to those young people

who did not respond. Health summaries have now been provided to all the young people that replied.

All letters sent included the contact details for the LAC Health Team and indicated that the young person could get in touch with the team at any point in the future, either to request a health summary or to discuss other health matters. As young people approach turning 18 in 2019-2020 they are routinely provided with a leaving care health summary, this matter is now business as usual.

The LAC team continue to deliver training and updates to BHT colleagues across the Trust to ensure competence in line with the Intercollegiate Framework (RCN, RCPCH 2015).

Bespoke training to Specialist Community Public Health Nurses (SCPHN's) and SCPHN students has also been delivered to aid the quality and timeliness of health assessments that are completed by BHT personnel. A new mechanism for reminders and escalation to individuals and their managers is being implemented to further aid this work.

The LAC team have developed an audit plan 2019-2020. The first audit will review the content and quality of leaving care summaries; a dip sample will be reviewed. A further audit of the LAC caseload will be undertaken to ensure LAC are appropriately referred onto the RiO caseload and an alert has been added to their health record. This will review standard operating procedures and ensure governance and quality measures are being appropriately followed.

Domestic abuse

Domestic violence and abuse is identified as a major public health issue, impacting on survivors and their children and families' physical and emotional health and well-being and may also include homelessness, loss of income/work, isolation, poverty and financial hardship (NICE 2015). Early intervention can reduce the many consequences of domestic violence and abuse (Violence against Women and Girls 2016-2020 Department of Health).

Aligned with the requirement for all NHS Trusts, BHT has a Domestic Violence and Abuse policy (awaiting final sign off at the time of writing this document) in line with the principles of The National Public Health Outcomes Framework for England (2013-2016) and NICE Quality Standard Domestic Violence and Abuse (QS116) 2016.

The safeguarding children and adults teams offer support and advice on domestic abuse issues across BHT both within the community and hospital setting, this includes any staff

member. This guidance includes whether referrals are necessary to the local authority (First Response or Adult social care). The safeguarding teams assist staff with completion of the DASH forms (Domestic Abuse Stalking Honour based violence forms).

The children's safeguarding team works in collaboration with partner agencies, including the Police and children and adult social care teams attending Multi Agency Referral Assessment Conferences (MARACs). These are regular local meetings where information about high risk domestic abuse victims (those at risk of being killed or seriously harmed) is shared between local agencies. By bringing all agencies together at a MARAC, a risk focused, co-ordinated safety plan is formulated to support the survivor. The children's team research all cases listed for the MARAC meetings which take place weekly. Information to raise awareness of those discussed at this meeting is disseminated to the relevant GP practice. In addition the safeguarding teams support and train staff in areas of high demand such as the emergency department, maternity and health visiting teams to raise awareness of any changes to policy and signposting across the Trust.

Identified staff groups such as midwives, health visitors, mental health and sexual health practitioners are required to complete routine enquiries. This creates an opportunity to ask all women who access these services about their experiences, if any, of domestic violence or abuse, regardless of whether there are indicators of abuse or violence is suspected. All safeguarding teams are aware that men as well as women can be a victim of domestic abuse. A member from the safeguarding adult and children teams attends the quarterly Domestic Abuse strategy group and provides feedback to staff across BHT.

Stalking is a criminal offence and should always be taken seriously. BHT takes extremely seriously the health, safety and welfare of all its employees, volunteers, students, patients and visitors. It believes that violence and/or aggression including stalking of staff and others is unacceptable. Members of staff have the right to be able to perform their duties without fear of being stalked by other staff, patients/clients or members of the public. No member of staff should consider violence or aggression including stalking to be an acceptable part of their employment. While differences of attitude or culture and the interpretation of social signs may mean that what is perceived as stalking by one person may not seem so to another, the defining feature of stalking is that the behaviour is a repeated, unwanted intrusion and causes the recipient to be fearful for themselves or those close to them. As with bullying and harassment the motivation for this unwanted behaviour is not a mitigating factor. Stalking

may involve individual acts which themselves might not cause alarm but have a cumulative effect. Any such behaviour will be reported to the police.

Trust employees will attend domestic violence and abuse training at a level identified appropriate to their role and responsibilities (Buckinghamshire Healthcare NHS Trust Strategy 2018 and NICE 2015, Nice Quality Standard 2016), such as DASH training and the opportunity to undertake a DVA Champions Role if appropriate. Further clarification of the training level appropriate to role can be accessed via the learning and development team and the safeguarding team.

The safeguarding teams deliver in conjunction with external partners such as Women's Aid Level 2/3 domestic abuse training.

Learning from never events

Never events are few in number, rarely attributable to one practitioner, and often found to involve a set of circumstances for which each individual aspect, perhaps inconsequential on its own, collectively creates an environment in which a 'never event' can occur. Serious incident investigation reports and action plans are always undertaken for all never events and important features include a robust investigation, rigorous analysis and an action plan with sustainable recommendations.

NHS England provides technical guidance on the specific criteria for inclusions and exclusions of what constitutes a never event. They are '...a subset of serious incidents.' *NHS England Revised Never Events Policy and Framework 2015 – definition extract from p.7 &8.* The Never Events List was updated in February 2018 with the list and supporting documentation accessible on the NHS England website.

During 2018/19 none of the reported never events were repeats of the circumstances of the never events reported in 2017/18, which suggests that the learning from 2017/18 was robust.

For 2018/19 Buckinghamshire Healthcare NHS Trust reported 5 never events. The date, number and categories of never events were:

- Quarter 1 – April 2018 (3 Never Events)
- Quarter 2 – August 2018 (1 Never Event)
- Quarter 3 – October 2018 (1 Never Event)

- Quarter 4 - Zero (0 Never Event)

The declared Never Events are summarised below:

- Retained urology guidewire piece - poor integrity of the wire casing, with no long term physical harm to the patient.
- Retained fragment following removal of single lumen tunnelled line, with no long term physical harm to the patient.
- A wrong tooth extracted as part of an intervention where multiple teeth were being extracted, and anatomical presentation was atypical.
- Unintentional connection of a patient requiring oxygen to an air flowmeter, no harm came to the patient. This was regarded as a near miss.
- Retained vaginal swab, following labour, with no long term physical harm to the patient.

In all cases duty of candour met contractual requirements. Each incident has been separately investigated and actions taken to minimise the risk of recurrence; key messages for learning from never events which occurred in the Trust in 2018/19 included:

An appreciation of how our staff can influence clinical human factors to prevent incidents through:

Situational awareness: gathering enough information; querying anomalies; checking 'mental pictures' with others; recognising increased risks.

Decision-making: checking when we are uncertain before proceeding with a task; removing a heavy reliance on assumptions whilst recognising that some assumptions assist with smooth running of tasks.

Teamwork: ensuring a sufficient exchange of information for a shared understanding of what needs to be done.

These are linked to our responsibilities within the Trust recognising the importance of:

- Actions which address Patient Safety Alerts to prevent significant incidents
- Vigilance in both familiar and infrequent procedures
- Avoiding an over reliance on assumptions
- Checking and questioning to offer constructive challenge
- Checking equipment at relevant points in a procedure
- Good documentation as a fundamental part of high quality care

- Learning what did not go well, but also from exemplars, by modelling, seeing and reporting excellence.

Additionally, learning from never events in 2018/19 was shared through a range of forums such as newsletters, through team safety boards, Trust wide communications and through the Serious Incident Learning Group with topics on Learning from Never Events (August 2018) and Exploring the Principles of Effective Handover. (December 2018).

A trustwide presentation on never events themes was delivered by the Chief Nurse and Head of Patient Safety and Litigation (February 2019). This presentation also explored the recommendations in the national report on Never Events by the Care Quality Commission and NHS Improvement (*'Opening the Door to Change'*, December 2018).

The Trust has been asked to support scoping work which the National Healthcare Safety Investigation Branch (HSIB) are undertaking with regard to 'retained vaginal swab incidents following labour' as these are a relatively common occurrence nationally; for this reason all Trusts where this type of never event has occurred are being asked to share their learning and engage with the HSIB investigators, and the Trust welcomes this collaboration.

Complaints

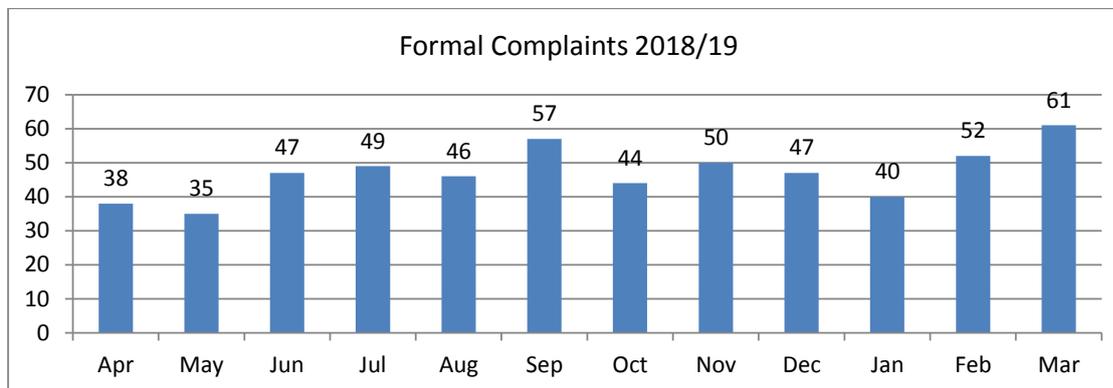
We know that a high quality complaints handling service is central to ensuring continuous improvement in the quality and safety of care at Buckinghamshire Healthcare NHS Trust.

The Trust invites patients, carers and visitors to contact our PALS (Patient Advice & Liaison Service) for support and advice regarding all services. This approach enables the PALS and complaints team to work together to appropriately manage enquiries and concerns that are raised by our service users. In 2018/19 we recorded 4663 PALS contacts from enquirers seeking advice and information about our services. This was an increase of 27% on last year.

Our complaints ethos is built on the Ombudsman's "Principles for Remedy" that state that complaints resolution should be based on:

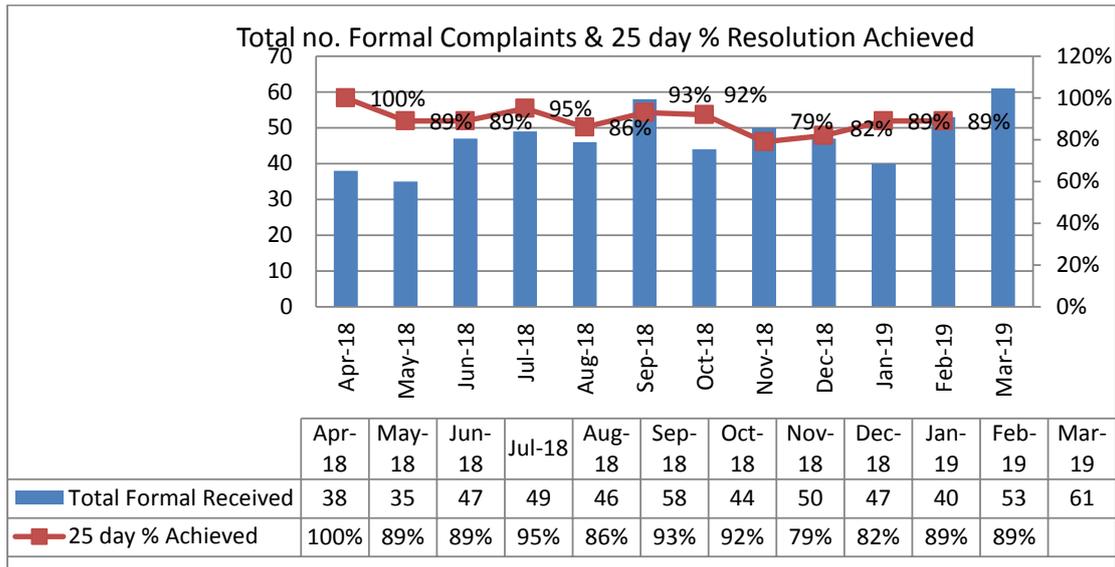
- Getting it right first the first time
- Being customer focused
- Being open and accountable
- Acting fairly and proportionately
- Putting things right
- Seeking continuous improvement

In 2018/19 Buckinghamshire Healthcare Trust received 565 formal complaints compared to 535 formal complaints received in 2017/18. This represents a 6% increase in complaints received when compared to the previous year.

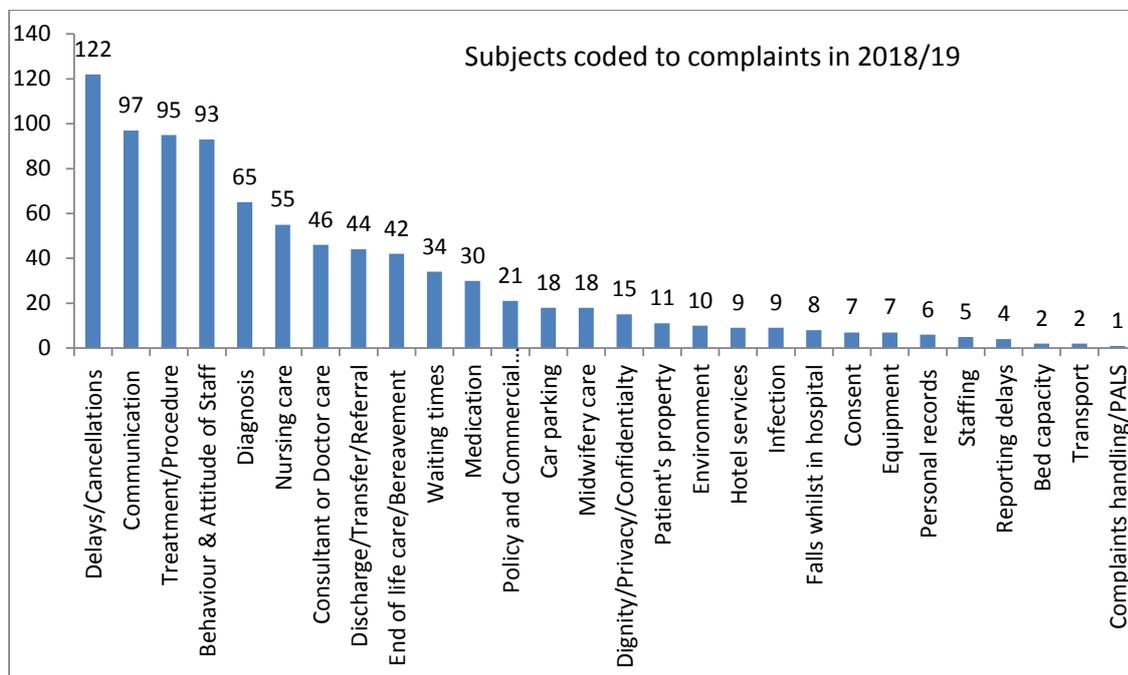


The Trust encourages feedback from a number of sources including our local partners, colleagues and patients which may include complaints. Complaints provide valuable feedback for the Trust about the quality of our services and the opportunity to learn from patients’ experiences and drive real change in our service provision.

The following graph shows the number of formal complaints received each month throughout the reporting period. The Trust has set an internal target of 85% of all category 4 complaints to be responded to within 25 working days. Category 4 complaints are those that cannot be immediately resolved through the PALS service, do not cross multiple services or other healthcare providers, or require a more complex investigation. The graph below shows our performance during 2018/19. We achieved an average of 89% of complaints responded to within the 25 day time frame at the time of the report date.



The graph below illustrates the reasons that people raised formal complaints against the Trust in 2018/19. Delays and cancellations, communication and treatment/procedure were the main causes for complaints in 2018/19:



In 2018/19 there were 12 complaints referred to the Parliamentary and Health Service Ombudsman (PHSO). Of the 12 cases referred, 4 were not upheld, 1 was partly or fully upheld and 7 are currently being investigated.

In April 2018, we introduced a newly designed quality survey for complaint handling based on the ‘User-led Vision for Raising Concerns and Complaints’ published by the PHSO in November 2014. The report ‘My Expectations for Raising Concerns and Complaints’ presented ‘I statements’, as expressions of what patients and service users might say if their experience was a good one at every stage of the complaints process. The results indicated that we have delivered an accessible service and responded in a way that was easy to understand. The area for improvement centred on timeframes and complainant updates. It is important to note that all complainants who used the service agreed that they would complain again if they needed to.

Q1. I felt that it was easy to make a complaint.	Q2. I felt that my complaint was dealt with within the timeframe agreed in my acknowledgment letter and I was kept informed of any delays.	Q3. I thought that the response was easy to understand.	Q4. I felt my concerns were addressed in an open and honest way.	Q5. I felt my concerns were taken seriously.	Q6. I would complain again if I felt I needed to	Q7. Overall rating
87%	73%	77%	67%	70%	100%	6.6

Learning from complaints

A key component of every complaint investigation is the learning identified to inform improvement. Each complaint has an action plan that is recorded and monitored by the individual clinical divisions.

In 2018/19 YTD, we have documented 582 actions in relation to complaints closed.

Action taken in 2018/19	Coded
Feedback for specific staff member/s OR teams	196
Complaint shared anonymously with wider staff	73
Process change to be reviewed/plan set or complete	56
Appointment expedited, made or offer of appointment	41
Staff training or Academic Half Day	37
Agenda item for Governance/Quality Meeting/Team Meeting	34
Feedback or liaison with another Trust/provider/GP	23
Documentation changed or introduced	22
Audit requested/to be carried out	16
Policy change or Guidelines reviewed - planned or complete	13
Increase in clinics or service provision	12
Inter-departmental working/MDT planned	12
Equipment/software changed or purchased	11

Reimbursement or ex-gratia payment	10
Signage changed or environment upgraded	10
Team communication sent in writing	8
Invitation for Public and Patient Involvement	5
Care plan change	2
Case Study or Patient Story provided by patient for learning	1
Totals:	582

NHS Staff Survey

The 16th NHS national annual staff survey was conducted between October and December 2018. All staff within the Trust were invited to participate in the survey either online or in paper format; 2,954 surveys were returned representing a 51% response rate. This was an increase when compared to the previous year’s response rate of 49%, and compares favourably with the national average response rate for combined acute and community Trusts in England of 41%.

Four of the six divisions achieved over a 50% response rate.

Corporate	Specialist Services	Integrated Medicine	Integrated Elderly & Community Care	Women & Children & Sexual Health	Surgery & Critical Care
68%	45%	40%	56%	52%	51%

There have been several changes to the national reporting structure this year. Key Findings have been replaced with 10 themes, and themes are all scored on a scale of 0-10. For all themes, higher scores indicate more positive results. In previous years, the staff engagement score was recorded on a scale between 1-5, but it is now scored between 0-10. Legacy data has been converted into the new format to allow for trend analysis.

Highlights

There are 10 themes which summarise groups of questions regarding staff experience. BHT is performing better than average in 6 themes, and in line with the national average in 4 themes. Since 2017, BHT has achieved statistically significant improvements in safety culture and staff engagement and no significant reductions in any themes.

Theme	Equality, Diversity & Inclusion	Health & Wellbeing	Immediate Managers	Morale	Quality of Appraisals
BHT	9.2	6.2	6.9	6.2	5.5
National average	9.2	5.9	6.8	6.2	5.4
Theme	Quality of care	Bulling & Harassment	Violence	Safety Culture	Staff Engagement
BHT	7.5	8.3	9.6	6.7	7.0
National average	7.4	8.1	9.5	6.7	7.0

Staff engagement

The Trust's overall staff engagement score was out of 10, a significant increase since 201 and the biggest increase in staff engagement at BHT since 2015. Of note, the Division of Integrated Elderly & Community Care reported an overall staff engagement score of 7.4 and the Division of Surgery and Critical Care reported a score of 7.2.

Equality, diversity & inclusion

The overall score remained at the same level as the previous year at 9.2. Within this, we are pleased to report that metrics reported as part of the Trust's national NHS Staff Survey have shown some improvements, notably the percentage of BAME (Black Asian and minority Ethnic) staff believing that the Trust provides equal opportunities for career progression (81% in 2018, compared to 78% in 2017 and higher than the average of 74% for similar Trusts).

Key actions this year were:

- Launch of our revised Equality and Diversity Policy (formerly Equal Opportunities Policy) in November 2018
- Introduction of a new Equality, Diversity and Inclusion (ED&I) steering group to set the strategic direction for ED&I and to drive this forward within the Trust

- The establishment of BAME and Disability Staff Networks. Work has also commenced on establishing an LGBTQQIA+ (Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Intersex, Asexual, Allies and Pansexual) Staff Network.
- The introduction of a reciprocal mentoring scheme initially for BAME staff. This scheme provides the opportunity for staff to mentor senior leaders within the Trust, to enable them to understand some of the lived experiences of staff with these protected characteristics.

There is, however, more work to do to ensure that BHT is a great place to work for all staff.

Recognising great professionalism and care

Monthly CARE awards

The Trust monthly CARE awards recognise individuals and teams who go to extraordinary lengths to deliver the Trust's values. Members of staff can be nominated by the community they care for or by colleagues and peers and awards are made in four categories that align with Trust values:

- Collaborate together as a team
- Aspire to be the best
- Respect everyone, valuing each person as an individual
- Enable people to take responsibility

Recipients of CARE awards are invited to a special ceremony that's a part of each public Board meeting to collect their award from the Chief Executive.

Annual CARE awards

Our annual staff awards recognise and celebrate the achievements and commitment of individuals and teams working for the Trust. Award winners are staff, volunteers and contractors who demonstrate safe, compassionate care and who embody our values and behaviours; Collaborate, Aspire, Respect, Enable.

Excellence reporting

For many years now the Trust has utilised incident reporting as a way to learn from the errors that we manage during our working lives. However, it's important that we learn from positive experiences too, the times of outstanding care and service. We need to know about these examples as much as we need to know about the adverse incidents that occur.

Staff are encouraged to submit their experiences of excellence at work so these examples can become part of the organisation's shared learning. Examples could be anything from positive outcomes for patients following effective escalation of deteriorating conditions to a particularly helpful member of staff going out of their way to ensure that someone's care pathway runs smoothly. Excellence reports identify specific examples the Trust can learn from and replicate elsewhere across the organisation.

Thank you cards

Our Trust thank you cards can be used by all managers to make it a little easier to acknowledge good work as it's being delivered. They are not as formal as nominating someone for a CARE award, or submitting an excellence report, and are used for acknowledging effort 'in the moment', as part of our day to day activities.

The premise for the 'thank you' cards is simple – managers, going about their day to day activities, if they spot someone going the extra mile or clearly exemplifying our CARE values, someone who just gets on and does their job quietly and effectively, or indeed if a staff member does something out of the ordinary then they use a thank you card to acknowledge this there and then on the same day.

Managers are encouraged to write a personal message on the card about what they witnessed and then give the card personally to the member of staff concerned.

Who we have involved in the Quality Account

1. We invited colleagues within the Trust to contribute to this Quality Account. The Quality Account was drafted by a Trust manager from the Quality Management team.
2. We wrote to the local Clinical Commissioning Groups, the local HealthWatch and the Buckinghamshire Health and Social Care Committee chair inviting their contribution. The report draft is circulated giving 30 days for their comments on the report to be added in this section.
3. These are added as appendices once we receive feedback.

Statement from Clinical Commissioning Group



Buckinghamshire
Clinical Commissioning Group

Second Floor
The Gateway
Gatehouse Rd
Aylesbury
HP19 8FF

Tel: 01296 587220

Email: buckscogs@nhs.net

10th June 2019

Dear Colleague,

Statement from Clinical Commissioning Group (CCG)

Buckinghamshire CCG, response to Buckinghamshire Healthcare NHS Trust
Quality Account 2018/2019

Buckinghamshire Clinical Commissioning Group (CCG) has reviewed the Buckinghamshire Healthcare NHS Trust Quality Account against the quality priorities for 2018/2019. There is evidence that the Trust has relied on both internal and external assurance mechanisms, to provide a comprehensive Quality Account review.

The CCG has provided detailed narrative separately to this statement to provide clarification on a number of points where information could be presented further to provide additional context.

The Quality Account demonstrates the Trust has made some progress in the quality priorities identified for the year under review, of the 11 areas identified as requiring quality improvement 5 areas met the quality priorities, 5 areas were partially met and 1 area was not rated as the outcome could not be measured, the areas that are considered to be partially met are to be carried over into the 19/20 Quality priorities.

The CCG would like to highlight that previously submitted areas of focus as detailed below and in our letter of the 8th March 2018 were not commented on within the Quality account for 2017/18; and therefore would require these to be included within the 18/19 Quality account for completeness.

- Use of the workforce resource planning tool to support the 'Care Hours per Patient

Day' programme

- Embedding and sustaining retired CQUINs from the 2016/17 financial year
- Progression of the Safeguarding Strategy implementation

The CCG would like to see progress against the following areas from 2018/19 into the 19/20 programme:

1. Implementing a Culture of Safety – includes establishing and further embedding the SAFER bundle and a single transfer of care process alongside other initiatives the latter requires a review as this was identified as difficult to measure as an outcome as reported in the Quality Account.

2. Listen to Our Patient Voice – A focus on improving three main areas, 12 hour waits in A&E, Outpatient cancellations and turnaround time for To Take Out medicines (TTOs).

The CCG would like to recognise the positive work that has been conducted in relation to the role of the Medical Examiner and the collaborative working for the LeDeR Learning Disability Mortality review programme with the CCG and other stakeholders within the ICS.

The Quality Account highlights there is a need for continued quality improvement over, avoidable infections, falls prevention and management and the applications of DNACPR and Treatment and Escalation Plans.

For 2018/19 Buckinghamshire Healthcare NHS Trust reported 5 Never Events which are summarised below.

- Quarter 1 – April 2018 (3 Never Events)
- Quarter 2 – August 2018 (1 Never Event)
- Quarter 3 – October 2018 (1 Never Event)
- Quarter - Zero (0 Never Event)

Reference; Quality Account 2018/19 Page 115

The CCG has worked with BHT to review the Never Events, identify learning and seek assurance on activities to reduce recurrence working with the Trust and NHS Improvement.

The Quality Account provides a detailed overview of the Trust's performance over the last 12 months and clearly identifies the achievements within the period reported, but also areas within service delivery where improvements could be made. We are grateful to the Trust for working collaboratively with commissioners and we will continue to work together to support the Trust on its improvement journey

Yours sincerely,



Louise Patten

Chief Executive

Oxfordshire and Buckinghamshire Clinical Commissioning Groups

Statement from Healthwatch Bucks

Response to Buckinghamshire Healthcare Trust Quality Account 2018-19

Part 1

We are pleased to see “Listening to and Involving our Patients” so high up the list of priorities for the Trust. We look forward to understanding how progress in this area is tracked.

We would like to understand how patient experience of going to theatre improves because of the Theatres Cultural Improvement Programme.

We are very pleased to see that volunteers help improve patient experience in the Emergency Department. We look forward to seeing how volunteers can do this throughout the Trust.

Many of the services used patient feedback to show quality. We would like this to be done across all services where possible. For example, patient feedback is not mentioned as a measure for the Elderly Consultant Physician of the Day.

We like to see where action has been taken as a result of patient feedback. This was in some sections, for example Paediatric Day Surgery, Radiology and Buckinghamshire Sexual Health and Wellbeing Service, but not all.

We were interested in the new approach to the Friend and Family Test being piloted by the Emergency Department. We look forward to understanding the outcome of the pilot.

We would like to understand what difference the Daily Facilitated meetings has made to improving patient experience of discharge in ward 2a.

Part 2

We see the inpatient survey results about responsiveness to personal needs is below the national average. The Trust is working to improve how patients leave hospital(discharge).

We see that the number of staff who would recommend the hospital as a provider of care for their family or friends is below average. The Trust is acting to address this.

We are pleased to have had supported the Trust to listen to the patient voice in particular Outpatients, Accident and Emergency and GP streaming.

We are pleased to have had supported the Trust to listen to the patient voice in particular Outpatients, Accident and Emergency and GP streaming.

Part 3

We are pleased to see that results of the staff survey are generally positive. We were pleased to see BAME staff feedback on promotion. We could not see figures on bullying and harassment which were available last year.

At Healthwatch Bucks we think that staff who are happy at work are more likely to provide patients with a good experience. This means we pay close attention to these figures.

We can see that figures for complaints have remained level. The report also shows that action can be taken as a result.

Overall

We encourage Bucks Healthcare Trust to use plain English when writing documents for the public.

We congratulate everyone who works for the Trust on the achievements of the last year. They reflect the hard work and commitment of staff throughout the organisation. We look forward to working with the Trust next year.

Thalia Jervis

Chief Executive

Statement from Health and Adult Social Care Select Committee

Buckinghamshire County Council's Health and Adult Social Care (HASC) Select Committee holds decision-makers to account for improving outcomes and services for the residents of Buckinghamshire. The Committee scrutinises issues in relation to NHS services, including how services are commissioned and the overall performance of the services.

As a critical friend to the Trust, we are pleased to have an opportunity to provide feedback on the Trust's Quality Account for 2018/19.

In last year's quality account, we focussed our response around the targets which had not been met, particularly around emergency neck of femur, patient experience and staff survey response rates, sepsis screening and pressure ulcers. In January 2019, the Committee was reassured that progress had been made in these specific areas to improve quality of care.

In light of this, we were particularly pleased to note the introduction of the 'Golden Patient' model for hip fracture patients and the introduction of the 'Freedom to Speak Up Guardian'. We were also pleased to note the pilot on-line Friends and Family Test platform which had resulted in an increase in response rates in Accident and Emergency. We also note the increase in the number of staff who would recommend the Trust to family and friends, which is now in line with the national average.

Whilst acknowledging the Trust's interventions around pressure ulcers resulting in a reduction of 30% in category 3, 4 and deep tissue injury and 20% reduction in category 2, we will continue to monitor the targets and specifically the interventions around the Trust's commitment to placing more emphasis on actions required from all divisions and the joint investigations with care homes and care agencies.

We were pleased to note the introduction of a Sepsis Nurse within the Emergency Department and the awarding of 'Sepsis Stars' for staff. We understand that a new national definition was introduced around sepsis ("suspicion to needle time"). We would request that next year's quality account includes the metrics around sepsis.

Having undertaken an in-depth inquiry into Hospital Discharge in 2017 which made a number of recommendations to help improve the process, we read with interest the Trust's work around establishing and implementing new processes to improve patient discharge, particularly around patient transport and the turnaround time for TTO medicines, as part of the single transfer of care project.

We note the effective partnership working with Oxford Health around mental health services and the Trust's commitment to recognise and promote parity of esteem for mental health alongside physical health. We also note the partnership working with Buckinghamshire County Council in areas, such as Safeguarding and Domestic Violence. The drop in DOLs training was noted but we understand that a new approach to Liberty Safeguarding will be introduced soon.

We make the following general observations:

- Accident and Emergency waiting times over 12 hours, whilst improved, remain on Amber;
- Perinatal mortality rate has reduced to 4.12 and is lower than the 5.2 national average (per 1000 births);
- A higher than anticipated rate of Clostridium Difficile.

Conclusion

Through its quality accounts, the Trust continues to demonstrate its commitment to improving services and outcomes for patients, evidenced by excellent examples and case studies. We acknowledge the Trust's progress and achievements in many clinical areas but we would have liked to see more metrics in the quality accounts to back-up these achievements. For example, cataracts – how much has the patient waiting times been reduced and how many additional operations have taken place?

The Health & Adult Social Care Select Committee will continue to review and challenge the Trust's performance over the coming months. The Committee acknowledges the workforce challenges, both nationally and locally, so we will be particularly interested to hear more about the Trust's plans to develop innovative new models of care and/or staffing to tackle gaps in the workforce.

We continue to welcome the Trust's open and transparent way of working with its partners and look forward to more integrated and partnership working over the coming year.

Submitted by Buckinghamshire County Council's Health and Adult Social Care Select Committee

Date: 27 June 2019

Statement by Directors

Statement of directors' responsibilities in respect of the Quality Account 2018/19

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amendment Regulations 2017).

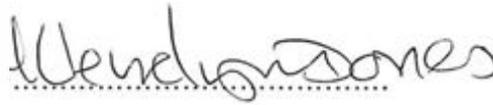
In preparing the Quality Account for 2018/19, directors are required to take steps to satisfy themselves that:

- the Quality Account presents a balanced picture of the Trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the appropriate Overview and Scrutiny Committee (OSC) have provided their view of the Trust's quality account
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and the Quality Account has been prepared in accordance with Department of Health guidance.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

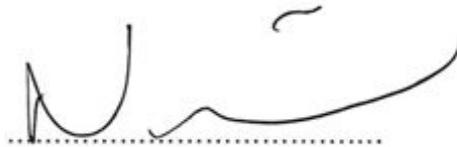
By order of the Board

26 June 2019

A handwritten signature in black ink, appearing to read "Wendy Jones", written over a horizontal dotted line.

Chair

26 June 2019

A handwritten signature in black ink, consisting of a large initial 'N' followed by a cursive name, written over a horizontal dotted line.

Chief Executive

Appendix 2- Auditors Limited Assurance Report

Independent Practitioner's Limited Assurance Report to the Board of Directors of Buckinghamshire Healthcare NHS Trust on the Quality Account

We have been engaged by the Board of Directors of Buckinghamshire Healthcare NHS Trust to perform an independent assurance engagement in respect of Buckinghamshire Healthcare NHS Trust's Quality Account for the year ended 31 March 2019 ("the Quality Account") and certain performance indicators contained therein as part of our work. NHS Trusts are required by section 8 of the Health Act 2009 to publish a Quality Account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010 and as subsequently amended in 2011, 2012, 2017 and 2018 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to the limited assurance engagement consist of the following indicators:

- Rate of Clostridium difficile infections per 100,000 bed days for patients aged two or more on the date the specimen was taken during the reporting period
- Percentage of reported patient safety incidents resulting in severe harm or death during the reporting period

We refer to these two indicators collectively as "the indicators".

Respective responsibilities of the directors and Practitioner

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health and NHS Improvement has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the Regulations).

In preparing the Quality Account, the directors are required to take steps to satisfy themselves that:

- the Quality Account presents a balanced picture of the Trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health and NHS Improvement guidance.

The Directors are required to confirm compliance with these requirements in a statement of directors' responsibilities within the Quality Account.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2014-15 issued by the Department of Health in March 2015 (“the Guidance”); and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

We read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Account and consider whether it is materially inconsistent with:

- Board minutes for the period 1 April 2018 to 26 June 2019;
- papers relating to quality reported to the Board over the period 1 April 2018 to 26 June 2019;
- feedback from the Trust’s main commissioner dated 10/06/2019;
- feedback from local Healthwatch organisation dated 27/06/2019;
- feedback from the Health and Adult Social Care Select Committee dated 27/06/2019;
- the Trust’s 2018/19 complaints report published under regulation 18 of the Local Authority, Social Services and National Health Service Complaints (England) Regulations 2009;
- the patient survey for Maternity services dated September 2018 and the patient survey for Urgent and Emergency Care dated April 2019;
- the 2018 national staff survey;
- the 2018/19 Head of Internal Audit’s annual opinion over the Trust’s control environment;
- the 2018/19 annual governance statement; and
- the Care Quality Commission’s inspection report dated 18/06/2019;

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these documents (collectively the “documents”). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Board of Directors of Buckinghamshire Healthcare NHS Trust. We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and Buckinghamshire Healthcare NHS Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement under the terms of the Guidance. Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- limited testing, on a selective basis, of the data used to calculate the indicators tested against supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; and
- reading the documents.

A limited assurance engagement is narrower in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques that can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

The nature, form and content required of Quality Accounts are determined by the Department of Health and NHS Improvement. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

In addition, the scope of our limited assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Buckinghamshire Healthcare NHS Trust.

Our audit work on the financial statements of Buckinghamshire Healthcare NHS Trust is carried out in accordance with our statutory obligations and is subject to separate terms and conditions. This engagement will not be treated as having any effect on our separate duties and responsibilities as Buckinghamshire Healthcare NHS Trust's external auditors. Our audit reports on the financial statements are made solely to Buckinghamshire Healthcare NHS Trust's directors, as a body, in accordance with the Local Audit and Accountability Act 2014. Our audit work is undertaken so that we might state to Buckinghamshire Healthcare NHS Trust's directors those matters we are required to state to them in an auditor's report and for no other purpose. Our audits of Buckinghamshire Healthcare NHS Trust's financial statements are not planned or conducted to address or reflect matters in which anyone other than such directors as a body may be interested for such purpose. In these circumstances, to the fullest extent permitted by law, we do not accept or assume any responsibility to anyone other than Buckinghamshire Healthcare NHS Trust and Buckinghamshire Healthcare NHS Trust's directors as a body, for our audit work, for our audit reports, or for the opinions we have formed in respect of those audits.

Conclusion

Based on the results of our procedures, as described in this report, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Account identified as having been subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

Grant Thornton UK LLP

Grant Thornton UK LLP
Chartered Accountants
London

28 June 2019

Appendix 3 – Glossary

7DS	Seven day services
7DSAT	Seven day services self-assessment template
A&E	Accident and Emergency department
ACSA	Anaesthesia Clinical Services Accreditation
ADHD	Attention deficit hyperactivity disorder
AHP	Allied Health Professional
AHSN	Academic Health Science Networks
ASD	Autistic spectrum disorder
BFI	Baby Friendly Initiative
BHT	Buckinghamshire Healthcare NHS Trust
BLISS	Charity for babies born premature or sick
BME	Black and minority ethnic
BMI	Body Mass Index
BOB	Buckinghamshire, Oxfordshire and Berkshire
bSHaW	Buckinghamshire Sexual Health and Wellbeing Service
CAMHS	Child and Adolescent Mental Health Service
CARE values	Collaborate, Aspire, Respect and Enable
CARF	Committee for Accreditation of Rehabilitation Facilities
CATS	Community Assessment Treatment Services
CCGs	Clinical Commissioning Groups
C.diff	Clostridium Difficile
CEO	Chief Executive Officer
CHIS	Community Head Injury Service
CIRCLE	Correlate Intelligence Responsibly, Circulate Learning Effectively

CQC	Care Quality Commission
DFM	Daily Facilitated Meetings
DNARCPR	Do Not Attempt Cardiopulmonary Resuscitation
DoLS	Deprivation of Liberty Safeguards
DQ	Data Quality
DSP	Data Security Protection
DTNT	Door to needle time
ECG	Electrocardiogram
ECLO	Eye Clinic Liaison Officer
ECPOD	Elderly Consultant Physician of the Day
ED	Emergency Department
EMC	Executive Management Committee
EPMA	Electronic and Medicines Administration System
FEES	Fiberoptic Endoscopic Evaluation of Swallowing
FFT	Friends and Family Test
FNP	Family Nurse Partnership
FTSUG	Freedom to Speak Up Guardian
GNBSI	Gram Negative Blood Stream Infections
GPAS	Guidelines for Provision of Anaesthetic Services
GPs	General Practitioners
GRACE	Global Registry of Acute Coronary Events
HIV	Human Immunodeficiency Virus
HPV	Human papilloma virus
HQIP	Healthcare Quality Improvement Partnership
HSCIC	Health and Social Care Information Centre
HSJ	Health Service Journal

ICS	Integrated care systems
IDDSI	International Dysphagia Diet Standardisation Initiative
IEC/IECC	Integrated Elderly and Community Care
IOL	Intraocular Lens
LD	Learning disability
LDL	low-density lipoprotein – bad cholesterol
LeDer	Learning Disabilities Mortality Review
LWSW	Live Well Stay Well
MCA	Mental Capacity Act
MDT	Multi-disciplinary team
ME	Medical Examiner
MFOP	Medicine for Older People
M&M	Mortality and morbidity
MSK	Musculoskeletal
MSW	Medical Support Workers
NDG	National Data Guardian
NED	Non-Executive Director
NEWS2	National Early warning signs
NHS	National Health Service
NHSI	NHS Improvement
NICE	National Institute of Clinical Excellence
NMT	Neurologic Music Therapy
NNU	Neonatal Unit
NSE	National Society for Epilepsy
NSIC	National Spinal Injuries Centre
NSTEMI	Non-ST-elevation myocardial infarction – a type of heart attack

OD	Organisational Development
OHFT	Oxford Health NHS Foundation Trust
OT	Occupational Therapy
PEG	Patient Experience Group
PHE	Public Health England
PLACE	Patient led assessment of care environment
POD	Physician of the Day
PROMS	Patient Reported Outcomes measures
Q1	Quarter 1, first quarter of the financial year (April-June)
Q2	Quarter 2, second quarter of the financial year (July-September)
Q3	Quarter 3, third quarter of the financial year (October-December)
Q4	Quarter 4, fourth quarter of the financial year (January-March)
QI	Quality Improvement
QNI	Queens Nursing Institute
QSIR	Quality Service Improvement and Redesign
RCP	Royal College of physicians
RTT	Referral to Treatment time
SACT	Systemic anti-cancer treatment
SAS	Specialty and Associate Specialist Doctor
SCI	Spinal Cord Injury
SHMI	Summary Hospital-level Mortality Indicator
SI	Serious Incident
SIRO	Senior Information Risk Owner
SJR	Structured Judgement Review
SLP	Senior Leaders Programme
SLT	Speech and Language Therapy

SME	Small medium enterprises
SMH	Stoke Mandeville Hospital
SOP	Standard Operating Procedures
SPEAC	Surgical and Plastics Emergency Ambulatory Care
SRT	Stereotactic Radiotherapy
SSNAP	Sentinel Stroke National Audit Programme
STNT	Suspicion to Needle Time (Sepsis)
STP	Sustainability and transformation partnership
T&O	Trauma & Orthopaedics
TEP	Treatment Escalation Plan
TNLU	Therapy and Nurse Led Unit
TTO	To take out (medicines given to patient on discharge from hospital stay)
UK	United Kingdom
UKAS	United Kingdom Accreditation Service
UKGRIS	UK GRACE Risk Score Intervention Study
UV	Ultra Violet
VTE	Venous Thromboembolism
WC&SH	Women, Children & Sexual Health
WH	Wycombe Hospital

Agenda item: 16.5

Enclosure no: TB2019/083

Safe & compassionate care,
every time

Buckinghamshire Healthcare **NHS**
NHS Trust

PUBLIC BOARD MEETING 31 July 2019

Details of the Paper

Title	Annual Report – Guardian of Safe Working Hours
Responsible Director	Medical Director
Purpose of the paper	To provide an overview on exception reporting and work schedule reviews relating to safe working hours for 2018/19
Action / decision required (e.g., approve, support, endorse)	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	<i>Financial Performance</i>	Operational Performance	<i>Strategy</i>	Workforce performance	<i>New or elevated risk</i>
<i>Legal</i>	Regulatory/ Compliance	Public Engagement /Reputation	Equality & Diversity	<i>Partnership Working</i>	<i>Information Technology / Property Services</i>

ANNUAL OBJECTIVE

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

Please summarise the potential benefit or value arising from this paper: Engaged junior doctors working safely and delivering high quality care to patients

RISK

Are there any specific risks associated with this paper? If so, please summarise here.	<i>Non-Financial Risk:</i> Assurance to the Board that doctors' working hours are safe
	<i>Financial Risk</i> Fines relating to exception reports

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)
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Author of paper: Dr Nawal Bahal

Presenter of Paper: Dr Nawal Bahal

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

Date of Paper: 23rd July 2019

Agenda item: 16.5

Enclosure no: TB2019/083

Guardian of Safe Working Hours – Annual Report

1. Executive Summary

This report has been provided to the board as required by Schedule 5, Paragraph 35 of the Terms and Conditions of Service (TCS) for NHS Doctors and Dentists in Training (England) 2016.

This report summarises the number and pattern made in submitted exception reports and looks at the trends. It highlights the major issues facing the Trust with regards to the junior doctor workforce and what steps are being taken to address these. It also provides updates on progress made by the Trust in promoting safe working and wellbeing amongst junior doctors. Reference will also be made to the outcome of the 2018 Contract Review and the impact it will have on the organisation.

2. Introduction

In August 2017, all junior doctors in training positions in the Trust transitioned to the 2016 TCS. The new contract mandates that NHS Trusts who employ junior doctors in training appoint a Guardian of Safe Working Hours to oversee the process of ensuring safe working hours for junior doctors. The role includes monitoring exception reports submitted by junior doctors and responding to issues raised by doctors about hours, working conditions or patient safety. The Guardian provides assurance to the Trust that issues of compliance with safe working hours will be addressed, as they arise.

The primary source of information in this report is exception reports raised by junior doctors. This is an electronic method of recording variations in working hours from those agreed in the doctor's work schedule, a lack of clinical support, or an immediate concern for the safety of a patient or themselves. Departments have a duty to respond to these reports in a timely fashion and provide assurance that changes are made where necessary.

Fines (at 4 times the doctors hourly rate) are levied against the Trust when a doctor reports working more than 72 hours in a week, more than an average of 48 hours over the life of a rota cycle, or have an 11 hour break reduced to 8 hours or fewer.

Other means of gathering information have included emails and face-to-face meetings with groups of junior doctors, Consultants and Service Manager to address concerns about working practices in certain areas.

3. Exception Reports

In the Academic year 2018/19 (May 2018- July 2019), there were 309 exception reports submitted. Just under half of these came from the division of Integrated Medicine. This reflects the issues covered later in this report – frequent rota gaps and a heavy workload. The Division of Integrated Elderly care had a large number of reports at the beginning of the year, but after setting up a forum and engaging with their junior staff the number of submitted reports came down significantly each quarter.

Junior doctors can also submit an Immediate Safety Concern (ISC) if they are concerned about the safety of themselves or their patients.

At this point there is no formal mechanism for benchmarking these numbers. The Thames Valley Guardians Network shares data on total number of reports submitted and BHT is roughly on par with other District General Hospitals in the region.

NHS Improvement (with Academy of Medical Royal Colleges (AoMRC), British Medical Association (BMA), Care Quality Commission (CQC), General Medical Council (GMC), Health Education England (HEE) and NHS England (NHSE) have created an Exception Reporting Working Group with 2 workstreams:

- i. Standardisation of Guardian Quarterly Board Reports
- ii. National data collection via NHSI Model Hospital reporting platform

Agenda item: 16.5
Enclosure no: TB2019/083

3.1 Exception Reports by Division

Division	Q1	Q2	Q3	Q4	Number of Reports
Integrated Medicine	58	59	22	10	149
Surgery and Critical Care	36	14	12	20	82
Integrated Elderly	32	8	1	0	41
Women & Childrens	6	18	9	3	36
Specialist Services	0	0	0	0	0
Other (psychiatry)	0	0	1	0	1
TOTAL	132	99	45	33	309

3.2 Exception Reports by SDU

SDU	Number of Reports
A&E	1
Acute Medicine	27
Anaesthetics	4
Cardiology	33
Diabetes	14
Gastroenterology	23
General Surgery	40
Haematology	2
MfOP	42
Obs & Gynae	5
Ophthalmology	1
Paediatrics	29
Pathology	2
Plastics	9
Respiratory	18
Rheumatology	0
Stroke and Neurology	35
Trauma	44
Urology	1
Other (Psychiatry)	1

3.3 Exception Types

Exception Type	Number of Reports
Late Finish	290
Inadequate supervision	19
Unable to achieve breaks/Late Finish	10
Unable to achieve breaks	8
Unable to attend teaching	4
Working Pattern	3
Early Start	2

3.4 Fines relating to Exception Reports

There were no fines for this period.

Agenda item: 16.5

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4. Major Issues Addressed this Year

4.1 Medical On-Call Rotas

The number of doctors allocated to the Trust by the Oxford Deanery was lower than expected and there is difficulty in filling positions directly, including for locum posts. As a result, numbers on the registrar (ST3+) rota have been consistently low – fill rates were 8.5/12 full-time equivalent (FTE) this year. Gaps in the on-call rota are frequent. To mitigate these gaps and provide continuity of care to patients, the rota was changed in March 2019; doctors are expected to work a '1 in 10' rota (1 in 10 weekends) replacing a 1 in 12 rota. The Divisional team is considering changing this rota again to become '1 in 8'. This has led to a situation where morale amongst junior doctors in this area is low and many are reporting stress and fatigue.

The Guardian of Safe Working Hours and the Divisional team are following up this issue as a priority; they will make recommendations for improvements to the Human Resources and Workforce Group. In addition, the Trust has commissioned an external review of the junior doctor rotas.

4.2 Medicine for Older People

An emergency meeting was convened in August 2018 following an immediate safety concern (ISC) and communications from doctors to the Guardian of Safe Working Hours, the Director of Medical Education (DME) and the Freedom to Speak Up Guardian (FTSUG). There was a deficiency of doctors at every level with fill rates of 2.6/5 (FTE) senior trainees and 6/11 (FTE) junior trainees. In addition there was inefficient distribution of the workload between teams, and issues identified with some International Medical Graduates (IMGs) understanding and navigating the NHS and poor morale.

With the support of the FTSUG a forum was set up to allow junior doctors and nurses to feed issues directly to the SDU Lead and Divisional Director. In addition the GMC Regional Liaison Adviser now provides a programme for IMGs on the 'Duties of a Doctor'. Speaking to the affected individuals, morale seems to have improved. Information from emails and exception reports suggest that whilst there is still a heavy workload, Consultants are helping by supporting junior members of the team.

4.3 Medical Outliers

Concerns were raised by FY1 doctors in medicine about the nature of covering medical outliers – having up to 40 patients across the hospital and staying up to 5 hours late on occasions. They felt this role was not managed in an organised manner.

The medical FY1 doctors are now rostered to work with the locum Consultant covering outliers to ensure the workload is fairly distributed. Face-to-face discussions with the affected doctors have taken place. They find the role particularly arduous but feel sharing it out is fairer than the previous method when it seemed to fall on a particular group more than others.

5. Improvements

5.1 Junior Doctors' Hub

This year the Trust has supported junior doctors by giving them a centrally located space at Stoke Mandeville Hospital to use for rest and recreation. This has replaced the off-site Mess and is designed to meet the needs of the doctors. There are 2 rooms, a quiet room for rest and sleep and another room with a TV and awaiting a kitchen for socialising.

5.2 Fatigue & Facilities Charter Funds

Agenda item: 16.5

Enclosure no: TB2019/083

By signing up to the BMA Fatigue & Facilities Charter, junior doctors were given £60,000 to spend to improve facilities and wellbeing. The Junior Doctors Forum (JDF) has implemented this spending in both Junior Doctors' Hubs and across the Trust.

5.3 Sleep Pods

A chief concern amongst many junior doctors has been the lack of an area to rest before ongoing journeys home or after long shifts. Various options were explored, and Sleep Pods were felt to be an option that could be of most benefit to the most doctors. This will also help the Trust to meet the criteria set out in the BMA Fatigue & Facilities Charter.

The JDF Chair was successful in a bid from the Trusts Charitable Funds and 2 have been ordered for Stoke Mandeville Hospital. Since the Fatigue & Facilities Charter Funds have arrived, a further 2 Pods have been purchased for Wycombe Hospital.

6. Summary

309 exception reports were submitted this year, with almost all of them (290) relating to late finishes. Whilst there is some concern about the nature of some of these late finishes, this also reflects well on the organisation in that a reporting culture is supported and encouraged. The numbers submitted did tail off as the year progressed (132 in Q1, 33 in Q4). Some of this is in response to the Trust reacting to issues raised, but there is also the concern that enthusiasm has decreased as the year goes on. The task for the Guardian and the JDF is to keep participation high throughout 2019/2020.

By working with NHSI we will hopefully soon be in a position to benchmark our exception reporting performance.

Almost half of the reports have come from one division – Integrated Medicine, and this is an accurate reflection of the difficulties faced by the division. Gaps in the registrar (ST3+) rota are frequent and morale is low. In turn this has made filling locum gaps difficult and understaffed clinical areas have occurred. The challenge for the organisation is to create a positive environment in this area in order to attract and retain talented doctors.

The Trust has been supportive of junior doctors, and the JDF Chair has been excellent in disseminating good news when we have it. In this year the juniors have received a well-located Hub in Stoke Mandeville, in addition to the one at Wycombe Hospital. Sleep Pods will soon be available for rest at both sites and funds given by the Secretary of State for Health have given the JDF an opportunity to further improve morale.

Following a review of the 2016 TCS by NHS Employers, a number of changes to the junior doctor contract will come into effect over 2019 and 2020. The areas affected include:

- Equalities, LTFT, and flexible training
- Pay and transitional arrangements
- Flexible pay premia
- Safety and rest limits
- Leave
- Locum work
- Guardian fines
- Exception reporting
- Work scheduling
- Code of practice
- Guardian of safe working hours
- GP trainees
- Facilities
- Commitment to future work

Agenda item: 16.5

Enclosure no: TB2019/083

An important role for the Guardian will be to explain these changes to doctors in medical departments and to other areas and ensuring we are prepared for the changes as they are introduced in a staggered approach.

Agenda item: 17
 Enclosure no: TB2019/084



PUBLIC TRUST BOARD MEETING 31st July 2019

Details of the Paper

Title	Getting It Right First Time (GIRFT) and reducing clinical variation
Responsible Director	Tina Kenny
Purpose of the paper	To provide Trust Board with an update on the corporate objective 'tackling inequalities and variation'.
Action / decision required (e.g., approve, support, endorse)	For information

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

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

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:
 To provide a quarterly update on the corporate objective.

RISK

Are there any specific risks associated with this paper? If so, please summarise here.	<i>Non-Financial Risk:</i> None
	<i>Financial Risk:</i> None

LINK TO CARE QUALITY COMMISSION ESSENTIAL STANDARDS OF SAFETY AND QUALITY

Which CQC standard/s does this paper relate to?	<i>(if you need advice on completing this box please contact the Director for Governance)</i>
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Author of paper: Andrew McLaren

Presenter of Paper: Andrew McLaren

**Other committees / groups where this paper / item has been considered:
 EMC, Quality and Clinical Governance Committee**

Date of Paper: 16/07/2019

Corporate Objective	Tackle inequalities and variation	
Project	Getting It Right First Time (GIRFT) and reduce clinical variation	
Executive Lead	Medical Director	
Reporting Period	Q1 – April - June 2019	
	<p style="text-align: center;">Achieved</p> <ul style="list-style-type: none"> • GIRFT reports received so far this year: <ul style="list-style-type: none"> • Dermatology • Diabetes • Endocrinology • Stroke • Dentistry • Improvements identified by teams. • Monitoring of progress through the GIRFT Board. Services who have update so far are: <ul style="list-style-type: none"> • Orthopaedics • ENT • General Surgery • Urology • Pain 	<p style="text-align: center;">Benefits</p> <ul style="list-style-type: none"> • A selection of key improvements delivered are: • Ophthalmology <ul style="list-style-type: none"> • Cataract operation productivity - improved from 4.5 cases per list to 7.5. Saving £900k assuming flat activity profile and 300 fewer lists / year. • Glaucoma clinic productivity - increase from 20 to 28 patients per clinic. Band 6 nurse injectors saves medical time – saving £47k • Orthopaedics <ul style="list-style-type: none"> • ACL reconstruction reduced number of surgeons undertaking / standardized kit / stopped loan kit. Saving £69k / year • Pain <ul style="list-style-type: none"> • Theatre productivity 4 cases per list increased to 7 cases per list. Will increase to 8 per list in next 6 months • Cessation of multiple treatments Epidural / facet joint injections limited to 2 per year maximum as per national guidance. • Reduction of 1300 procedures per year (from 2012/15 period to current) • System saving of £539 per procedure = £700k / year

Concerns	Do Next
<ul style="list-style-type: none">• None	<ul style="list-style-type: none">• Reports due to be received this year are:<ul style="list-style-type: none">• Geriatric Medicine• Radiology• Anaesthetics / Perioperative Medicine• Gastroenterology• Service updates scheduled to attend GIRFT Board:<ul style="list-style-type: none">• Breast• Ophthalmology• Diabetes• Endocrinology• OMFS

Agenda item: 18, Enclosure no: TB2019/085



PUBLIC BOARD MEETING July 2019

Details of the Paper

Title	Information Communication and Technology (ICT) Strategy 2019 – 2024
Responsible Director	David Williams, Director of Strategy
Purpose of the paper	To present the ICT Strategy to the Board
Action / decision required (e.g., approve, support, endorse)	For approval

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

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

ANNUAL OBJECTIVE

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

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

To deploy integrated technology and data to improve services, so they are:

- shaped around patient need and convenience,
- built on a secure, value for money, responsive and accessible infrastructure
- proactive and smart providing responsive and timely information on individual care needs
- aligned with our ambition to be a learning health system

Benefits - exploiting digital solutions to change and drive business improvement enables several other business changes - better use of estates, reduced overheads, join up services and increase productivity

RISK

Are there any specific risks associated with this paper? If so, please summarise here.	<p><i>Non-Financial Risk:</i> Investment in technology is critical to support the provision of quality services, save clinical time to focus on patient care, improve patient experience and deliver productivity and efficiency gains across the Trust. If we don't exploit the opportunities provided by digital we risk being unable to deliver long term, sustainable cost reductions and efficiency improvements - automating where possible, providing real time access to data at the point of care and providing our workforce with the right tools in the right place</p> <p><i>Financial Risk:</i></p> <ul style="list-style-type: none"> Risk of significant ICO fines through loss of data by Cyber attack Trust will not be able to release financial and productivity gains without the delivery of this strategy
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LINK TO CARE QUALITY COMMISSION ESSENTIAL STANDARDS OF SAFETY AND QUALITY

Which CQC standard/s does this paper relate to?	Safe, Effective, Caring, Responsive and Well-led
Author of paper: Balvinder Heran	
Presenter of Paper: Balvinder Heran	
Other committees / groups where this paper / item has been considered: EMC	
Date of Paper: 23 rd July 2019	

Buckinghamshire Healthcare NHS Trust

Information Communications and Technology Strategy (ICT) 2019 – 2024

Executive Summary

The Information Communication and Technology (ICT) Strategy sets out our ambitions and plans for Buckinghamshire Healthcare NHS Trust (BHT). This Strategy supports BHT and the Integrated Care Partnership (ICP) in delivering an agile, flexible and readily available digital resource which is shaped around the needs of our patients, staff and business processes.

It supports our strategic vision to be one of the safest healthcare providers in the country, as well as being at the forefront of innovation and technology.

Investment in technology is critical to support the provision of quality services, save clinical time to focus on patient care, improve patient experience and deliver productivity and efficiency gains across the Trust. Whilst the financial pressures remain, we must urgently address the level of investment to deliver long term, sustainable cost reductions and efficiency improvements: -

- automating where possible
- real time access to data at the point of care
- providing our workforce with the right tools in the right place

It supports our key priorities: **quality, people and money**. Technology, information and digital tools are key enablers of the “BHT Way” “safe and compassionate care every time” and it’s three strategic priorities:

- to offer safe and compassionate care in patients’ homes, the community or one of our hospitals
- to be a great place to work where our people have the right skills and values to deliver excellence in care
- to be financially sustainable, will make the best use of our buildings, and be at the forefront of innovation and technology

Whilst our overall aim is to undertake programmes which are ICP wide, it is important given the scale of technology and digital developments required that the Trust has a clear understanding of what it needs to put in place to meet the needs of our patients.

The Board are asked to endorse the priorities set out in this strategy and see it is a critical building block in enabling the Trust to continue its transformation journey and realise its ambition to be the safest healthcare system in the country.

i) Introduction

The ICT Strategy sets out the direction of travel and key deliverables to ensure we fully realise the benefits of investment in technology. Our Vision is to deploy integrated technology and data to improve services so they are:

- shaped around patient need and convenience,
- built on a secure, value for money, responsive and accessible infrastructure
- proactive and smart providing responsive and timely information on individual care needs
- aligned with our ambition to be a learning health system

It comprises three main pillars: -

- 1) **Technology** - infrastructure, hardware and software;
- 2) **Digital** – culture change, improved patient experience, improved processes and better tools for our people to deliver better and safer patient care
- 3) **Information** - creating information and intelligence that drive delivery and improvements in care.

It takes account of national, regional and local priorities.

ii) **Guiding Principles**

Engagement

We will engage with users of the services

- Our People are our greatest asset - use their knowledge to remove duplication, manual processes and workarounds
- Our Patients – co-design our digital offerings so they are shaped around individual need and convenience.
- Our Partners - design and build one digital approach which is used by all public services across Buckinghamshire to reduce costs and maximise productivity

Process Re-design

This strategy is supported by the Trust's corporate business process redesign programme, working with staff and stakeholders to identify what gets in the way of effective, digital working. A digital by design ethos will aim to avoid re-creating our paper records and forms and will be underpinned by validated Quality, Service Improvement and Redesign (QSIR) methodology.

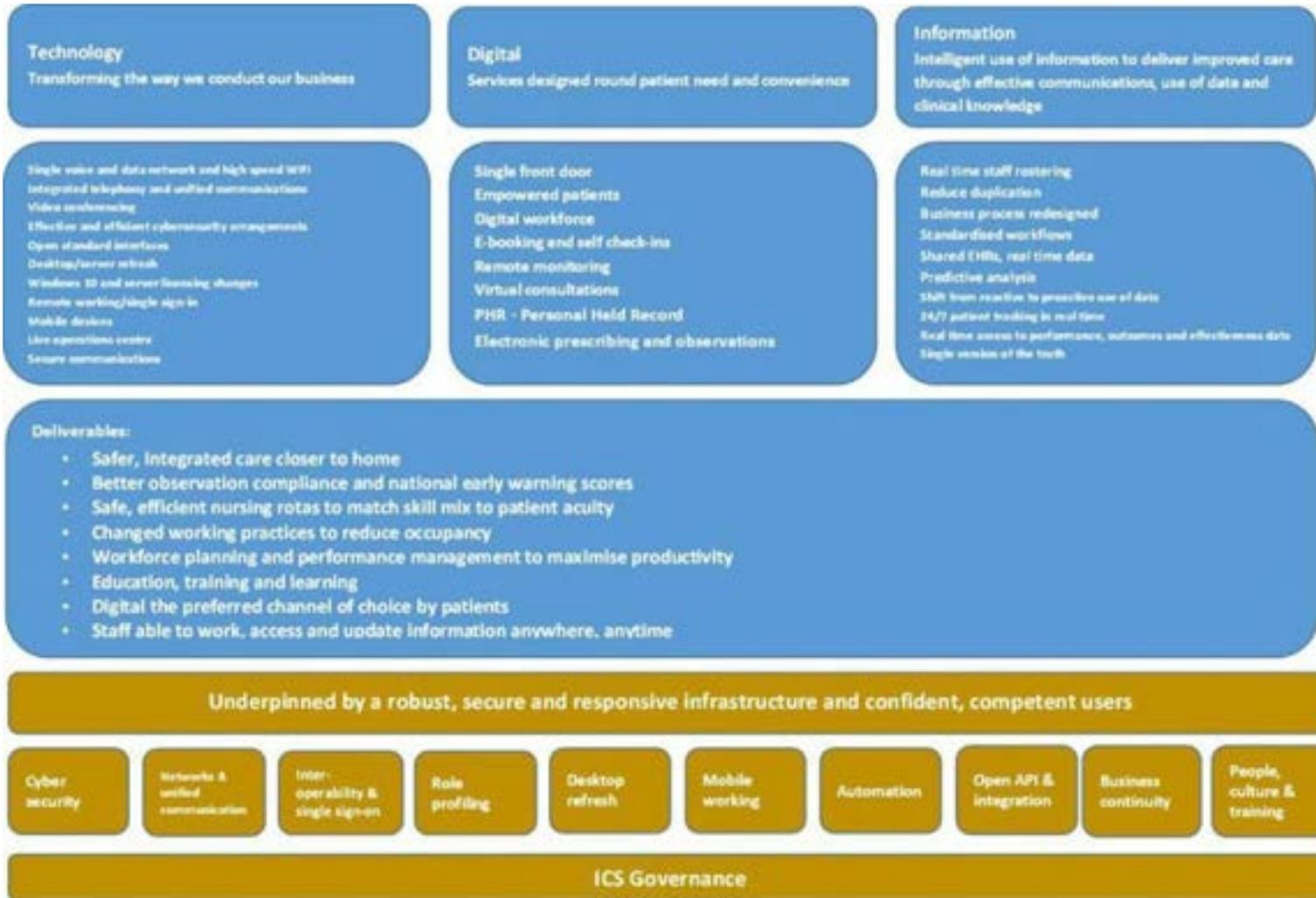
Resourcing

To deliver on the ambitions set out in this Strategy requires significant investment both in our systems and our people. It is estimated the costs to fully implement this Strategy will be more than £50M over the life of the strategy. Detailed business cases for each programme will be developed along with how they will be financed. The longer the Trust runs with its current ICT infrastructure the greater the risk it faces not only from Cybersecurity but missing out on opportunities to make productivity gains and so we can enable our patients to move away from the more expensive, not so convenient, traditional channels such as face to face and telephony

The challenge of funding the ICT Strategy is being tackled through on-going discussions with NHSE and NHSX, Buckinghamshire County Council and other providers. It is accepted that the Trust has very limited capital or revenue funding available to fund this Strategy. To support the delivery and success of this Strategy we will: -

- Seek more external investment through NHS England, partner with other organisations such as Buckinghamshire County Council as well as other investments.
- Re-shape and build on our existing skilled resources into a central department which supports all technical, digital and business intelligence programmes across the Buckinghamshire ICP. This will increase capacity and skills as well as reducing costs and overheads for all partners.

Vision and Deliverables



1) National Context

Our strategy addresses the key requirements in national plans and guidance specifically: -

Digital Priorities set out in the NHS Long Term Plan

Transformation	Leadership
<ul style="list-style-type: none"> • Straightforward digital access to NHS services helping patients and carers manage their health • Ensure that clinicians can access and interact with patient records in any care setting • Improved consistency across the whole care pathway supporting patients managing their health • Useful information to plan care for its whole – whole what? • Intuitive tools to capture data at the point of care • Protect patients’ privacy giving them control over their medical record • Confidence that data is secure through the implementation of security monitoring systems and staff education • Mandate and enforce technology standards (as described in The Future of Healthcare) ensuring data is interoperable and accessible 	<ul style="list-style-type: none"> • Informatics leadership representation on the board of every NHS organisation, with chief executives capable of driving the transformation of their organisations and non-executive directors able to support and demand increasing digital maturity over the next five years • Digital capabilities for the health and care workforce and focus on attracting excellent technical expertise and skills, particularly in ‘newer’ digital fields so that our workforce can continue to deliver our technology strategy.”

Principles set out in the NHS digital data security and protection toolkit

- 1) Understand users, their needs and the context
- 2) Define the outcome and how the technology will contribute to it
- 3) Use data that is in line with appropriate guidelines for the purpose for which it is being used
- 4) Be fair, transparent and accountable about what data is being used
- 5) Make use of open standards
- 6) Be transparent about the limitations of the data used
- 7) Show what type of algorithm is being developed or deployed, the ethical examination of how the data is used, how its performance will be validated and how it will be integrated into health and care provision
- 8) Generate evidence of effectiveness for the intended use and value for money
- 9) Make security integral to the design
- 10) Define the commercial strategy

Findings from The Queen’s Nursing Institute (QNI) survey “Nursing in the digital age: Using technology to support patients in the home” (2018)

- Third of community nurses who responded cited “uploading onto systems that do not talk to each other leading to multiple data entry” as a challenge to working effectively in patients’ homes
- Clinicians, health and care professionals not necessarily being focused on collecting information about what they do

The Topol review (February 2019) “Preparing the workforce to deliver the digital future”

- Patients need to be included as partners and informed about health technologies, with a focus on marginalised and vulnerable groups, to ensure use of technology is equitable and does not reinforce inequalities present in society
- The healthcare workforce needs expertise and guidance to evaluate new technologies
- The adoption of new technologies should enable staff to gain more time to care, promoting deeper interaction with patients

2) Local Position

We aim to deliver services shaped around individual needs and convenience. This strategic direction aligns and contributes to local and national drivers:-

- BHT strategic priorities: **quality, people and money**
- The Buckinghamshire Integrated Care Partnership (ICP)



- The Berkshire, Oxfordshire and Buckinghamshire Integrated Care System (BOB ICS) Strategy
- Buckinghamshire move to single unitary council on 1st April 2020
- Local Health Care Record Exemplar (LHCRE)

3) The Trust

Making best use of available and emerging technologies is critical to the delivery of our strategic priorities; quality, people and money. These technologies enable delivery of our corporate objectives and strategies summarised below: -

Corporate Objectives

<p><i>Continue to improve our culture:</i></p> <ul style="list-style-type: none"> • Listening to the patient voice • An organisation that learns • Culture of quality improvement • Making it easier to get things done • Clinically-led financial plan 	<p><i>Implement new workforce models:</i></p> <ul style="list-style-type: none"> • Innovate with new models of care and/or staffing to tackle gaps in workforce • Make BHT a great place to work • Develop teams, talent and an inclusive workforce 	<p><i>Tackle inequalities and variation:</i></p> <ul style="list-style-type: none"> • Build new community partnerships • Get It Right First Time and reduce clinical variation • Modernise outpatient services • Embed use of accurate data across the Trust
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Trust Strategies

<p><i>Quality</i></p> <ul style="list-style-type: none"> • Safer integrated care closer to home • Better observations compliance Safer, efficient nursing rotas to match skill mix to patient acuity • Increased patient safety, compliance and decision support tools 	<p><i>Workforce:</i></p> <ul style="list-style-type: none"> • Agile highly skilled and engaged workforce • Build a great place to work for now and in the future • Able to access the systems they need from the most suitable location • Effective education, training and learning • Improved workforce planning and performance management 	<p><i>Estates:</i></p> <ul style="list-style-type: none"> • Support changing working practices • Increase flexibility of how physical space is used • Secure access from anywhere, anytime • E-meetings and flexible workspaces • Reduce cost and free up time
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4) Consultation

This strategy has been developed through consultation with key stakeholders and staff to ensure they align with the Trust’s clinical and business needs:

- Executive Management Committee – October, November 2018
- Trust Board away day – December 2018

- Public Trust Board meeting – February 2019
- ICP – November 2018
- Various meetings to ensure they align with Trust strategies e.g. Clinical, Workforce, Estates
- Liaison with clinical CIOs
- Patient Engagement Group

5) The Trust - current position - Financing

Our infrastructure (networks, telephony and hardware) is in need of significant investment. Whilst there is strong commitment from the Trust leadership who fully understand the benefits of moving to a fully digital platform the financial investment needed to grow and maintain our technical platforms and solutions is a major challenge.

Historically the Trust has not received the same level of investment that others have received through NHS England and other bodies. Whilst this position has reversed recently, and we have received funding support from NHS England, there is still a significant shortfall in the amount of funding required to ensure our infrastructure is fit for purpose in the digital world today.

We will continue to robustly pursue external funding routes to help support the significant financial investment required to bring our infrastructure and digital solutions up to date, maintain and grow them.

- Delivery of this strategy will increase the BHT digital maturity scores (set out on following page) and which are assessed against BOB ICS (January 2019)

DMA	Readiness					Capabilities 1				Capabilities 2				Infrastructure	
	Strategic Alignment	Leadership	Resourcing	Governance	IG	Medicines management and optimisation	Orders & results management	Records assessments and plans	Transfers of care	Asset and resource optimisation	Decision Support	Remote & assistive care	Clinical & Bus Intelligence	standards	Enabling infrastructure
Trust	2018 %	%	%	%	%	%	%	%	%	%	%	%	%	%	%
BHT	70	70	55	70	58	21	52	31	58	29	5	40	68	54	31
OUH	85	91	90	75	83	96	88	64	92	75	75	60	64	96	81
OH	90	91	90	92	88	11	27	55	53	32	35	67	70	42	83
RBH	90	91	85	83	68	25	83	48	68	55	43	35	57	60	72
BHFT	100	91	95	100	90	37	45	68	54	57	11	68	70	58	83
SCAS	75	84	80	79	75	35	55	67	90	75	58	0	90	77	81

Key

- Green - good progress in delivering capabilities (since when)
- Blue - some progress made
- Red - further progress required

The capability and capacity needed now – not just for transformation but for day-to-day operations – needs to be addressed. This strategy addresses our current weaknesses while building on our strengths. We are growing the skills and capabilities currently held by several dedicated ICT individuals to ensure appropriate resourcing of our operations/programmes. We are clear there is a lot to do, but we are ambitious, clear on our direction and see ICT as the key enabler to delivering on our ambition to be one of the most technologically enabled and digitally advanced Trust’s nationally.

In addition to the initial funding a rolling investment programme is required to deliver the on-going refresh required.

We have growing support from clinical, health and care professionals, are growing our digital faculty and our people are keen to maximise the benefits that moving to digital can bring.

Alongside the need to have a strong central technical and customer focussed resource is a digital workforce, confident and well trained using digital tools at work in the same way as they use their smartphone or mobile apps at home.

As well as the technical resources (networking, telephony, server, and programme management) we will put in place a specialist team of report developers, apps and website developers and integration specialists to serve up data across the ICP. We will deliver this through upskilling existing information analysts and to build a central resource which is available across Buckinghamshire.

6) The Issues address by this Strategy

Current Position	Solution
<p>Infrastructure (voice and data networks, hardware). A large proportion of existing infrastructure requires replacement, is at the end of life, and/or is not compatible with modern digital systems</p>	<p>Align with our public sector partners to design, build and deliver a single resilient, highly available set of systems supported and continually developed by a single Bucks ICT, Digital and Business Intelligence Department across Buckinghamshire to enable truly integrated systems across all public services in Bucks</p>
<p>Cybersecurity. While patching of devices is in place it requires more automation. There are limited resources within the Technology team – increased downtime during updates and lack of progress in other areas. The age of the infrastructure makes automation of patching not fully effective.</p>	<p>The infrastructure and ICT, Digital and Business Intelligence changes delivered by this strategy will make possible robust cyber security practices</p>
<p>Patients are not yet our partners - systems are not designed around patient need</p>	<p>A Single Digital Front Door for Buckinghamshire, resulting in</p> <ul style="list-style-type: none"> • services shaped around individual needs • users asked to enter personal details only once <p>information available across all of Buckinghamshire Public Services</p>
<p>Workforce. People in all parts of the organisation are entering data</p>	<p>Develop the Digital Workforce</p> <ul style="list-style-type: none"> • design all new solutions in partnership

<p>multiple times across multiple systems or resorting to paper-based workarounds because systems are slow</p>	<ul style="list-style-type: none"> • develop digital skills program (training, self-help, education) • increase the number of clinical information officers from all professions <p>digital culture embedded in BHT</p>
<p>Fragmented view of demand Information about demand for health and care services is currently fragmented across the Trust and the ICP. There is no single view of patient flow, home to hospital to home Services are working in silos rather than across the System as a result.</p>	<p>Invigorating Information- Breaking down silos</p> <ul style="list-style-type: none"> • real time dashboards showing at-a-glance understanding of the position at any one time. • modelling and analytics -delivering a single version of the truth (services & population) • information which is reliable and robust gives confidence to act and make decisions.

The five year programme presented on the next page is a summary of the key work programmes required to build our digital ambitions. We will work closely across the ICP to put in place joint resources so we maximise the opportunities to efficiently resource our ICT teams and programmes.

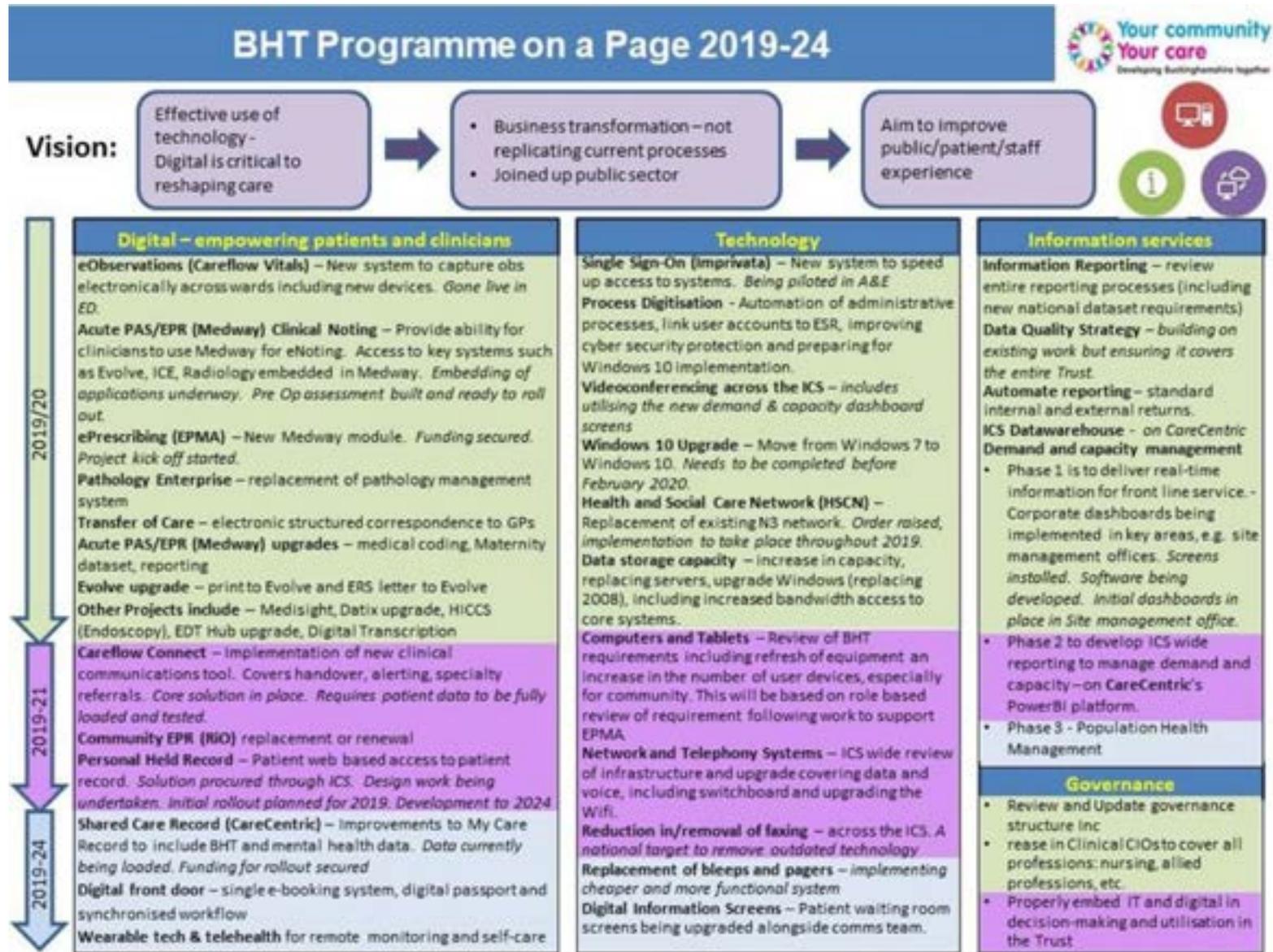
There are a number of critical infrastructure projects which are required to deliver on statutory requirements and to ensure stability of our ICT applications and access.

These include:-

- the move to Windows 10
- replacement of legacy servers and operating system (end of life and not supported so poses a security and stability risk)
- new voice and data network with WIFI, upgraded telephony, switchboard and bleeps.

To deliver these critical projects it is estimated that £16 million of capital funding is required supported by the appropriate on-going support and maintenance costs. Each project will be presented through a business case which will set out the return on investment, productivity gains and improved patient experience to be delivered. We will prioritise the business cases so they can be considered alongside the many competing demands of the Trust and the financial challenge it faces. Given the capital constraints in 2019/20 all avenues including external funding are being explored. All ICT projects will be presented on an 'invest to save' basis.

We will need to continue to seek external support and funding to support these essential programmes to meet the requirement to accelerate our digital ambitions.



Pillar 1 - Technology

Transforming the way, we deliver safe and compassionate care through effective use of technology

This Chapter focusses on the ICT tools and systems required to transform way we conduct business through the effective use of technology. It is an ambitious programme and there are major challenges – funding, resources, managing supplier performance and mostly importantly the cultural change required to fully exploit our technology assets.

Approach

- We will seek to meet funding challenge by constantly looking for new ways of funding and building programmes on an ‘invest to save’ basis where the payback is no longer than 3 years
- We are risk aware, especially in relation to the significant risk presented by continually evolving and ever-present cybersecurity threats
- We are taking a “people-led” approach in that while Technology is concerned with, hardware, software, telephony, data communications and the various systems that sit on those networks, everything starts from the position of the patient and our people providing care to them.

Overall aim is to “automate where possible”, to give back to clinicians the time currently lost to patient care through looking for information, waiting for records to be updated. Our aim is to reduce silo working and move to a more joined up approach through the effective use of technology.

1) Benefits

<p>Organisation</p> <ul style="list-style-type: none"> • Flexible, fast and highly available ICT environment which shapes and flexes around business need. • Strong return on investment - increased capacity and time release. 	<p>Workforce</p> <ul style="list-style-type: none"> • Integrated digital tools at the point of care • Real-time, accurate and complete integrated care record • More easily able to develop and share care plans across health and social care • Easy access to decision support tools to improve patient safety and quality of care • Access best practice guidance to reduce clinical variation and improve outcomes
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2) Delivery

Technology is split in two main parts:

- Infrastructure
- Organisational

2.1) Infrastructure

The current infrastructure is out dated and unable to support the speedy, secure access expected and required by our people and our patients. Four core areas are significant:

- i. Voice and data
- ii. Cybersecurity
- iii. Integration and automation
- iv. Hardware

i) Voice and Data

The voice and data networks and telephony systems are due for replacement and do not deliver the requirements for our patients or people, consequently costly manual systems exist. The Trust has seen a strong return on its original ICT investment it now needs high speed networks and communication tools which support the need for an agile workforce and a changing estates landscape.

Our digital ambitions can only be realised once the limitations of our infrastructure are removed. Implementation of a Buckinghamshire wide and local area network, high speed WiFi and single integrated telephony infrastructure are key building blocks in this area. Other related solutions to support mobile and flexible working will be a single unified communications and video conferencing system across Buckinghamshire to more easily bring people and expertise together not only across the Trust but across all public services in Buckinghamshire.

ii. Cybersecurity

We will increase the organisational maturity of the Trust's cybersecurity position and resilience in line with best practice. Our aim is to achieve mandatory Cyber Essential Plus accreditation by 2021 and ensure that our network and information systems remain compliant and adhere to best practice. Our cyber security arrangements have been reviewed and a programme of further development in this growing area is underway and forms part of our planned investment.

We will automate our patching and updating to release technical time to develop and maintain the system. This automation needs to be in place prior to the Windows 10 deployment.

Other tools to be implemented: -

- Automate starters, movers and leavers
- Granular management for Active Directory, password management,
- Improved diagnostic tools
- Cyber Security awareness training, which should be mandatory for all, including the board
- Live awareness of patching status and live cyber threat analysis

iii. Integration and Automation

Automating non-value adding parts of processes will free up staff time. We will introduce technology in areas such as pharmacy cabinets and wards prescription. For example, the person needing access to the cabinet will have immediate access – saving time and access to cabinets will be tracked and audited – improving safety. Information about access captured as a by-product of the activity, rather than a separate activity. This is just one example of where we will use technology to automate to reduce waste and duplication and enable our clinicians to spend more time with our patients.

There are many hundreds of systems in use across Buckinghamshire health and local government services, and for them all to be able to talk to each other is not a realistic ambition or good return on investment. We intend to use NHS and industry-standard integration engines to deliver automation.

iv. Hardware

A major programme to refresh our servers will be undertaken to deliver on our ambition to have responsive, highly available systems which support the new ways of working being introduced and to ensure we remain legally compliant. We will move to Windows 10 across all devices. For individuals our approach to procuring personal devices reflects roles and functions to ensure the right tools are available at the right time for our entire workforce. Our device strategy is no longer a “one size fits all” but one which looks at the functionality our people require to deliver high-quality care. We have undertaken role and functional profiling and reviewed our mobile and data arrangements to deliver on the priority of enabling updating of information in real time, from anywhere, anytime.

We will provide devices that are easy to use, flexible, reliable and appropriate connected to modern, integrated systems that improve patient care, outcomes and safety in an efficient and effective way.

2.2) Organisational

Overall our aim is to drive down costs through improved procurement of contracts and reducing non-productive time currently spent accessing multiple systems and travelling between sites (cost and time efficiency). The following projects are an example of some of the work will undertake to release capacity and reduce cost: -

i. *Single sign-on*

This will consolidate individual account logins to improve access to applications without having to re-enter credentials. It also supports our move away from dependency on physical locations to allow updating anywhere, anytime. It will be a significant cultural change, some people will find it liberating, others will not. We will support our workforce to transition to this new way of working through education/training and working with our colleagues in HR to support the transformational change required.

ii. *Real time staff rostering*

We will deliver systems enabling real time staff rostering to increase efficiency and ensure we have the right staff in the right place, at the right time, to deliver

safe and compassionate levels of care and more responsive to demand. This will allow us to match skill mix to patient acuity and co-design with staff.

iii. *Reduced duplication*

Improved integration - co-designed with staff – will enable information to be automatically pulled from different systems and presented as one combined record to support the full transition away from manual records.

There is a need to tackle some large-scale document back-scanning as well as putting in place new working practices to ensure we do not build up paper records again. Capacity will be released, and accuracy improved as all our records are fully electronic, integrated and updated at the point of care.

iv. *Live operations centre*

Clear, reliable and up-to-the-minute picture of patient flow is critical to efficient operations. We will deliver a live operations centre, enabling real time information to be shared across the Trust and ICP so that flow and capacity across all areas is seen and managed in real time.

Digital tools supported by robust infrastructure enable us to move to standardisation and the resultant benefits of clear accountability and control and reduced risk.

v. *Skills development – the digital workforce*

We will set out a skills development programme (training, self-help and education) is in place to support our workforce to gain and update their skills so they can exploit the benefits of new ways of working and be partners in their design.

- Programme (training, self-help and education) in place to support our workforce to gain and update their skills to exploit new ways of working.
- Chief Clinical Information Officer(s) (CCIO) continue to lead the transformation of clinical practice to accompany the implementation of the digital agenda
- Supported by a faculty of digital clinical leads who will be both leaders and “end users” of digital transformational change in their own clinical areas.

3) **Summary**

Technology is the key enabler for the digital tools and smart use of information necessary to deliver:

- Safer integrated care closer to home
- Complete patient-centred health record accessible where and when it is required
- Safer and more effective handover of patient care
- Better observations compliance, national early warning scores (NEWS) and safer prescribing of medications
- Safe, efficient rotas to match skill mix to patient acuity
- Change working practices to improve choice and increase flexibility for both patients and our workforce through reviewing our processes and business change
- Improved workforce planning and performance management to ensure the most effective use of resources
- Education, training and learning

4) **Project Summary**

Theme	Project
Voice and data	<ul style="list-style-type: none"> • Single voice/data network and high speed WIFI across Buckinghamshire • New mobile voice and data contract • Telephony – single consistent system across Buckinghamshire to include physical telephony in wards, theatres, clinics, unified communications contact centre, switchboard, bleeps and mobile devices • Video conferencing
Cybersecurity	Cyber security survey commission from NHS Digital which will set out requirements to achieve accreditation to Cyber Essentials Plus by 2021 and outline what other budget, tools and resource will be required
Integration and Automation	Integration and automation strategy developed in line with other Buckinghamshire public services
Hardware	<ul style="list-style-type: none"> • Device replacement (individual and function, i.e., on Wards and clinics) using Windows 10 • Server upgrade programme/ Windows Server OS Upgrade to 2016 • Improved monitoring system for systems including network/server performance • Asset and contract management tools
Organisational	<ul style="list-style-type: none"> • Single sign on • Real time staff rostering • Reduced duplication • Demand, capacity and modelling - live operations centre (virtual and physical) • Redesign of business processes and delivery of standardised workflows • Building the Digital Workforce • Review of corporate applications – HR, finance, etc

Pillar 2 – Digital

Shaping services around individual need and convenience

Our digital priorities both at the Trust and across the ICP, are designed so that patients equally benefit from our investment in technology and help to address health inequalities. Working with patients and staff, our digital solutions will be designed around individual need, convenience and enable patients to better manage their health. We will re-design our clinics, the way results are reported, and all points of access from the perspective of our patients, and shape services around their convenience and choice as far as possible.

Patients won't be passive recipients of good advice and messages – digital tools will enable active self-management, and participation in shaping how services are delivered. People managing long term conditions will be able to submit their own data and benefit from remote monitoring through wearable technology and online resources, removing the need for frequent clinic attendances.

Visiting a clinic for pre-op requirements or for a consultation with a specialist will not always be required: patients will have the option of a consultation over skype, facetime or other secure digital service.

Our digital ambitions are shaped around three key themes:

- 1) Treating patients as our partners, who are well informed, help design our customer journeys and shape health technologies with a clear focus on hard to reach groups, those with protected characteristics for equitable delivery and not to increase inequalities.
- 2) Supporting our people to fully exploit the digital tools in their day to day work and to equip them to evaluate and propose new technologies with confidence
- 3) New ways of working deployed to increase the time to care, promoting deeper interaction with patients

We are taking a mobile first, device agnostic approach so that the same services are available from phones, tablets, laptops and assistive technologies. We will have less reliance on proprietary services and provide tools that work just as well as the ones we use at home. We will comply with and recognise the importance of the ten data security standards set out in the digital data security and protection toolkit (NHS Digital, 2018).

The objective is to operate digitally at the point of care, taking paper out of the system, reduce duplication and giving access to a shared care record.

We will facilitate professionals across all disciplines to view a real time, accurate and complete integrated digital care record, which can be developed and shared across health and social care. CareCentric has been identified as the best strategic fit to deliver this, and to support access to best practice guidance to reduce clinical variation and improve outcomes for people.

Patients	<ul style="list-style-type: none"> • Partnering with our patients will increase engagement in service design, increase take-up and generate population level data which will move Buckinghamshire to “push” services ahead of demand, reduce risk of deterioration and need for more complex services. • Services designed around patient need and convenience will provide more choice of access and enable patients (our partners)
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	<p>to work with us to reduce the overheads of physical activities and records. We will co-design our solutions which gives us more confidence of sustained take up as well as exploiting maturing tools in the area of detection, prevention and diagnosis through the use of wearables, implantable devices, and telemetry to move to a virtual delivery of care.</p> <ul style="list-style-type: none"> • Patients’ actively managing information about themselves that they want professionals who see them to know. • Will need to tell their story only once; reduces the need to repeatedly give their full history every time they access a service • Have an electronic patient record, the single digital front door will support seamless movement of people through the system, from home to community health or hospital and out again • Benefit from increased convenience and reduced costs through less travelling to appointments
Workforce	<ul style="list-style-type: none"> • Clinicians will have access up to date/real time information about patients who are able to update their own care record, and include own information to help clinicians understand ‘what is normal for me, the patient’ • All partners will have access to relevant information held by other local health and social care organisations • Health and care professionals will be able to see who else is involved in the patient’s immediate care to ensure a holistic and seamless approach to care delivery • Decision support tools supporting, for example, prescribing will contribute to reduced error • Routine use of assistive technologies (smart forms, voice recognition) to reduce administrative time • Ability to treat more patients through efficiencies in appointment technologies, reduced inter-site travel, flexible hours of work as clinicians are no longer reliant on administration OP staff • We will have more responsive management of variations through the ability to review and respond to real time individual patient data submitted routinely by the patient; a move from checks scheduled by the calendar, to checks when something requires examination; • Technologies which enable clinicians to monitor patients remotely, will reduce the need for follow up consultation • There will be less need for physical consultations in specific settings where that is appropriate
Organisation	<ul style="list-style-type: none"> • Each person’s journey from first contact will be fully visible and the data will be available for analysis and continuous process improvement, leading to improved demand management, forecasting, skills deployment, and cost per contact. • The Trust will be enabled to make better use of its estates through increased use of virtual clinics shaped around patient convenience and choice, and through reducing dependency on

	<p>paper records.</p> <ul style="list-style-type: none"> • Our single digital front door - “single version of the truth” – will give us transparency of demand, and the ability to direct people to the most appropriate services, first time every time; • Improved digital engagement - more responsive dimension to patient consultation; • A single view of bookings and appointments will enable analysis of individual patient service clustering • Services pushed to patients ahead of demand will reduce deterioration and increased demand for complex services; • Increased virtual consultations and remote monitoring will enable better use of our resources; • We will have a clearer picture of why people come to the front door • We will be able to develop self-help materials and tools, supporting people to actively manage their health and care, • Single platform for digital participation.
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1) Delivery

Delivery of our digital objectives is split into three components:

- 1) Patients as our partners
- 2) Single Digital Front Door
- 3) Digital Workforce

1)	Patients as our Partners	<ul style="list-style-type: none"> • Part of the co-design, testing and promotion • Help to identify changes which improve their experience, reduce their costs and time • Be part of continuous improvement programme flexing as needs and requirements change.
2)	Single Digital Front Door	<ul style="list-style-type: none"> • Co-designed with residents, this will provide a single point of entry to health, care and wider public services for people in Buckinghamshire. <p>People will be: -</p> <ul style="list-style-type: none"> • able to record personal details once and use them across multiple public services and; • a single e-system across Buckinghamshire public services to fill forms, make payments or access appointments); • A Buckinghamshire single “public services passport”, will hold details of all the person’s transactions and records, including their personal digital health record,

		<p>all electronic correspondence received from health and local government. The owner will be able to add information to their “passport” about ‘me as a person’ not necessarily recorded as part of standard information but relevant to how the person wishes to be viewed or treated. This might include phobias, speech/hearing disability, or circumstances such as a recent bereavement;</p> <ul style="list-style-type: none"> • Supportive health information will be “pushed” to individuals giving them easy access to relevant and appropriate information and services without having to go looking for them; • There will be access to remote monitoring for preventative and self-care management, through wearable tech and telehealth tools to capture biometrics such as heart monitoring and a • choice of consultation types, including virtual and remote, using the technology of choice; • Those unable to use digital methods of service access or keep electronic records themselves, will benefit from those same systems being used on their behalf by people they contact by telephone or approach face to face, or by someone they nominate to act for them. • Those using our services but living outside Buckinghamshire will receive the same level of access and ability to store their information centrally in their personal passport.
3)	Digital workforce	<ul style="list-style-type: none"> • Staff will be equipped with appropriate level of digital literacy to implement technology in their day to day roles and enhance patient care. • Digital access will be provided at the bedside so that updating is close to the patient and all professionals able view real time, accurate and complete integrated digital care record (health and social care). They will have easy access to multiple data sets, i.e., prescribing - decision support tools, linked to allergy information and alerts to avoid incorrect and adverse prescribing. • Intelligent workflow will deliver properly synchronised tests and consultations; non-clashing appointments and trigger, automatic actions in response to information updates supporting safer prescribing and medicines administration;

2) **Project Summary**

Core Area	Project
Patients as our partners	<ul style="list-style-type: none"> • A programme to fully engage with all resident and business groups across Buckinghamshire to co-design

	and prioritise digital services
Single Digital Front Door	<ul style="list-style-type: none"> • Build the business case and full detailed specification which meets not only health needs but also those of the new unitary council from 1st April 2020. • Design the approach that ensures the single digital front door is co-designed with residents, providing a single point of entry to health, care and wider public services for people in Buckinghamshire underpinned by single account, e-booking, appointment, payment and repository (public services passport) for all correspondence and transactions and where supportive health information can be “pushed” to individuals giving them easy access to relevant information and services without having to go looking for them; • Remote monitoring for preventative and self-care management, through wearable tech and telehealth tools to capture biometrics such as heart monitoring; • Virtual consultations using the technology of choice; • Access to the digital care record at the bedside.
Digital Workforce	A programme to ensure digital competencies form part of route job requirements for new entrants and put in place training/education for all workforce to develop appropriate level of digital literacy to implement technology in their day to day roles and enhance patient care.
Technical	Patient held record programme
	eObservations (Careflow Vitals) ePrescribing (EPMA) – Medway Careflow Connect - clinical communications across the ICP My Care Record - CareCentric
	Acute PAS/EPR (Medway) Clinical Noting
	Acute PAS/EPR (Medway) upgrades – medical coding, Maternity dataset, reporting BlueSpier and ED, BI platform
	Transfer of Care - electronic structured correspondence to GPs
	Pathology Enterprise - replacement of pathology management system
	Evolve (document management) upgrade Evolve e-noting to complete paperless outpatient programme ITU and Anaesthetic EPR solutions and medical examiner data base

<p>Upgrade/review or development of existing applications to ensure they are fit for the digital hospital</p>	<p>Medway – patient administration system Medway – clinical noting Careflow Vitals - e-observations EPMA - digital prescribing Evolve - document management Review of Rio – Community Services Careflow Connect - clinical communications across the ICP My Care Record - CareCentric Medisight – ophthalmology Professional to professional and patient to professional telehealth Automation of non-value-added processes through teletracking Consultant Connect Datix upgrade</p>
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Pillar 3 – Information

Access to accurate, relevant and timely data enabling the Trust to make decisions based on business intelligence to drive its three strategic priorities of quality, people and money

Our ambition is to make information a central and trusted asset, providing the means to move the Trust from a position where we react to what the data tells us about yesterday to one where we can use our information assets proactively to model different tomorrows, prepare for and predict our resource needs – even controlling the demand.

Approach

To focus on outcomes and capability, making the most of what we’ve got already by mapping our information assets, identifying and removing duplication, and filling gaps. Our aim is to capture and store data just once, by the person who is creating the information, as close to the time of its creation as possible, making it available in usable form as quickly as possible. Collecting information is not an end and should be as easy as possible. Our aim is to enable staff to capture all health and care information digitally at the point of care, improve the patient and staff experience, optimise resources, and identify opportunities for efficiencies and cost-savings.

1) Benefits

<p>Patients</p>	<p>We will see more efficient use of resources and less waiting by patients between steps in the care process or between referrals from one team to another.</p> <ul style="list-style-type: none"> • Intelligent use of data enabling us to push services to patients - shaped around their individual needs; • The ability to move more easily through the different parts of the system, as improved patient tracking allows the right skills and resources to be available at the right time to achieve more efficient use of resources, less waiting by patients between steps in the care process or between referrals from one team to another; • Fewer patients will experience delays in leaving hospital, or delays in A&E – due to better use of resources; • Our improved ability to forecast demand will mean we are better equipped to meet and control peaks; patient experience is much improved; • A complete and up to date picture of their health (which both the patient and the clinician see) and care history available at all points of service access, so that the most appropriate service can be provided at the first contact; the person gets what they need much more quickly;
<p>Workforce</p>	<p>Information will be available to health care professionals where and when they want it, in a form that supports inquiry, audit and further analysis, and better manage variations in care and outcomes.</p> <ul style="list-style-type: none"> • Clinicians will have fingertip access to information, through the right tools and be equipped with the necessary knowledge and skills to do so.

	<ul style="list-style-type: none"> • Clinicians will have easy access to real time, accurate, data to support evidence-based decision making which is fresh, complete and reliable, and available wherever and whenever the clinician needs it; • Alerting and risk analysis based on the whole patient record; • Improvements to patient flow through the ability to understand and control demand across the whole clinical and care environment; • E-rostering will support the SAFER care system, using demand forecasting to mix internal skills with temporary staffing; • Easy access to referral decision trees, referral templates and direct access to investigations that reflect evidence-based best practice and universal access to 'one click away' specialist advice and guidance; • Clinicians and care professionals will spend less time trying to find the information they need to make decisions.
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2) Organisation and ICP

Demand

- A whole-system view of demand in real time, supporting pro-active decision-making and rostering.
- Our improved information assets will support predictive analytics, risk stratification and knowledge management so that we spot and investigate emerging trends before issues emerge, and take steps to avoid problems, and better manage variations in care and outcomes.

Capacity and patient tracking

- A clear understanding of capacity across the system, in real time, including community, intermediate and social care, supporting problem avoidance and patient flow;
- Knowledge and understanding build-up over times of the systematic symptoms that should ring alarm bells and trigger action, supporting the OPEL process and managing potential escalations before they occur. This will enable the development of appropriate alerts, alarms and trigger points.

Data collection

- Information will be available to health care professionals where and when they want it, in a form that supports inquiry, audit and further analysis. Making the information useful will in turn motivate everyone to maximise its quality.
- Significantly improved Information Governance, data quality, use and security assurance.

Real time access to information

- Increased capability to use proactive and agile analytics to design and deliver innovative information services that accelerate the use of data and information to drive improvements in health and care;
- A single view of the ICP information, enabling service transformation;
- Ability to use real time system data to spot problems developing and take proactive steps to avoid them being realised.
- The right information presented to the right person at the right time;

Resources matched to demand

- Reduced costs through “more proactive and targeted care, which allows providers to intervene earlier to keep people well” (KPMG, 2016); more planned care leading to less urgent care;
- Staffing linked to patient acuity, using real time information to enable e-rostering, matching resource to demand.

Prevention

- Better health and wellbeing in our population by enhancing the ability of our providers, commissioners, national bodies and researchers to use data to make better decisions to improve prevention and healthcare provision. This extends to making information available to our residents, in order that they may take more control of their health and wellbeing;
- Improved support to prevention activity through the ability to link population health analytics to patients exhibiting specific characteristics;
- An information asset of use to all public services in Buckinghamshire, delivering population-level data, analysis of which can allow providers not just of health and care services but all public services, to identify actions and interventions to keep people safe and well, instead of treating them when they are not.

Performance and quality

- Improvements in patient safety and experience from better, proactively, targeted services;
- Information management will promote opportunities to control increasing costs of clinical care - for example, patient tracking will give us insight into how beds can be used more effectively than they are at present.
- As use of information-driven alerts and alarms in patient records increases, care will improve because of increased knowledge based, timely and efficient clinical interventions. In turn this should reduce inappropriate care, reduce length of stay, unnecessary non-elective admissions, readmissions, delayed transfers of care etc.

3) Delivery

There are four core areas covered: -

- 1) Population level - using data to model, predict, and manage, future need;
- 2) Service level - understand demand now and forecast future demand and shape our resources in the most efficient way - matching staff rostering to patient acuity;
- 3) Activity level - monitoring what is happening in real time within our services, so that we can drive efficiencies and become more proactive in demand management;

- 4) Patient level - learning from analysis of our data – such as the identification of disease predictors - available and usable to front line staff and patients.

We will also review data and information about how we work and what we work with.

Projects

Core Area	Key Deliverables
Population	Creation of one data resource for all – fed by all systems;
Service	Delivery of real time information - via dashboards and other tools, across the ICP
	Automated standard and bespoke analysis reporting for the routine questions.
	Automated statistical reporting required for national, regional and system wide purposes to reduce the administrative burden across the system
	Population health analytics to patients linked to patients to give insight to our demand
	Review of our capacity within Informatics to deliver on ambitions
	Users have the right tools and knowledge to access and deploy information resources
	All information assets fully mapped and understood
	Data quality improvement programme
	Paperlight – undertake all back scanning and put in place arrangements so that it does not build up again

Deliverables	Benefits
One data resource for all – fed by all systems;	<ul style="list-style-type: none"> Enabling common, joined up, analysis and interpretations. Removing duplicated reporting processes and incomplete analysis.
Real time information - via dashboards and other tools, across the ICP	<ul style="list-style-type: none"> Enabling health and care services are, or should be, managing capacity, demand, and flow. This will allow the development of appropriate alerts, alarms, trigger points, and proactively managed services. This is part of real-time 24/7 patient tracking, which dovetails with the benefits being delivered by the Digital and Technology Strategies.
Automating standard and bespoke analysis reporting for the routine questions.	<ul style="list-style-type: none"> Timely production of reports Reduced demand on information team Focussed analytics support
Automating statistical reporting required for national, regional and system wide purposes to reduce the administrative burden across the system	<ul style="list-style-type: none"> Reduction in time producing returns and reports
Understanding our demand - linking population health analytics to patients	<ul style="list-style-type: none"> If we can understand what drives demand we can manage that demand and match our capacity to deliver the necessary services to that demand. Determining demand, from analysis of our population, will identify what

	capacity we need and what gaps there are in that capacity.
Understanding our capacity	<ul style="list-style-type: none"> • Knowledge of our capacity enables us to manage out capacity and allocate according to demand.
Users provided with the right tools to access information resources	<ul style="list-style-type: none"> • Enabling users to form their own questions and get quick answers. • Reduction in ad-hoc demand to information services

4) Conclusion

This is an ambitious strategy but essential if the Trust is to maximise the benefits and efficiencies that investment and on-going development in technology brings. All the elements are designed to support and underpin the way the Trust and wider ICP conducts its business.

There are major challenges in achieving a successful outcome – funding, resources, supplier performance and mostly importantly the cultural change required to fully exploit our technology assets to provide the full return on investment.

5) Next Steps

We will seek new ways of funding and ensure all programmes are developed on an ‘invest to save’ basis where the payback is no longer than 3 years.

We will build a single team and programme across Buckinghamshire to deliver a single model for public services through the effective use of technology, digital and information

We will engage with our Workforce and patients to ensure the solutions and direction of travel suits their on-going needs and drives improved performance and efficiency

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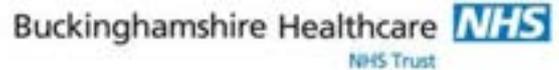
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Agenda item: 19
Enclosure no: TB2019/086



PUBLIC BOARD MEETING
31 July 2019

Details of the Paper

Title	Board Assurance Framework (BAF)
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)

<i>Patient Quality</i>	<i>Financial Performance</i>	<i>Operational Performance</i>	<i>Strategy</i>	<i>Workforce performance</i>	<i>New or elevated risk</i>
<i>Legal</i>	Regulatory/ Compliance	Public Engagement /Reputation	<i>Equality & Diversity</i>	Partnership Working	Informat ion Technol ogy / 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.	<i>Non-Financial Risk:</i> All risks of the Board Assurance Framework
	<i>Financial Risk:</i> 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 <i>(if you need advice on completing this box please contact the Director for Governance)</i>
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Author of paper: Sue Manthorpe

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: 22 July 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.

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 have received regular updates on the relevant BAF risks linked to the corporate objectives they monitor. The Executive Management Committee (EMC) continues to receive both the BAF and Corporate Risk Register monthly.

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 utilises 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,

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 1.3 Culture of quality improvement 1.4 Making it easier 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									

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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. <i>Board Committee with oversight: Quality and Clinical Governance</i>	16	<p>Systematic collection of Friends and Family Test (FFT) information. All our services within a hospital setting are asked to provide this feedback.(EC)</p> <p>National surveys for Inpatient, cancer, A&E, Maternity and CYP monitor patient experience (EC)</p> <p>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)</p> <p>Non-Executive director review of a sample of complaints each month. (IC)</p> <p>Chief Executive Officer and Chief Nurse see every complaint that comes to the organisation. (IC)</p> <p>Themes from FFT and compliments fed back at local level. (IC)</p> <p>Patient story at each public board meeting. (IC)</p> <p>Patient representative on the Quality and Clinical Governance Committee. (IC)</p> <p>Patient Experience Strategy and Implementation Plan. (IC)</p> <p>Patient Experience Group chaired by Associate Chief Nurse for Quality standards and Patient experience, provide patient oversight of implementation of PE strategy (IC)</p>	<p>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)</p> <p>Patient Safety and Quality Group receives progress reports on a bi-monthly basis on the implementation plan. (IA)</p> <p>Summary report from Quality Rounds reported to Patient Safety and Quality Group, Executive Management Committee and Quality and Clinical Governance Committee. (IA)</p> <p>External peer reviews seek patient views as part of the process e.g. CARF, cancer. (EA)</p> <p>Healthwatch oversight of quality including focused reviews. (EA)</p>	Green	<p>Listening to the patient voice is not prioritised within the QSIR methodology</p> <p>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</p>	8 (4x2)	<p>Work with the Quality Improvement team to incorporate listening to the patient voice into QSIR methodology</p> <p>Seek funding for Envoy FFT platform</p>	Chief Nurse
<p>1.2 Develop as a learning organisation (Chief Nurse)</p> <p>Key Focus: The key performance indicators that will used to monitor the progress of this project is the following:</p> <p>One defined purpose that will result in one KPI with the following objectives</p> <ol style="list-style-type: none"> 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. <i>Board Committee with oversight: Strategic Workforce Committee</i>	16	<p>Overarching framework in place setting out a systematic set of interventions (IC)</p> <p>Go Engage programme introduced across the Trust (IC)</p> <p>Quality improvement training rolled out across the Trust (IC)</p> <p>BHT way programme in place for the year (IC)</p>	<p>Minutes from Executive Management Committee. (IA)</p> <p>Reporting of results to EMC and Strategic Workforce Committee. (IA)</p> <p>No. of staff enrolled in Quality Improvement training, internal and external (IA)</p> <p>Records of content and numbers of staff attending BHT Way (IA)</p>	Amber	<p>There needs to be dedicated time and support to review and re-balance quality control, assurance and improvement</p> <p>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.</p>	9 (3x3)	<p>Work with the Quality Improvement team and other stakeholders to ensure successful delivery of this project.</p>	Chief Nurse

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<p>1.3 Culture of quality improvement (Director of Strategy)</p> <p>Key Focus: March 2021 • Implementation of the dosing strategy within BHT to build capability in QI, i.e. number of staff trained in the following courses: <input type="checkbox"/> Practitioners course <input type="checkbox"/> Fundamentals <input type="checkbox"/> Essentials</p> <p>• Number of projects supported by QSIR trained staff – to be 75 by end of March 2020 (This could range from small projects known as ‘Mounds’, to bigger ones – ‘Hills’ and Trust wide programmes – ‘Mountains’)</p>									
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 <i>Board Committee with oversight: Quality and Clinical Governance??</i>	26	Fortnightly monitoring 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 Associate 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 Strategic priorities. Ensuring staff have sufficient time to engage in QI projects. Ensuring QI methodology 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 ‘faculty’ 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 Quality Improvement training, internal and external (IA) Number of projects undertaken 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)					

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BAF 1.3a	<p>There is a risk that the Quality Peer Review process established in June 2018 does not reduce variation in quality.</p> <p><i>Board Committee with oversight: Quality and Clinical Governance</i></p>	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	<p>There is an assurance gap in that we are not yet confident that all the self reviews are done in a consistent way.</p> <p>Variability in the way trends are reviewed at Divisional Quality Boards.</p>	8 (4x2)	<p>Internal audit action plan in place including working to embed the process within Divisions.</p> <p>Commence Clinical Accreditation programme by March 2019 based on the outputs from Quality rounds.</p>	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)	<p>Outputs from the Perfect Ward App (IA)</p> <p>Monthly reports to the Quality and Patient Safety Group and minutes from that meeting. (IA)</p> <p>Quarterly reports to the Quality and Clinical Governance Committee and minutes from that meeting. (IA)</p> <p>Excellent reporting in place and increasing over the past 6 months. (IA)</p>					
BAF 1.4a	<p>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.</p> <p>Risks: Quality - impact on patient experience Financial - link to STF Regulatory</p>	16	<p>IPR and Exception reports monthly Weekly demand and capacity group managing access for RTT, Cancer and diagnostics. (IC)</p> <p>Demand Management Programme to commence with the Buckinghamshire Clinical Commissioning Group Plan for reducing non-elective and elective admissions. (EC)</p> <p>Escalation of all patients within 10 days of a breach to Divisional Directors and Divisional Chairs for cancer pathways. (IC)</p>	<p>Demand and Capacity Group minutes (IA)</p> <p>Operational performance dashboard reported at Divisional, Board and Committee level (IA)</p> <p>Internal audit of performance reporting Service Strategies (IA)</p> <p>Deep dives and performance reviews (IA)</p> <p>Deep dive presentations to Finance and Business Performance Committee (IA)</p>	Green		20 (5x4)	<p>40% reduction in LLOS requirements on 18/18 baseline by March 2020.</p> <p>Detailed work programme through the Urgent Care Recovery Board & A&E delivery board. Unplanned care forecasting tool launched as planned.</p> <p>RTT recovery plan for specific specialities, including outsourcing. Demand management and scheduling between winter and summer and reduce cancer wait time.</p> <p>New Director of Planning and Performance in post.</p> <p>Build capacity in Accident and Emergency.</p>	Chief Operating Officer
			Planned Care Board (CCG led, launched Sept 2016) (EC)	Meeting minutes (EA)					

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	(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)					
BAF 1.5	There is a risk to the organisation of not being financially 'well led' if the cultural approach to finance does not change. Board Committee with oversight: Quality and Clinical Governance Committee	20	Develop a cultural social movement around waste reduction (small change big difference (SCBD)) (IC) Ongoing communication strategy to support SCBD. (IC) Finance department is scrutinising the Purchase Order process (IC) Finance department development plan(IC) Finance department systems upgrade (IC) Enhance financial management skills across the organisation (IC). Development of a new financial management escalation framework (IC)	Project structure in place.(IC) Monthly Steering Group. Quarterly reporting to Finance and Business Performance/EMC. IT Strategy to support financial systems upgrade. New escalation framework in development. Training records for financial management skills.	Red	Social movement not yet developed. Non-adherence to purchase order process. Funding and timeliness of the IT financial systems upgrade. Embedding the new escalation framework. Finance training not yet mandatory for budget holders.	12 (3x4)	The Finance Department has implemented a process to stop payment on any invoice without a purchase order. IT project bids process in place to obtain funding. Identified the source problem as the processing speed of the hardware device; preparing business case. New escalation framework to be embedded across the organisation. Develop a training plan - access to new ledger will be dependant on training compliance.	Medical Director/Director of Finance

People

We will be a great 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 develop teams, talent and an inclusive workforce (Director of Workforce and Organisational Development)

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BAF 2.1	<p>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</p> <p><i>Board Committee with oversight: Strategic Workforce Committee</i></p>	9	<p>6 teams engaged in the Go Engage programme in both June and 8 in December (IC)</p> <p>Survey results as part of Go Engage programme (IC)</p>	<p>Outputs from Go Engage programme reported to Strategic Workforce Committee on a quarterly basis - cohort of 6 pioneer teams (IA)</p>	Amber	Go Engage programme may not have required numbers	6 (2x3)	<p>Separate recruitment plan in place. Actions include: Students final placements to areas that they have expressed an interest in working in</p> <p>Offer letters sent in year 2</p> <p>Close support for students and line managers by recruitment and education teams</p> <p>Retention action plan in place as part of NHSI work</p>	Chief Nurse
			<p>75 Leaders (in 3 cohorts) enrolled in Trust leadership programme during the year (IC)</p>	<p>Cohort numbers reported to SWC (IA)</p> <p>Feedback from cohorts reported to SWC (IA)</p>					
			<p>Trust-wide programme to transform the clinical workforce:</p> <ul style="list-style-type: none"> - Recruitment including career pathways and skills mix (IC) - Education and training, including language training (IC) - Promoting excellence (including health & wellbeing) (IC) <ul style="list-style-type: none"> - Smart working (IC) - Temporary staffing (IC) - Participating in Cohort 4 of NHSI's retention programme (EC) 	<p>Outcomes of actions from the programme, reported to Executive Management Committee and Strategic Workforce Committee (IA)</p> <p>Nurse turnover rate (IA)</p> <p>Nurse vacancy rate (IA)</p> <p>Sickness absence rate (IA)</p>	Amber	Individuals may choose to apply to other employers or choose to leave the Trust for factors outside our control			
	<p>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</p>	20	<p>Minutes of the Workforce Development Committee,</p> <p>Minutes of EMC (IC),</p> <p>Minutes of the Quality Committee (IC)</p>	<p>Service Improvement Training and Development Plan (IA),</p> <p>Communications and Engagement Plan (IA),</p> <p>Action Notes of Service Improvement Taskforce (IA),</p> <p>Monthly Team brief (IA)</p> <p>Quality improvement launch across the Trust at BHT Way in October 2018</p>	Amber	Assurance that rollout has impacted every service, clinical area, acute and community.	12 (3x4)	<p>Ongoing training and communications in the agreed Quality Improvement methodology.</p> <p>Application for the Board to receive training in Leading for Quality submitted in October 2018. Outcome awaited.</p>	Chief Nurse
<p>2.2 Make BHT a great place to work (Pioneering new ways of working) Previous Key Focus:</p> <p>Use apprentices to provide skilled workers for the future</p> <p>60 Level 3 by March 2019</p> <p>60 Level 5 by March 2019</p> <p>20 Level 6 by March 2019</p>									

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BAF 2.2	<p>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.</p> <p><i>Board Committee with oversight: Strategic Workforce Committee</i></p>	12	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)	Amber	Numbers attending relevant 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
			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)					
			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 survey not meeting target			

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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	Current staff survey scores from 2018. WRES Data	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	
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									

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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 Strategy 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 Strategy
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 Amersham 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 Amersham, Thame, Marlow and Buckingham, Engagement Strategy, CCG to provide resources and leadership for engagement procesS	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 Q2), extended from Q1	Director of 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: Quality and Efficiency									
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

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3.3 Modernise outpatient services Key Focus Reduce clinic cancellations (contained in the IPR) Improve clinic slot utilisation by speciality Reduce low value appointments measured through new to follow up ratios Increase alternative practitioner appointments reduction in Consultant led RTT size Reduced attendances due to self-management pathways Increase in the number of non- face to face appointments with the use of technology Productivity opportunity – clinicians diverted to non-outpatient duties by reducing inefficiencies within system.									
BAF 3.3	The risk of not modernising the Trust Out patient Service will affect the Trust's ability to achieve the NHS Long term plan of a 33% reduction in face to face appointments. This will also 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 October 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 speciality and by type and agree outturn/baseline upon which activity needs to be improved – End of April Complete demand and capacity modelling for agreed specialities with the view to expand to wider range of specialities. – End of May Each speciality 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 decisions	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:									

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<p>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</p>									
<p>BAF 4.1a (link to CRR 32)</p>	<p>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</p> <p>(Monitored through Finance and Business Performance Committee, F&BP)</p>	20	<p>Compliance with Standing Orders and Standing Financial Instructions. (IC)</p>	<p>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.)</p>	<p>Amber</p>	<p>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</p>	<p>20 (5x4)</p>	<p>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.</p>	<p>Director of Finance</p>
			<p>Signed Service Level Agreements (EC)</p>	<p>Performance management process against service / contractual specifications both internal and external with Buckinghamshire Clinical Commissioning Group. (IA & EA)</p>					
			<p>Divisional Performance Management process including monitoring, review and actions to address variances on Key Performance Indicators. (IC)</p>	<p>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.</p>					
			<p>Delivery of action plan for Bank and Agency reduction.</p>	<p>Performance against NHS Improvement cap reviewed monthly (IA)</p>					

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 <i>Board Committee with oversight: Finance and Business Performance Committee</i>	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 mitigated 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)					
<p>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 ("WU") across all specialties.</p>									
BAF 4.2a	<p>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.</p> <p>(Monitored through Finance and Business Performance Committee, F&BP)</p>	20	<p>Programme Management Office (PMO) Lead and PMO function in place (IC).</p>	<p>Monthly financial reporting to Board, divisions, EMC, corporate services and NHSI (IA).</p> <p>Transformation Board minutes. (IA)</p> <p>Project Initiation Documents (IA)</p> <p>Quality Impact Assessment process (IA)</p> <p>Planning and documentary evidence of CIPS. (IA)</p> <p>Monitoring of delivery. (IA)</p>	Amber	<p>Further schemes required.</p> <p>All schemes not rated Green or Amber.</p>	20 (5x4)	<p>Continued focus on financial control and accountability at all levels of the organisation.</p> <p>Specific actions to manage risks and deliver mitigating actions.</p>	Director of Finance
			<p>Full governance methodology and process in place for cost improvement plans (IC).</p>	<p>Reports of internal and external audit (EA).</p>					
			<p>Performance management framework for divisions and corporate services (IC).</p>	<p>Financial control totals agreed for divisions and corporate services.</p> <p>Monthly performance meetings by exception and quarterly monitoring review process and action plans.</p>					

Reference	Description of risk to achieving objective	Risk score mitigated 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 additional 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
HORIZON SCANNING									

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

		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 breach of guidance/ statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating Critical report	Multiple breaches in statutory duty Prosecution Complete systems change required 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	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently
	<0.1 %	<0.1 – 1%	1 – 10%	10 – 50%	>50%

Appendix A continued

Risk Scoring Matrix

Likelihood	Severity				
	Insignificant	Minor	Moderate	Major	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			
		<p>A Received within the last 12 months and minimal organisational change in this areas since assessment</p> <p>B Received within the last 12 months and significant organisational change in this areas since assessment</p> <p>C Greater than 12 months old and minimal organisational change in this areas since assessment</p> <p>D Greater than 12 months old significant organisational change in this areas since assessment</p>	

Table 2
How relevant is the assurance?

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

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.

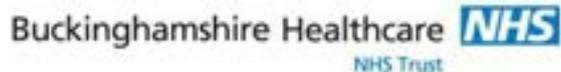
Internal	Score	Independent 3 rd party	Score
Performance scorecard	2	External audit	1
Training records	2	Internal audit	1
Satisfaction surveys	2	Royal College inspections	1
Infection control audits	2	NHSLA assessments	1
Minutes of meetings	2	Health & Safety Exec inspections	1
	2	National patient/staff 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: 20
 Enclosure no: TB2019087



**Public Trust Board
 31 July 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)

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

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.	<i>Non-Financial Risk:</i> There is a risk to the governance process of joint working if an appropriate methodology is not in place.
	<i>Financial Risk:</i> 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
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Author of paper Sue Manthorpe
Presenter of Paper: Sue Manthorpe
Other committees / groups where this paper / item has been considered: Quality Committee and EMC
Date of Paper: 22/07/19

Agenda item: 20
Enclosure no: TB2019087

1. Purpose

The purpose of this report is to inform the Board of the top corporate 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 trust.

2. Background

The CRR has been reviewed at Divisional level and by the Executive Management team. The following risks have been regraded following completion of mitigations actions. These will now be removed from the corporate risk register and will continue to be monitored at divisional level.

CRR 63: The Accessible Information System (AIS) and the education and training of staff has improved the information given to patients. This has improved patient experience and understanding and reduced the risk. This risk will be removed from the corporate risk register and will continue to be monitored at the divisional level.

CRR 81: training has been completed on the use of e-prescribing for Urology nurses reducing the risk for patients and staff in the management of medications.

CRR 87: the devices for staff safety are now in place which allows mitigation of the risk

CRR103: The risk actions have been reviewed and the 62 day target has is being achieved consistently.

CRR 104: The risk is being managed and monitored. Audit results are 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.

3. Recommendation

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

Corporate Risk Register reference	Divisional Risk Register reference	Division	Date added to CRR	Trust Objective	Description of risk	Unmitigated risk score	Key controls	Risk Score			Gaps in controls	Actions to address risk, including target completion dates (bold) for each action.	Target overall completion date	Lead	Predicted residual score		
								C	L	C x L					C	L	C x L
CRR 10	HR 4/14	Trust	24/11/2014	Implement new workforce models	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)	<ul style="list-style-type: none"> Performance management of Recruitment Service - HR & Workforce Group. Performance management of Divisions and Corporate Services Performance management of NHSF 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. Detailed recruitment plan. Active retention strategy (recognised nationally). Monitored through Strategic Workforce Committee. 	5	4	20	<ul style="list-style-type: none"> 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 IELTS and the time it takes to register with the NMC. 	<ul style="list-style-type: none"> Trust-wide recruitment plans in place - this includes, local, national and international recruitment of nurses from Portugal (from Erasmus students) and the 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. 	30/03/2020	Director of Workforce and Organisational Development			10
CRR 27A	S195, PS117	Surgery	27/07/2014	Estate strategy	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)	<ul style="list-style-type: none"> Electrical installations are checked in accordance with the Electricity at Work regulations. Regular maintenance checks. BRT 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. 	4	4	16	<ul style="list-style-type: none"> £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. 	<ul style="list-style-type: none"> The Estates ten year strategy has been approved by the Board. The one public estate funding initiative due to be completed in October 2019. The High Voltage works have to be completed before the Low Voltage works can commence, ensuring High Voltage supply security. The Low Voltage project is likely to be moved into the financial year 2020/2021 with the current Trust financial challenges on capital being at a very challenging position. The local works conducted over the last six months have focussed on improving the electrical safety in the theatres and the working environment for staff and patients, greatly improving the overall environment within theatres. Regular monthly safety check audits completed with the Estates team and the Theatres management team 	Project will run for 60 weeks from the start date, which will now not be before March 2020. The end date is, therefore, likely to be June 2021.	Commercial Director			4
CRR 27B	PS153	Property Services	20/10/2017	Estate strategy	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.	5	4	20	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> 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. The HV project works are due to commence in August 2019 starting the 60 week program to put in a new 11kVA incomer and to upgrade the main HV switch to 3MW. 	30/6/2020	Commercial Director			5
CRR 32		Trust	18/19	Continue to improve our culture	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)	<ul style="list-style-type: none"> 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. 	5	4	20	<ul style="list-style-type: none"> Delay in Cost Improvement Programme delivery. Detailed financial recovery plan required. 	<ul style="list-style-type: none"> 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. 	31/03/2019	Director of Finance			15
CRR 38		Trust	18/19	Continue to improve our culture	The Trust has insufficient cash with which to support its strategic and operational objectives.	25 (5x5)	<ul style="list-style-type: none"> 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. 	5	4	20	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> Working capital loan application. NHSI engagement on liquidity and 2019/20 planning round. Estates disposal strategy. 	31/03/2020	Director of Finance			16
CRR 39	RAD03	Trust	19/12/2015	Digital strategy	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)	<ul style="list-style-type: none"> 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. 	4	4	16	<ul style="list-style-type: none"> 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 in the ICE system and monitoring of compliance. Clarification required on the location of requests in ICE and how these are allocated. 	<ul style="list-style-type: none"> 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 department will clarify the timescale to re-establishment of this support. Specific SunQuest issues to be addressed. Action: issued tagged with SunQuest. Clarification regarding ICE/Winpath locations. Action: ICE project team are working 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. 	30/11/2019	Medical Director			8

CRR 45	S199	Surgery	27/10/2014	Clinical strategy	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 retina speciality the most affected. This has resulted in compromised patient outcomes.	20 (5x4)	<ul style="list-style-type: none"> 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/GPs will have a direct point of access. Daily safety huddles introduced at the beginning and the end of all One Stop clinics. Midnight Steering group, chaired by the Divisional Director for Surgery, meeting fortnightly to ensure robust project oversight. Recruitment of a retinal fallsafe co-ordinator in 10/19 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. 	5	3	15	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> 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 and Cataract hub with increased workflow and capacity. This would future proof the service for the next ten years. Ophthalmology specific electronic patient record system now live for cataract patients, next sub speciality is for retinal patients. Expected completion date September 2019 Review of Ophthalmology booking processes to reduce appointment cancellations. To be completed by the end of July 2019 	31/10/2019 (changed from 31/03/2019)	Chief Operating Officer			5
CRR 49	IM128 formerly MD46	Trust	25/05/2017	Clinical strategy	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)	<ul style="list-style-type: none"> 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 capacity managed internally and with partners. GP streaming in place. System wide weekly escalation meeting in Place. Length of Stay initiatives. Winter System Winter Director. 	5	4	20	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> 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 Ambulatory Emergency Care for Ambulatory Patients, Community Transformation, 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 national review of Clinical Standards. 	31/10/2019; Extended to 31/07/2019	Chief Operating Officer			10
CRR 53	C&YP 14	Women, Children & Sexual Health Services	07/12/2015	Implement new workforce models	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)	<ul style="list-style-type: none"> 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. 	4	4	16	<ul style="list-style-type: none"> Clinical risk to patients whose treatment might be delayed as a result of capacity 	<ul style="list-style-type: none"> Improvement plan produced. Vacant posts filled. Demand and capacity pathways complete. Service manager in post. Priority list of work in place. Psychologist commenced 01/12/18. Joint working with CCG, OUH and CAMHS. Launch of joint SPA 31/03/19. Referrals now being received at SPA not BHT. Trajectory indicates positive impact on waiting list (reduction of 200 patients on list) Discussions with commissioners re overall service specification. To request peer review by RCPCH 	31/03/2020	Chief Operating Officer			8
CRR 54	IT061	IT	22/06/2016	Digital strategy	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)	<ul style="list-style-type: none"> Defined list of information deliverables for Information Department. Encourage staff requiring information to use self-service wherever possible through Outlook. 	4	5	20	<ul style="list-style-type: none"> Comprehensive and complete Data Warehouse and BI Solution. 	<ul style="list-style-type: none"> Review tools to be used to access information. Build dashboards etc. required by the Trust internally so as not to exacerbate the situation. Implemented 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. 	30/9/2019 Extended from 30/11/2018	Director of Strategy			8
CRR 59	IT054	IT	26/04/2016	Digital strategy	There is a risk of cyber attack and potential disruption to IT systems and services of the Trust.	25 (5x5)	<ul style="list-style-type: none"> 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 (Caldicot 3/CCOC requirements moving forward). Anti-Ransomware software in place (heuristic monitoring of devices). 	5	4	20	<ul style="list-style-type: none"> Cyber Security strategy not yet in place. 	<ul style="list-style-type: none"> NHS digital pilot cyber security programme supporting the Trust with detailed risk assessment. 	31/12/2019	Director of Finance			10
CRR 60	IT071	IT	22/01/2014 13/06/2016	Digital strategy	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 telephony due to age of equipment at SMH, Wycombe and Amersham. Risk also includes bleep system and switchboard.	25	<ul style="list-style-type: none"> 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. 	5	4	20	<ul style="list-style-type: none"> 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 support or parts. The new network/telephony programme will address the replacement devices before loss of technical support. However, the risk of a complete outage which requires a replacement product is high and being managed with the technical suppliers to ensure down time will be kept to a minimum. 	<ul style="list-style-type: none"> Business case being developed to replace all telephony in line with wider ICS to obtain economies of scale and greater capacity in technical 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 resilience in the future. 	30/10/2019	Director of Strategy and Business Development			15

CRR 63 (HR 4/2016)	HR	Jul-16	Tackle inequalities and variation	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)	<ul style="list-style-type: none"> 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 testing. • Communication need alerts are established on the Trust primary patient administration system (PAS) for acute (SystemC Midway) and community services (Servicee RC). • Brouseout on public website. • Bulk mail went live end June 2018, including yellow paper and large font for ophthalmology letters Learning Disability Nurses reviewing opportunities for further support the Trust can offer to patients. 	4	3	12	<ul style="list-style-type: none"> Accessibility of patient records/flags to all front line clinical staff systematically, in particular in outpatients - flags are currently available systematically to reception staff. Evidence of understanding of staff implementation of AIS across all areas/teams. • Testing of awareness of AIS across the organisation. 	Rollout of communication/education programme during 2019-20	30/3/2020	Director of Workforce and Organisational Development				8	
CRR 68 (S228)	Trust	23/09/2016	Clinical strategy	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 3 areas which have significant growth above the 1.27% agreed in the Trusts CCG contract.	20 (4x5)	<ul style="list-style-type: none"> BHT recovery and sustainability plan submitted to NHSE. Plan is monitored through 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 FRF 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. 	4	4	16	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> 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. 	31/03/2020	Chief Operating Officer				8	
CRR 73	S196	Surgery	21.4.17	Estate strategy	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 MDD03/42/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	<ul style="list-style-type: none"> Letters of intent signed by the Finance Director (September 2018 and December 2018) Final contract documentation for agreement and signed November 2018) Monthly steering group for supervision of CSSD rebuild established. Survey and core drilling completed (31 Jan 2019) IT removal of infrastructure completed (Jan 19) Final agreement on preliminary works including Core Drilling and appropriate surveys completed Monthly reports on progress and expenditure submitted to the Capital Management Group IT to formulate options for phone lines by March 2019 completed 	4	4	16	Storage of records not fit for purpose and becoming overcrowded.	<ul style="list-style-type: none"> Estates team to lead on review of the storage of all records stored in the SMH CSSD building and allocate alternative storage areas (by August 2019) CSSD staff working 24/6 to ensure adequate provision of service Business Continuity plans in place for the event of the WH site failure. Next review due August 2019 Proposed date for contractor on site is 9 July 2019 – will take 33 weeks to build. Expected completion date March 2020 Asbestos removal to begin following HSE submission External building demolition to begin August 2019 	31/03/2020	Chief Operating Officer				4
CRR 76	IT045	IT	21.4.17	Digital strategy	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)	<ul style="list-style-type: none"> 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. 	4	5	20	hardware and infrastructure issues have identified the systems and q equipment are out of date and no longer for for purpose	<ul style="list-style-type: none"> Bucks IT review includes assessment of infrastructure issues. • Cost estimates provided and to be built 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. 	31/03/2019	Director Strategy and Business Development	3	2		6
CRR 79 (RAD 19)	RAD19	Specialist Services	12.6.17	Clinical strategy	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 be diverted to Care UK resulting in lost income.	20 (4x5)	<ul style="list-style-type: none"> 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. 	4	4	16	Lack of capital funding for replacement	<ul style="list-style-type: none"> 25/02/19 Div Dir SSD - Project started. Scanners ordered and work begins on the Wycombe scanner in April 2019, risk is still high as the VGH scanner is at risk of failing. 25/02/19 Div Dir SSD - Delays due to pre-installation works have hampered the project. Go live date now set for September 2019 	31/10/2019	Chief Operating Officer				4
CRR 81	HAEM09/ CAN07	Specialist Services	12.6.17	Clinical strategy	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 B19/S1a (Cancer: Chemotherapy (Adult) per month (approx. £25000 per month) until full implementation is achieved).	16 (4x4)	<ul style="list-style-type: none"> 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. 	4	3	12	Process not yet fully embedded.	<ul style="list-style-type: none"> Training has been completed on the use of eprescribing for Urology nursing and medical staff. Use needs to be embedded. 26/04/2019: Urology CNS has been trained to schedule and Urologist has been trained to prescribe. Urology still working out internal processes on prescribing. 27/06/19: Establish that this is not a problem with Aria then escalate issue to divisional management team 17/07/19: Macmillan Advanced Nurse Practitioner to liaise with Urology to establish a deadline for discontinuation of paper scripts 	30/09/2019 Extended from 30/11/2018	Chief Operating Officer				4

CRR 83	Trust	22/09/2017	Corporate services transformation	There is a risk that payroll processes are not sufficiently robust.	25 (5x5)	<ul style="list-style-type: none"> Quality assurance by Payroll department to reduce risk of errors. • Trust process reminders sent out to all staff. • Contractual review to determine legal options. 	5	3	15	Additional payroll resource to be recruited.	<ul style="list-style-type: none"> 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. 	31/12/2018	Director of Finance	5
CRR 85	Paed 20	Trust	20/10/2017	Implement new workforce models 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	<ul style="list-style-type: none"> 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 specialist Registrar grade time in the week. 	5	3	15	<p>National shortage of doctors from key groups.</p> <p>Internal audit has identified the need for more central oversight of leave management.</p> <p>There are identified gaps in rotas in medicine.</p>	<ul style="list-style-type: none"> 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.) 	30/09/2019	Medical Director	5
CRR 87	Trust	20/10/2017	Digital strategy	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)	<ul style="list-style-type: none"> RIO diaries to show where visits are planned. • Tracks 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. 	4	4	8	<p>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.</p>	<ul style="list-style-type: none"> 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 <p>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.</p> <ul style="list-style-type: none"> 1000 Sky Guard devices now purchased 653 devices issued to lone workers 810 user accounts set up 870 staff now trained <p>Risk rating reduced from 16 to 8 and to come off the CRR but remain on PS Divisional RR</p>	31/12/2018; extended 31/12/19	Commercial Director	8
CRR 88	S220, IM138 and IM 139	Trust	19/02/2018	Digital strategy 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)	<ul style="list-style-type: none"> 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. 	5	4	16	<ul style="list-style-type: none"> Availability of a follow up patient tracking list. • Ability to be able to track non-compliance with agreed standard operating procedures. • Outpatient capacity. 	<ul style="list-style-type: none"> 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 as rolled out. • Funding agreed and equipment purchased for SMH. Estates are initiating set up. 	31/03/2020	Chief Operating Officer	10
CRR 91	RAD24	Specialist Services	23/03/2018	Clinical strategy 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 falling 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)	<ul style="list-style-type: none"> If X-ray down, extra appointment made for patients at another site of another day <p>Business case to replace the three units has been written.</p>	4	4	16	<ul style="list-style-type: none"> 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. 	<p>22/05/19: SMH dental unit - issue with installation currently being reviewed by Divisional Director and Estates. Risk score increased to 16 until issues resolved</p> <p>02/07/19: Div Dir SSD: Delays have pushed the SMH project</p>	31/10/2020	Chief Operating Officer	8
CRR 94	CYP 30	Women, Children & Sexual Health Services	04/05/18	Implement new workforce models Attendance at Child Protection case conferences is increasing beyond capacity for School Nurse team.	20 (4x5)	<ul style="list-style-type: none"> 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. 	4	4	16	<p>Lack of capacity to deliver HCP and reduced delivery of screening services.</p>	<ul style="list-style-type: none"> New safeguarding referral process in place. Project manager in place to support transformation <p>Monthly project board to oversee and monitor service. Plan for transformed service delivery to be circulated in september 2019 - commence revised service from next academic year.</p>	01/09/2020	Chief Operating Officer	12
CRR 95	IM137	Integrated Medicine	04/05/2018	Estate strategy 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. Decontamination is not compliant with dirty/clean separation of scopes. The waiting area is too small	20	<ul style="list-style-type: none"> Currently managing on a day to day basis to keep patient experience at the best possible level given the space issue. • SoP are in use to mitigate the risk of contamination between clean and dirty scopes. 	4	5	20	<ul style="list-style-type: none"> 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. • Longer term decontamination solution not yet identified. • Waiting area size not addressed. 	<ul style="list-style-type: none"> Recognition that new Endoscopy unit required, business case developed, strategy to be revisited for a final solution. • Short term - Outsourcing of scopes to be procured until a longer term solution is identified. • Potential waiting area has been identified for short term use. 	31/03/2020 in totality	Chief Operating Officer	16

CRR 98	Trust	31/07/2018	Clinical strategy	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.	5	3	15	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 – Adaptors 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.	30th August 2019 (Extended from 31/03/2019)	Chief Nurse		5
CRR 99	Property Services	07/09/2018	Estate strategy	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.	5	3	15	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. The SI recovery program has delivered significant risk reduction and in assurance to the Board, the Property Services reports have gone from weekly to monthly to quarterly at F and BP and to monthly at EMC. The progress is on plan and delivering the recovery program and, therefore, the risk has been reduced to a 5x2 at this stage in the recovery program.	31/03/2019 Extended from 30/11/2018 The reporting program should now be reviewed to move the risk from the CRR to the PSS Risk register as a result of the work progress achieved	Commercial Director		5
CRR 100	Trust	07/09/2018		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	5	3	15	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.	31/10/2019	Director of workforce & OD		5
CRR 102	CYP 36 Women, Children & Sexual Health Services	26-Oct-18	Implement new workforce models	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 referral 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, Jill in post and monthly project Board meetings with Commissioners taking place. • School Nurse referral 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.	4	4	16	Potential not to deliver to contract.	• Chalfonts and Amersham teams to merge. New safeguarding referral 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.	Extended to 31 August (Extended from 31/03/2019, JC to review at Project board 29/5/19)	Chief Nurse		8
CRR 103	S232 Surgery	26-Oct-18	Clinical strategy	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.	4	4	16	It is difficult to determine 62 day performance by sub-specialty.	• 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 achieved in May.	31/03/2020	Chief Operating Officer		8
CRR 104	Trust	21/12/2018	Clinical strategy	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) thus taken place at front door.	5	2	10	• The contract does not enable us to enforce the 'output' elements required. • There is inconsistency in audit results, but with no specific trend.	Audit results are 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. Building a cleaning business case in preparation for contract renewal in 2020/21 Review of cleaning products with NHS infection prevention lead input with a view to changing the products Commercial Director and Chief Executive liaising with PFI Partner Executive team.	30/12/2020	Medical Director / Director of Infection Prevention and Control		5
CRR 105	CYP33 Women, Children & Sexual Health Services	22/05/2019	Clinical strategy	Increased demand for integrated therapy input not matching the tender staffing model. Large increase in demand for SEND work including tribunals and EHCP (work 40% increase in SLT EHCP input over 2 years). A larger number of complaints - formal and informal have been received, increased incidents of abuse to staff. Risk of retention of staff due to well-being issues. Lack of partnership working impacting on referrals and demand for therapy input. focus on delivery to quantity of referrals rather than need and early help.	20	• Engagement with the Service Improvement Team for SLT Record kept of all formal and informal complaints and who is responsible for addressing. • SLT Service Project Board commenced July 18 to address demand and capacity, vacancies and redesign of workforce, clinical pathway design. SEN action plan in place. • Separation of main contract and external contract income to identify gaps in recruitment against income. Monthly commissioner meetings. Engagement with Health and Well-being team and other trust resources.	3	4	12	• Impact on full delivery of KPI's for the Integrated Therapies contract. Inability to deliver statutory SEND work in full. • Under resourcing of the therapy contract.	• New specialist roles recruited to support leadership, recruitment and retention, income generation and data analysis. Clinical pathway re-design. Referral and discharge criteria update. Engagement with SEND improvement and strategy planning groups - May 2019. Service delivery proposals presented to commissioners to stop elements of service delivery to enable statutory work to be fulfilled - May 2019. • Demand and capacity completed. July 2018 SLT project board commenced and continuing. Vacancy position improved new roles created statutory work currently covered. • Further redesign of service over next 6 months needs to take place. Attendance at SEN work streams with task and finish groups identified. Meeting with commissioners to agree cuts to service delivery for SLT May 2019 for roll out from June 2019. • Data analysed for increased demand, awaiting analysis for increase of complexity of presentation and demand. SEND appendices meetings commenced April 2019 - held monthly. SpeechLink business case escalated to new Head of SEN with proposal for implementation Sept 2019 to manage demand.	31/12/2019	Chief Operating Officer		8

Agenda item: 21
 Enclosure no: TB2019/088

PUBLIC TRUST BOARD MEETING 31st July 2019

Details of the Paper

Title	Feedback and action plans from NACEL audit 2018
Responsible Director	Carolyn Morrice
Purpose of the paper	Update
Action / decision required (e.g., approve, support, endorse)	Support

21

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

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

ANNUAL OBJECTIVE

Which Strategic Objective/s does this paper link to?

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

- We were above national average in six out of nine domains
- We were below in Communication with dying patient
- We were below in Involvement in decision making

RISK

Are there any specific risks associated with this paper? If so, please summarise here.	<i>Non-Financial Risk:</i>
	<i>Financial Risk:</i>

LINK TO CARE QUALITY COMMISSION ESSENTIAL STANDARDS OF SAFETY AND QUALITY

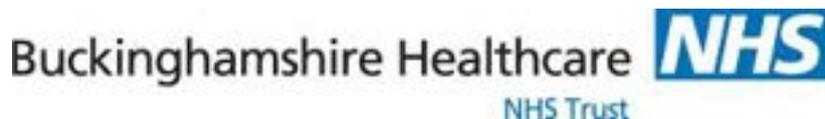
Which CQC standard/s does this paper relate to?	<i>(if you need advice on completing this box please contact the Director for Governance)</i>
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Author of paper: Liz Monaghan, Matron Palliative Care

Presenter of Paper: Carolyn Morrice

Other committees / groups where this paper / item has been considered: Quality and Clinical Governance Committee, EMC

Date of Paper: February 2019



National Audit for Care at the End of Life (NACEL)

England & Wales

Bespoke dashboard 2018/2019

Acute and Community Trusts involved and 3 sets of data collected:

- a) Organisational Audit – completed
- b) Case Notes Review – 69 notes reviewed (deaths in April 2018)
- c) Quality Survey – (sent to the bereaved relatives of the Case Note Review patients) – 3 replied (N.B. Only 7% of Case Notes Review nationally – too few to interpret for our Trust.)

Results published – February 2019.

Below is a table with National Summary Scores versus Summary Scores for Buckinghamshire Healthcare NHS Trust:

Domain Theme	National Summary Score	BHT Summary Score
Recognising the imminent possibility of death	9.1	9.2
Communication with the dying person	6.9	5.9
Communication with families and others	6.6	7.1
Involvement in decision making	8.4	7.3
Needs of families and others	6.1	8.3
Individual plan of care	6.7	7.9
Families and others experience of care	7.1	-
Governance	9.5	10.0
Workforce/specialist palliative care	7.4	9.2

We score above the National Average in six out of nine domains.

One domain cannot be assessed owing to low response numbers; however, we have evidence of excellent patient and family reviews via Medical Examiner contact calls, and we are planning also to conduct a Bereavement Survey twice per year which will cover a month's worth of patient deaths, and will take place six months after the deaths occurred. The first of these Surveys is planned for June 2019.

The two domains where we scored below the National Summary Score are:

- Communication with the dying person
- Involvement in decision making

Please see action plans below.

Please note that this Audit looks predominantly at care in the last few weeks/days of life, and does not focus on planning for end of life care across the last year of life.

➤ **Communication with the dying person**

This looked at:

- Patient's opportunity to be involved in discussing their plan of care
 - Whether the patient was informed of the person responsible for their care
 - Whether the potential side-effects of any medication were discussed with the patient
 - Whether risks versus benefits of hydration were discussed with the patient
 - Whether risks versus benefits of nutrition were discussed with the patient
-
- ✚ We are not documenting discussions with patients with regard to their plan of care
 - ✚ Patients do know whom is responsible for their care = 56% BHT versus 33% National
 - ✚ We do need to discuss the side-effects of medication; although this is poor nationally = 23% BHT versus 8% National
 - ✚ Low levels of discussion with regard to hydration and nutrition, but higher than average in both areas than nationally: hydration = BHT 18% versus 9% National; nutrition = BHT 19% versus 9% National

Action Plans

Focus on teaching:

- Documentation of discussions around hydration and nutrition
- Having discussions around side-effects of medication
- Documenting discussions with patient around plans of care

➤ **Involvement in decision making**

This looked at documented evidence of:

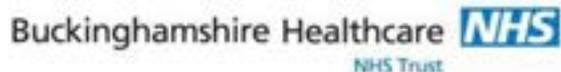
- Extent to which the patient wished to be involved with decisions about care
 - Whether the patient had their capacity assessed to be involved in care planning
 - Whether life-sustaining measures were discussed with the patient
 - Whether life-sustaining measure were discussed with family/others
 - Whether a clinician had discussed Cardio Pulmonary Resuscitation with the patient
 - Whether a senior clinician had discussed Cardio Pulmonary Resuscitation with family/others
-
- ✚ We had not documented sufficiently the extent to which patients want to discuss decisions about care = 12% BHT versus 18% National
 - ✚ Our assessment of capacity is above average = 58% BHT versus 43% National; however, this could still be improved
 - ✚ Our discussions with patients and family/others with regard to life-saving measures are above the national average: patients = 43% BHT versus 15 % National; family/others = 87% BHT versus 35% National
 - ✚ Poor documentation of discussion of Do Not Attempt Cardio Pulmonary Resuscitation with patient = 40% BHT versus 42% National; and with family/others = 73% BHT versus 80% National

Action Plan

- Ongoing teaching on palliative care and end of life care delivered by Specialist Palliative Care SDU (as above).

<p>Involvement in decision making</p> <ul style="list-style-type: none">  We had not documented sufficiently the extent to which patients want to discuss decisions about care      Poor documentation of discussion of Do Not Attempt Cardio Pulmonary Resuscitation with patient; and with family/others 	<p>Developed into the New End of Life care plan Audit to be completed every 3 months with a growth of documentation to 50% completed for discussions with patients.</p> <p>Ongoing teaching of communication skills (via sims training) Audit completed both by NACEL and annual DNACPR audit Goal 60% documentation achieved for conversation with patient 90% documented discussion with family.</p>	<p>Palliative Care SDU</p>	<p>February 2020</p> <p>February 2020</p>	
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Agenda item: 22
 Enclosure number: TB2019/089



PUBLIC BOARD MEETING 31 JULY 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

22

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

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

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.	<i>Non-Financial Risk:</i>
	<i>Financial Risk:</i>

LINK TO CARE QUALITY COMMISSION ESSENTIAL STANDARDS OF SAFETY AND QUALITY

Which CQC standard/s does this paper relate to?	Well led Domain <i>(if you need advice on completing this box please contact the Director for Governance)</i>
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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: 24 July 2019

Board Attendance Record: May 2019 to July 2019

	Strategic Workforce Committee	Finance and Business Performance Committee		Quality & Clinical Governance Committee			Trust Board Seminars	Commercial Development Committee	Audit Committee		Trust Board
	4 Jun	28 May	25 Jun	7 May	4 Jun	2 Jul	26 Jun	4 Jun	9 May	4 Jul	29 May
Hattie Llewelyn-Davies Trust Chair *	✓	✓	✓				✓				✓
Neil Macdonald, Chief Executive Officer *	✓	✓	✓	x	✓	x	✓		✓		✓
Dipti Amin NED*				x	x	✓	✓		x	x	✓
Natalie Fox Chief Operating Officer*		x		✓	x		x				x
Rajiv Jaitly NED *		✓	✓				✓		✓	✓	✓
Graeme Johnston NED * (SID)		✓	✓				✓		✓	✓	✓
Tina Kenny Medical Director *	✓			✓	✓	✓	✓				✓
Carolyn Morrice Chief Nurse *	x	x	x	✓	x	✓	✓				✓

	Strategic Workforce Committee	Finance and Business Performance Committee		Quality & Clinical Governance Committee			Trust Board Seminars	Commercial Development Committee	Audit Committee		Trust Board
	4 Jun	28 May	25 Jun	7 May	4 Jun	2 Jul	26 Jun	4 Jun	9 May	4 Jul	29 May
Bridget O'Kelly Director of Workforce & Organisational Development	✓	✓	✓				✓				✓
Tom Roche Associate NED	✓	✓	✓				✓	✓	✓	✓	✓
David Sines Associate NED	✓			✓	✓	✓	✓				✓
Wayne Preston Deputy Director of Finance		✓	✓				✓		✓	✓	✓
David Williams Director of Strategy & Business Development	x	✓	✓ As COO			✓ As COO	✓				✓
Ali Williams Commercial Director		✓	✓				✓	✓			✓
Dan Leveson Deputy Director of Strategy			✓				✓				

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: 23
Enclosure number: TB2019/090

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NHS Trust

BOARD MEETING IN PUBLIC 31 JULY 2019

Details of the Paper

Title	Private Board Summary 29 May 2019				
Responsible Director	Trust Chair				
Purpose of the paper	<p>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:</p> <ul style="list-style-type: none"> • Financial Recovery Plan • Serious Incident Report and Tracker • Excluded Practitioners • Annual Report and Annual Governance Statement • Quality Accounts • Buckinghamshire Healthcare Projects Limited (BHPL) • NHSI Letter of Proposed Enforcement Action • Committees in Common Proposal • CQC Proposal to impose a condition on the Trust registration and options appraisal • Application for University Hospital status 				
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	<i>Financial Performance</i>	<i>Operational Performance</i>	Strategy	<i>Workforce performance</i>	<i>New or elevated risk</i>
<i>Legal</i>	Regulatory/ Compliance	<i>Public Engagement /Reputation</i>	<i>Equality & Diversity</i>	Partnership Working	<i>Information Technology / Property Services</i>
ANNUAL OBJECTIVE					
<i>Which Strategic Objective/s does this paper link to?</i> Relates to all objectives					
<i>Please summarise the potential benefit or value arising from this paper:</i>					
RISK					
Are there any specific risks associated with this paper? If so, please summarise here.	<i>Non-Financial Risk:</i>				
	<i>Financial Risk:</i>				
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: 24 July 2019					

Agenda item: 24.1
 Enclosure no: TB2019/091



**BOARD COMMITTEE ASSURANCE REPORT FOR PUBLIC BOARD
 Wednesday 31st July 2019**

Details of the Committee

Name of Committee	Quality and Clinical Governance Committee: Service Review meeting and Formal meeting
Committee Chair	Professor David Sines
Meeting dates:	4 th June 2019 and 2 nd July 2019
Was the meeting quorate?	Yes
Any specific conflicts of interest?	None
Any apologies	4 th June 2019: Mrs Morrice, Ms Fox, Mr Williams, Miss Tasker. 2 nd July 2019: Mr Macdonald. Mrs Ricketts, Mrs Brooke, Ms Dickinson, Mrs Waide, Miss Tasker.

KEY AREAS OF DISCUSSION:

4th June 2019

The Committee focused its discussions around the following areas:

- Service Review: Specialist Service Division
- Type 1 Diabetes patients: exploring barriers to attending appointments with the Local Diabetes Service
- Corporate Risk Register
- Paediatric action plan following Serious Incident regarding unexpected death of a child
- Quarter 4 learning from deaths report
- Integrated Performance Report and exception reports
- Non-executive feedback: visit to Wycombe Treatment Care

2nd July 2019

The Committee focused its discussion around the following areas:-

- Corporate Risk Register
- Acuity & Dependency
- Clinical Audit annual plan 2019/20
- Integrated Performance Report and exception reports; in particular, Deep Dive Frailty report
- 2019 CQC report
- Quality Impact Assurance process

24.1

Agenda item: 24.1

Enclosure no: TB2019/091

- Medical Appraisal and revalidation annual report
- Infection Prevention and Control report, April 2019, Antimicrobial report 2018-19
- National Audit of Care at the End of Life
- Maternity Safety Quarterly report
- Safeguarding Adults and Children's annual report
- Winter resilience annual report
- Patient/staff story
- Safeguarding Committee exception report
- Quality and patient safety group chair's monthly report
- Cancer – analysis of 104 day breach position/review of processes
- Serious incident report - confidential

24.1

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

4th June 2019

Service Review

- Workforce challenge compounded by national shortage of oncologists.
- Culture of leadership issues; urged that the improvements already underway continue to be supported.
- Major shift in pathology department management; timescales of results to be shared with GPs when tests are requested from Specialist Services.

Corporate Risk Register

- How the Board is assured that this Committee is appropriately managing risks where the completion date is extended but the action deadlines do not move reflectively and there is no indication of which action is causing this change of timescales. The CRR is under review and has been thoroughly challenged Risk and Compliance Committee.

Integrated Performance Report

- Risks on MRSA: waiting time standard compliance and outpatient appointment disruption and requested that information on how these risks are being dealt with ongoing forward is presented at the next Committee meeting.

2nd July 2019

- Comments around understanding data; variation and data presented to the Committee; the use of the terminology of 'timely' when discussing data and recommended data is reported reflecting an up-to-date understanding of actions taken/completed and influence operationally.
- Recognised the increasing demands on cancer services and collaborative working as a risk requesting regular updates and continued monitoring.
- Community hospitals, as an emerging mitigation risk; as identified by the CQC – risk to be noted.

ANY EXAMPLES OF OUTSTANDING PRACTICE OR INNOVATION:

Agenda item: 24.1

Enclosure no: TB2019/091

4th June 2019

- Service review: ongoing good figures for Time to Treatment for patients with newly diagnosed cancer, reflective of the improved speed of pathway achieved. This exemplary performance against national averages was recognised
- Continuing to share good practice in areas of learning though it was recognised that further efforts are required.
- Achieved UKAS recognition for cell-path with work ongoing for the other areas of pathology.
- Medical Examiners process and learning embedded within organisation

2nd July 2019

- Sustained improvement reporting on frailty.
- Outcome of the recent CQC inspection, in particular outstanding caring and end of life care.
- Reduction in antibiotic usage.

AUTHOR OF PAPER: Carolyn Morrice, Chief Nurse

Agenda item: 24.2
Enclosure no: TB2019/092

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BOARD COMMITTEE SUMMARY REPORT

Name of Committee	Finance and Business Performance Committee
Committee Chair	Mr Rajiv Jaitly
Meeting date:	25 th June 2019
Was the meeting quorate?	Yes
Any specific conflicts of interest?	None
Any apologies	Mrs Carolyn Morrice, Dr Tina Kenny
KEY AREAS OF DISCUSSION:	
<p>Month 2 finance report The Trust delivered a £1.3m deficit in line with plan, including benefit of £1.75m non-recurrent ICS income phasing. Committee noted the Undertakings letter and meeting.</p> <p>Efficiency Programme 2019/2020 The Committee recognised the gap to delivering the £15m plan and the need for additional schemes to be incorporated into delivery.</p> <p>ICS Financial Position The system delivered to plan at Month 2, but recognises the risk to ongoing delivery, and the currently unmitigated £5m system risk.</p> <p>Drivers of Deficit The system deficit of £60m was discussed and the main drivers acknowledged as per the report, scheduled to be submitted to NHSI/E by the end of June.</p> <p>Priority Actions from External Reviews The improvements seen were commented upon with regard to improved reporting timelines and outputs. The full detail action tracker will be reported to future committees.</p> <p>Capital The summary capital programme was presented and discussion focussed on the constraints of resource versus the requirements, there was debate about national capital claw back due to shortages across the NHS. The lack of resource was further discussed under the Digital Strategy, a later item on the Agenda.</p> <p>Performance Floodlight Integrated Performance Report Discussion focused on A&E performance, cancer and RTT targets.</p> <p>Performance Governance Framework The revised framework was presented. The operationalisation will be confirmed through EMC.</p> <p>Finance Risk Log The risk log will be built into the main finance report for future meetings.</p>	

24.2

Agenda item: 24.2

Enclosure no: TB2019/092

AREAS OF RISK REVIEWED IN THE MEETING	
<ul style="list-style-type: none"> • Divisional understanding of savings required against a £15m or £18m target • Concerns around continuing quality in services against difficult decisions • Drivers of the deficit – risks around the tariff and PFI implications • CCG £17m underfunding • Estates issues – financial implications • Quality Committee representation and IPR understanding • IT • Clinical Coding • Complaints • 12 hour waits • Readmissions – the potential double counting • Business plans around A&E • Lack of clinical representative at the meeting 	
ANY EXAMPLES OF OUTSTANDING PRACTICE OR INNOVATION:	
AUTHOR OF PAPER:	Wayne Preston, Director of Finance (Interim)

24.2

Agenda item: 24.3
Enclosure no: TB2019/093

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NHS Trust

BOARD COMMITTEE SUMMARY REPORT FOR AUDIT COMMITTEE

Name of Committee	Audit Committee
Committee Chair	Mr Graeme Johnston
Meeting date:	4 th July 2019
Was the meeting quorate?	Yes
Any specific conflicts of interest?	None
Any apologies	Dr D Amin
KEY AREAS OF DISCUSSION:	
<p>The Audit Committee would like to bring the following points to the attention of the Board:</p> <ul style="list-style-type: none"> • Board Assurance Framework • External Audit report • Purchase Orders • Overseas Visitors <p>Board Assurance Framework The Committee noted the need for an information workshop on the BAF is required as part of the board development plan.</p> <p>External Audit Report The Committee recommended 'Areas of focus for the Board in 2019/20' be discussed at a future Board Seminar and to link to the BAF to understand and triangulate risk. This is scheduled for October 2019</p> <p>Purchase Orders The Committee was concerned Purchase orders were not being raised in a timely manner. It was suggested if a PO was not raised appropriately then this may cause delay in payment.</p> <p>Overseas Visitors The Committee noted there needs to be a change in approach and culture within the trust on the charging of patients for care when appropriate to do so. It is apparent the process for this has been unclear and staff need to be supported to ensure appropriate charging does take place.</p>	
AUTHOR OF PAPER:	Sue Manthorpe, Director for Governance

24.3

Agenda item: 24.4
Enclosure no: TB2019/094

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Buckinghamshire Healthcare **NHS**
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SUB-COMMITTEE ASSURANCE REPORT FOR PUBLIC BOARD 31st July 2019

Details of the Committee

Name of Committee	Charitable Funds Committee (CFC)
Committee Chair	Rajiv Jaitly, Non-Executive Director
Meeting date:	5 th February 19 and 30 th May 2019
Was the meeting quorate?	YES
Any specific conflicts of interest?	<p>Rajiv Jaitly (Chair) stated a declaration of interest regarding his investments – he has (immaterial) direct investments in health related businesses and in funds managed by Schroders. He holds shares in M&G Global Dividends Fund which is also held by the Charitable Funds.</p> <p>Les Broude (Honorary Independent Member) stated a declaration of interest indicating that he is a non-executive director at South Central Ambulance Trust.</p> <p>Mike Mackenzie (Honorary Independent Member) stated a declaration of interest indicating that he is Patron at Horatio's Garden Charity, Chairman at The Poppa Guttman Trust and Trustee & Director at Bucks County Museum.</p>
Any apologies	N/A

24.4

KEY AREAS OF DISCUSSION:

1. Investments

The Committee received a portfolio valuation report as at 31st March 2019, presenting the performance of the charity's investment portfolio over the last quarter. The Committee was informed that the total portfolio market value based on a bid price was **£8.37m** which represents an increase of **£0.09m** compared to the previous valuation of **£8.27m** as at 31st March 2018 that was presented on 17th May 2018 meeting. The overall performance of the portfolio market value has been an increase of **1.20%** in the last twelve months, due to the market conditions during this period.

2. Financial Statements and Reports

The Committee noted the Charitable Funds Financial Reports as at 31st March 2019.

3. Bids

The Committee was presented with the following Bid Applications with a value over £100,000, which requires presentation to the **Trust Board for endorsement**:

- Bid application seeking funding at a total cost of **£125,000** from the Scientific Research Legacy Fund (No.1020 - £62,500) and the Masson Legacy for Spinal Research Fund (No.2094 - £62,500) in order to

contribute with the development of the Research and Innovation Centre that would enable entrepreneurs to work on Stoke Mandeville site with patients and clinicians and provide clinical rooms for patients.

- Bid application seeking funding at a total cost **£843,960** from the SMH MRI Scanner Fund (No. 2272 - £333,960), the Scientific Research Legacy Fund (No.1020 - £40,000), the Masson Legacy for Spinal Research Fund (No.2094 - £250,000) and the NSIC General Amenity Fund (No.2121 - £220,000) to contribute towards the purchasing of Package Deal to acquire a MRI scanner for SMH and another one for WH. The Committee was informed that the acquisition of these New MRI Scanners will improve the services that are currently provided by the Trust to the patients and due to the advance technology in the Scanners being acquired, it is considered that the proposed expenditure is over and above the level that the NHS Trust would be expected to cover.

After some questioning and deliberations, the Committee agreed with the merit and benefits to the patients of the bids presented and their compliance with the charitable funds guidelines and objectives and approved the bids with the following caveats:

- The Charitable Funds will be contributing for the costs related to MRI Scanner that will be allocated at SMH.
- The bid applications should be presented to the Trust Board for endorsement.

The Committee also was presented with the following Bid Applications with a value under £100,000, which were approved and they are being presented to the Trust Board for information purpose:

- Bid application seeking funding from all the Unrestricted General Funds at the total cost of **£22,000** for the continuation of the staff wellbeing and staff recognition programmes. This application was approved with the caveat that the Trust should identify the financial sustainability of these activities for next year.
- Bid application from the Healthcare Governance Department seeking funding at the total cost of **£32,795** to support a digital online platform for the Trust’s Friends and Family. The funds requested are to cover the expansion of a pilot into the inpatient, outpatients and day cases services.

4. Other Items

Management of Charitable Funds Policy & Procedures, The Charitable Funds Investment Policy, The Charitable Funds Unrestricted Reserve Policy and the Terms of Reference were reviewed and approved by the Committee.

The Committee has requested to inform the Board that they are considering streamlining the management and use of the Charitable Funds for Training, Education, Conference, Seminars and similar events. Therefore, this type of expenditure will be examined by the members in the next Charitable Funds Committee that is taking place on 29th August 2019.

KEY ACTIONS FOR THE BOARD:

- To **NOTE** this report.
- To **ENDORSE** the bid applications with value over £100,000.

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

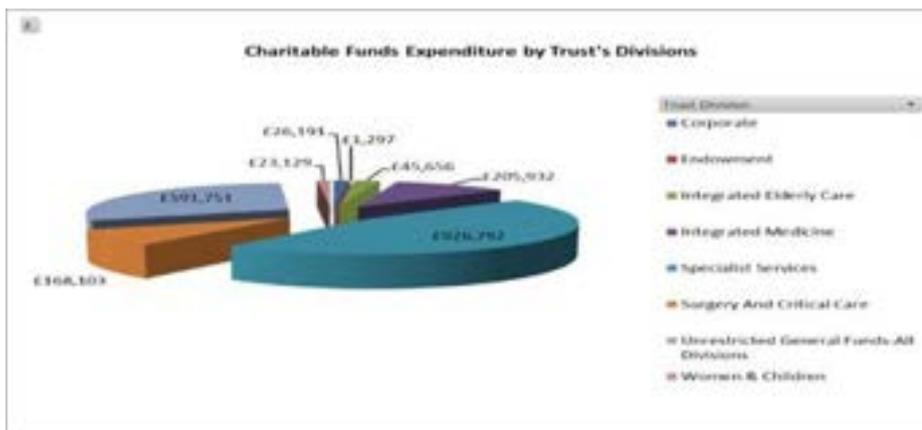
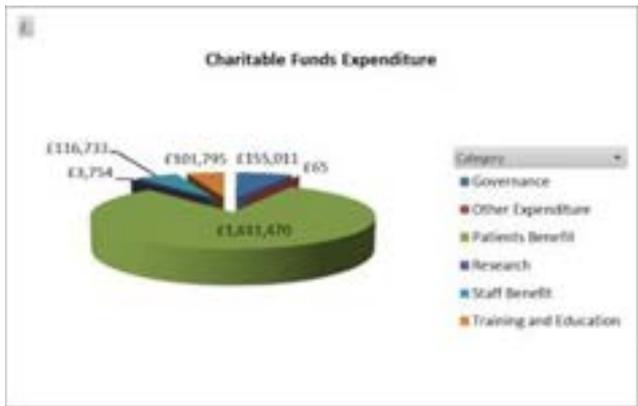
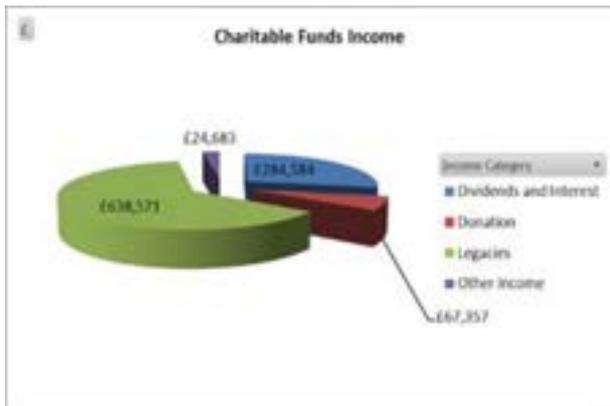
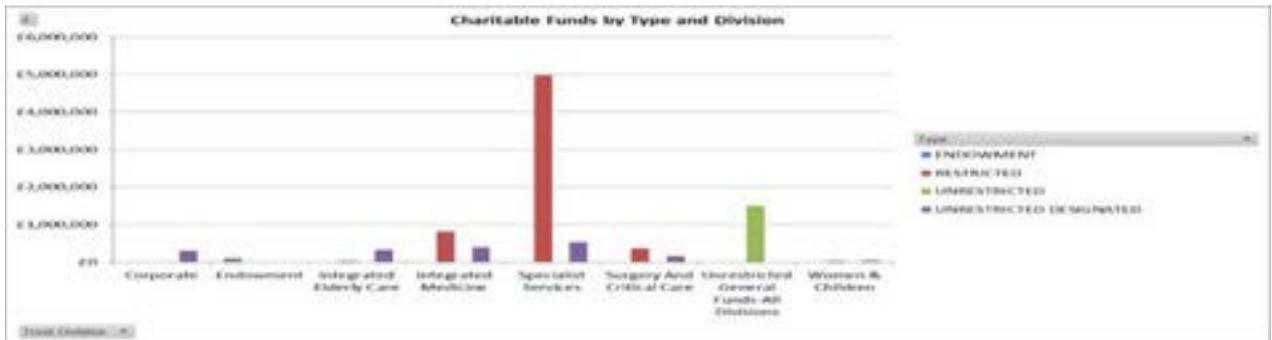
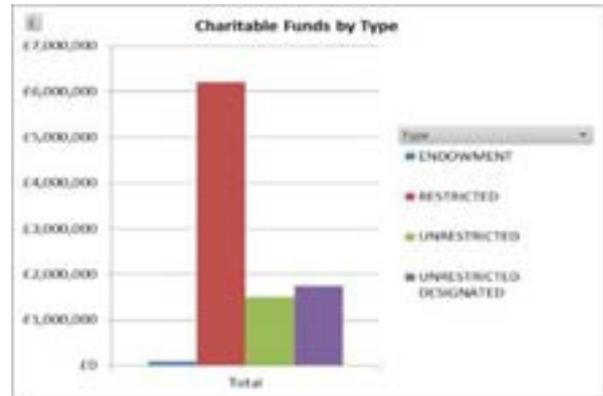
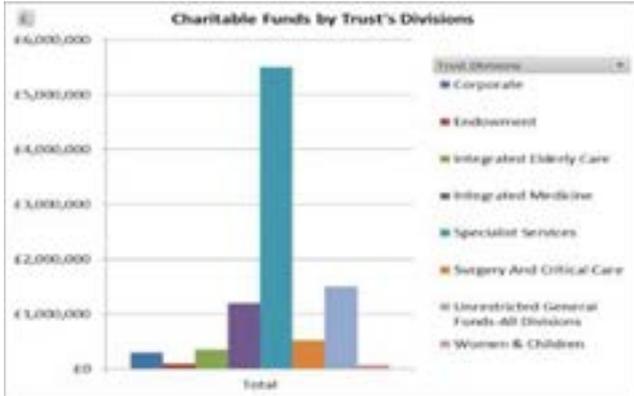
None identified.

ANY EXAMPLES OF OUTSTANDING PRACTICE OR INNOVATION:

AUTHOR OF PAPER:	Nelson Garcia-Narvaez, Head of Charities Finance & Governance
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24.4

Charitable Funds Dashboard as at 31st March 2019



24.4

Safe & compassionate care,
every time

PUBLIC / PRIVATE / SEMINAR / BOARD MEETING
31 / JULY / 2019

Details of the Paper

Title	BHT POL063 - Management of Charitable Funds Policy & Procedures
Responsible Director	Wayne Preston, Interim Director of Finance
Purpose of the paper	<ul style="list-style-type: none"> To ask the Board to Note and Endorse the propose changes in this policy.
Action / decision required (e.g., approve, support, endorse)	The Board is asked to ENDORSE proposed changes in the Management of Charitable Funds Policy & Procedures.

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

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

24.4

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.	<i>Non-Financial Risk: N/A</i>
	<i>Financial Risk: N/A</i>

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: Nelson Garcia- Narvaez (Charitable Funds Head of Finance and Governance)

Presenter of Paper: Wayne Preston (Interim Director of Finance)

Other committees / groups where this paper / item has been considered:
Charitable Funds Committee, TPSG and Executive Management Committee.

Date of Paper: 15/07/2019



Introduction

The Management of Charitable Funds Policy & Procedures (BHT Pol 063) was presented and approved by the Charitable Funds Committee, the TPSG and the Executive Management Committee. These Committees authorised submission to the Board in order to be endorsed.

This policy was thoroughly scrutinised and amended last year (2018) by the Director of Finance, the Charitable Funds Committee and endorsed by the Board.

This Policy is required to be only modified in order to introduce new requirements as instructed by the Charitable Funds Committee regarding the use of the Charitable Funds for Training, Education and Travelling expenses.

The inclusion of the following paragraphs in the Expenditure-Staff Amenities-Training and Education (Page 21 of this policy) are the only changes being proposed in this policy:

Paragraphs 1

Charitable Funds should have confirmation from the applicant and fund holders that this petition for Training/Conference/Courses support has been previously requested to the Trust and cannot be covered by:

- **Statutory and Mandatory training – BHT.**
- **Health Education England funded training.**
- **Apprenticeship levy funds.**

Paragraphs 2

Reimbursement claims must be submitted within three months of the expense being incurred. Failure to submit by the deadline will result in the expense claim being rejected.

The Charitable Funds Committee requested to present this policy to the Board in order to be ratified.

Recommendation

The Board is asked to **ENDORSE** proposed changes in this policy.

The Committee has requested to inform the Board that they are considering streamlining the management and use of the Charitable Funds for Training, Education, Conference, Seminars and similar events. Therefore, this type of expenditure will be examined by the members in the next Charitable Funds Committee that is taking place on 29th August 2019.

Once printed off this is an uncontrolled document. Please check the intranet for the most up to date version.

May 2019 Version 9

Management of Charitable Funds Policy & Procedures

Summary of Changes:

This version has been significantly revised to take into account the Trust's requirements on the writing of Policies

Version:	9
Approved by:	Charitable Funds Committee
Date approved:	May 2019
Ratified by:	Trust Board
Date ratified:	TBC
Consultation:	Charitable Funds Committee
Name of originator/author	Revision: Nelson Garcia-Narvaez Charity Head of Finance Originator: Nelson Garcia-Narvaez Original Policy: Charity Head of Finance
Lead Director	Wayne Preston – Interim Finance Director
Name of responsible committee/individual	Charitable Funds Committee / Charity Head of Finance and Governance
Document Reference	BHT POL 063
Date Issued:	July 2019
Review date:	July 2021
Target Audience:	Directors, Non-Executive Directors and Fund managers
Equality Impact Assessment:	May 2019

24.4

Version	Issue	Reason for change	Authorising body	Date
1	0	New Document-Issued	Charitable Funds Committee	March 2008
2	0	Formal Review	Charitable Funds Committee	July 2010
3	0	Formal Review	Charitable Funds Committee	February 2011
4	0	Formal Review	Charitable Funds Committee Trust Board	August 2011
5	0	Formal Review	Charitable Funds Committee Trust Board	March 2013
6	0	Update and Formal Review – January 2015	Charitable Funds Committee Trust Management Committee Trust Board	January 2015 February 2015 March 2015
7	0	Update and Formal Review – May 2016	Charitable Funds Committee Executive Management Committee & Trust Board	May 2016 July 2016
8	0	Formal Review	Charitable Funds Committee Trust Board	February 2018 May 2018
9	0	Formal Review	Charitable Funds Committee Trust Board	May 2019 TBC

Associated Documents

BHT Ref	Title	Location/Link
n/a	Charity Commission – NHS Charity Guidance	https://www.gov.uk/government/publications/nhs-charities-guidance
n/a	Charity Act 2011	https://www.legislation.gov.uk/ukpga/2011/25/contents
n/a	Charity Act 2016	www.legislation.gov.uk/ukpga/2016/4/contents/enacted
n/a	Trustee Act 2000	http://www.legislation.gov.uk/ukpga/2000/29/contents
n/a	SORP 2015 / FRS102	https://www.gov.uk/government/publications/charities-sorp-2005 ; http://www.charitycorp.org/download-a-full-sorp/ http://www.charitycorp.org/media/619101/frs102_complete.pdf
n/a	Regulations 2008	www.legislation.gov.uk/uksi/2008/629/contents/made
n/a	Fundraising Regulator – new fundraising guidance	https://www.fundraisingregulator.org.uk/

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1. Introduction

This policy governs the way in which the Trust's charitable funds are managed and utilised. The document also incorporates more detailed procedures and templates of some of the forms that are required to be used.

The Health Services Act 1977 as updated by subsequent Acts, gives NHS bodies the authority to hold charitable funds. The Trust's charitable funds are derived from donations, legacies and investment returns. The charity's objectives are to utilise the charitable funds for the benefit of the National Health Service rather than to accumulate funds with which to achieve investment returns.

This document reflects charity law and guidance issued to NHS Bodies by the Charity Commissioners for England and Wales. The issue by the Charity Commissioners of the 'NHS Charitable Funds Guide' sets out in some detail the legal requirements and best practice to be followed by NHS Bodies. It can be accessed at <https://www.gov.uk/government/publications/nhs-charities-guidance>

Details of other sources of guidance and law are provided at the end of this document.

It is essential that authorising officers and fund managers familiarise themselves with these procedures and comply with them at all times. If any member of staff is in any doubt about any matter relating to the receipt, ordering or payment of any item relating to Charitable Funds, then they should contact The Charity Head of Finance and Governance.

2. Purposes

To provide clear guidance of the Trustee's Policy on how the Charitable Funds are to be managed, especially procedures around income and expenditure.

3. Scope

The Charity Commission

The Charity Commissioners for England & Wales is the organisation responsible for overseeing all charitable organisations. Under the Charities Act 2011 as amended by Charity Act 2016, the Commission is required to:-

- a) Keep a register of charities
- b) Promote the effective use of charitable resources
- c) Give charity trustees information or advice
- d) Change trustees of a charity where necessary
- e) Investigate and check abuse

The Commission does not have power to administer charities and will not normally interfere with the trustee's exercise of their discretion.

NHS Charities are within the jurisdiction of the Commission and are regulated by them.

All NHS Charities have to be registered with the Commission.

Charitable Purpose

Health Service bodies are not themselves charities, only the funds and property they hold on trust for exclusively charitable purposes constitute charities.

For a fund to be a charity it must have purposes which according to the law in England & Wales are exclusively charitable. Four main criteria are accepted :-

- a) The relief of those in need, by reason of ill health or disability
- b) The advancement of education
- c) The advancement of religion
- d) Other purposes beneficial to the community not falling in a), b) or c)

The Buckinghamshire Healthcare NHS Trust Charity is not set up for the relief of financial need.

Charities administered by Health bodies fall into category a) the relief of those in need, by reason of ill health or disability.

A purpose is not charitable unless it is for the public benefit. It must be of actual benefit, and must benefit the public as a whole or a sufficient section of the public. **A purpose is not charitable if it is wholly or mainly for the benefit of specific individuals.**

The Charity Commission allows expenditure on staff where it clearly enhances patient care.

Advancement of education - this is a charitable purpose where it enhances staffs knowledge above and beyond that which is required to carry out their duties. It includes funds for charitable medical research and the professional development of staff. If medical research is being financed by a charitable fund, the useful results of the research must be published so that the public will benefit.

Hospital staff welfare and amenity funds - these are charitable only because their immediate non-charitable purpose of providing benefits to the employees of the Trust, is perceived as being conducive to the furtherance of the charitable purposes of the Trust i.e. relieving people who are ill. The benefits must not go beyond what a good employer would consider reasonable to provide for its staff. The Charity Commission does not give specific guidance regarding what is reasonable.

More detailed guidance on expenditure types that meet charitable purposes is given below in the Addendum.

Structure, Registration and Objectives of funds

The Trust has registered with the Charity Commission, the “Buckinghamshire Healthcare NHS Trust General Charitable Fund” as an NHS Umbrella Charity.

Within the Umbrella Charity, the Trust has registered individual Special Purpose Charities. Each Charity includes several “internal” funds, which have been allocated to it.

The funds are a means of earmarking monies internally within the Trust for a specific purpose and are not separately registered with the Charity Commission.

Each Charitable Fund must have written objectives, which state the purpose(s) for which the fund is to be used and all payments from each fund must be in accordance with these. The objectives for each Charitable Fund must be approved by the Charitable Funds Committee and accord with the definition of charitable purposes (see above).

4. Definitions

Legal requirements covered within this Policy are outlined in the Charities Act 2011 as amended by Charity Act 2016 and the Trustee Act 2000.

The Charity: the Buckinghamshire Healthcare Charitable Fund, registered charity number 1053113, is separate legal entity from Buckinghamshire Healthcare NHS Trust.

Trustee: If an NHS body holds charitable funds as sole corporate trustee, the board members of that body are jointly responsible for the management of those charitable funds. Members of both the Trust Board and Charitable Funds Committee are not individual trustees under charity law but act as agents on behalf of the corporate trustee.

Charitable Funds Committee – a sub-committee of the Board whose responsibility is to oversee the management of Charitable Funds. This sub-committee has delegated responsibility under the Trust's Standing Orders and full details of the scope of its responsibilities can be found under its Terms of Reference.

Fund holders – key staff, in particular, wards/departments/services which 'advise' the trustee on spending the charitable funds within those service delivery units. They have delegated authority to make spending decisions within defined spending limits. However, where the Charitable Funds Committee feels that funds are being utilised for purposes that do not meet the definition of Charitable purpose above or disproportionate amounts are being allocated to a narrow group of staff or patients they may restrict this delegation of powers.

The Standing Financial Instructions (SFI's) set out the rules which regulate the financial arrangements within the Trust. The SFI's apply equally to Charitable Funds and, therefore, must be understood and applied by the fund managers acting as Authorising Officers. In addition, members of staff should apply normal ordering, receipting and payment for goods and services procedures for charitable fund purchases. <http://swanlive/policies-guidelines/standing-financial-instructions-and-limits>

'Umbrella' Charity – a charity registered under a single name and number under which several funds are held and administered. These funds may have separate purposes and objectives and the balance will be managed by different fund holders. Income and expenditure is allocated to these fund balances individually, whereas investment returns will be allocated in proportion to the fund balances held.

5. Roles and Responsibilities

This policy complies with Charity law and the Trust's Standing Orders and Standing Financial Instructions.

All members of staff who deal with charitable funds are responsible for following this policy and must ensure they adhere to it.

The Charitable Funds Committee acting as Trustees for the charity are responsible for the development, management and implementation of the policy, with the assistance of The Charity Head of Finance and Governance and finance team.

Trustees – Role and function

Where an NHS body has exercised its powers to accept, hold or administer trust property or funds for exclusively charitable purposes, they will be acting as charity trustees in respect of that property or funds.

Buckinghamshire Healthcare NHS Trust (BHT) holds and administers charitable funds and does so as a corporate body (known as the *corporate trustee*).

5.1 Trusteeship and the Board

The Trust is the sole corporate trustee of the Charity and the individual persons who, from time to time are responsible for the management of the corporate body, i.e. the Trust Board, are not themselves trustees of the charity. The duties, responsibilities and liabilities of trusteeship lie with the corporate body.

The corporate body must act through individuals to express its will, and therefore if the corporate body commits a breach of duty as trustee, it will have done so as result of a breach by the directors or other officers of their duties towards the corporate body.

The Trust has wide statutory powers to delegate administration of its trusts to officers, committees or sub committees. Where such powers are exercised the corporate body will remain as sole trustee and will be accountable for actions taken on its behalf. The Trust Board has delegated significant powers relating to Charitable Funds to the Charitable Funds Committee.

5.2 Charitable Funds Committee

The Committee has the responsibility to monitor performance of the portfolio of investments through the receipt and review of reports from the investment manager. The investment manager will attend each Charitable Funds Committee in order to give the members the opportunity to raise questions about the performance of the investments and the appropriateness of moving investments into other areas. The Committee will update the Board with regard to significant changes or issues with performance of the investments.

5.3 Investment Manager

The investment managers appointed will be responsible for investing the available funds as far as possible to fulfil the investment objectives. Further information is included within the Charitable Funds Investment Policy.

5.4 Trust managers and staff

For each Charitable Fund within the Trust, day to day responsibility must be vested with at least two members of Trust staff (fund managers). These must be staff members with a reasonable level of responsibility and have delegated authority to make spending decisions within the ward/department where the charitable fund is allocated. The Charity Commission allows delegation but only to the extent that responsibility for exchequer budgets is delegated.

An up to date record of these members of staff must be held by the Charity Head of Finance and Governance, who must be informed of required changes to fund signatories before a new signatory starts authorising expenditure. This should include the names, designation and sample signatures. The Charity Head of Finance and Governance simply verifies expenditure (see Addendum) and is NOT a Fund Manager or Authorising Officer.

6. Consultation and Dissemination

This Policy has been formulated by taking into account the guidance issued by the Charity Commission as well as the previously documented objectives of the Trustees in achieving investment returns. It was presented to the Charitable Funds Committee on 28th February 2018 for their comments before they ratified it.

Once ratified by the Board, this Policy will be published on the Trust's intranet within the Finance Policies section.

7. Monitoring Compliance with Policy

The Charitable Funds Committee, The Director of Finance, The Trust Head of Financial Control and The Charity Head of Finance and Governance have responsibility for the overall monitoring of the policy.

8. Related Policies

The following related policies & guidance are available on the Trust Intranet.

	Document
(a)	Standing Orders / Standing Financial Instructions (BHT Pol 089)
(b)	Limits of Delegation Policy (BHT Pol 061)
(c)	Code of Conduct (BHT Pol 019)
(d)	Standards of Business Conduct (Corporate Policies)
(e)	Charitable Funds Investment Policy (BHT Pol 041)
(f)	Charity Commission website for guidance documents https://www.gov.uk/government/publications/nhs-charities-guidance
(g)	Charitable Funds Committee Terms of Reference
(h)	Charities Statement of Recommended Practice 2005 and 2015 www.charitycommission.gov.uk/Library/guidance/sorp05textcolour.pdf http://www.charitycorp.org/media/619101/frs102_complete.pdf
(i)	Body of charity law including Charities Act 2011 as amended by Charity Act 2016, Trustee Investment Acts 1961 and 2000
(j)	Charitable Funds Reserve Policy
(k)	Fundraising regulator – new guidance https://www.fundraisingregulator.org.uk/

Addendum

DETAILED FINANCIAL PROCEDURES RELATING TO THE COLLECTION AND USE OF CHARITABLE FUNDS

1. INCOME

a) General

Charitable Funds must be kept separate from NHS Exchequer monies. Neither NHS organisations nor Exchequer funds can make donations to Charitable Funds.

Monies must not be accepted for the personal benefit of any individual staff member. All members of staff must account for donations and gifts in kind received. See section 7 "Non Cash Gifts"

Any donations or other income received are held in trust and must be paid **promptly** (the next working day) into Charitable Fund bank accounts, via the Cashiers Office.

b) Donations

The receipt of any donation for Charitable Funds must be acknowledged to the donor by way of a receipt which are produced within the Cashiering system

When a donation is received it is important to identify the area of benefit and to ensure that any condition or direction attached is noted **and is able to be complied with**. Where a restriction has been placed on the donation and the donor is very specific that it should be used for that purpose e.g. it must be used to pay for a certain item of equipment, the donation should be refused unless it is clear that the restriction can be complied with. Ideally donors should be encouraged to donate to a general fund.

Non-charitable income, i.e. payment for a good service supplied by the Trust or one of its employees in Trust time must not be paid into the charitable funds. This includes payments for services or the use of Trust equipment which are not a core function of the NHS. Examples of payments that may be received that are Trust income generating activities rather than charitable are:

- Payments from insurers of other third parties for medical reports, copies of medical records etc. that have been prepared by Trust staff in Trust time using Trust facilities. If Trust staff prepare such information in their own time they are free to state that the payment should be made to the Charity. (see section 1d below)
- Payments from third parties for the hire or use of Trust premises, equipment or other facilities.
- Payments for clinical trials that have taken part using Trust staff, facilities and time.

All donations are reviewed and income identified as potentially non-charitable income will be queried with the department concerned. The income will be transferred into the departmental NHS budget/clinical trial budget if no details are supplied upon request or the information provided shows that the income is not charitable.

As far as possible, there must be an avoidance of the creation of new funds and, where possible, funds of a similar nature should be amalgamated. Requests for new funds will be considered by The Charity Head of Finance and Governance and approved by the Charitable Funds Committee, but will not be set up for anticipated **donations of less than £10,000**. It is also necessary to avoid establishing impossible, undesirable or administratively difficult objectives from any donation received.

If members of staff require advice on any problems relating to donations given or offered they should contact The Charity Head of Finance and Governance.

All Wards and Departments should display the Charity Donations Poster (**see appendix 7**) giving details on how donations should be made. Where possible any staff, patients or visitors who wish to make a donation should be directed to the Cashiers office in order that an official receipt can be given and information and forms on Gift Aid can be provided. If they are unwilling to do this the process below should be followed.

- Wards or Departments.
A receipt (see **appendix 5** for sample) must be issued to the donor by the ward or department as soon as the donation is received. Cash and cheques should then be taken to the nearest Cashiers office with the blue copy of the receipt as a backing document. **It is up to the fund holder or nominated officer to code the backing document with the fund number, observing the donor wish.** If this is not done the donation will be credited to the general fund. The Cashiers Office will issue an official numbered receipt, which can then be sent with any 'Thank You' letter by the initial recipient.

To ensure effective security donations must be taken to the Cashiers for banking as soon as possible and not kept on the wards/department.
- Centrally Received.
Charitable Funds/Treasury Management Staff arrange for income to be banked and pass the receipt to The Charity Head of Finance and Governance for acknowledgement.

If payment is to be made by cheque, the donor should be advised to make the cheque payable to **'Buckinghamshire Healthcare NHS Trust Charitable Fund'**.

c) Other Issues

Instruction in how to make a Donation and Donations Posters

The steps to make Donations are available from the Charity Head of Finance and Governance, Charitable Funds Officer or on the Charitable Funds Website.

The Charity's website and the posters provide donors with information on how to donate to Buckinghamshire Healthcare NHS Charitable Fund and all the fundraising activities that could be organised in order to help our charity. The Charity's website address is <http://www.buckshealthcare.nhs.uk/gettinginvolved/charitable-funds.htm>

Gift Aid

In 2000 substantial changes regarding donations given under the Gift Aid scheme came into effect. If a donor is a tax payer the Trust merely needs to obtain a Gift Aid Declaration from the donor. The Charity Head of Finance and Governance has these forms or they are available on the [Charity's website](#). The basic information needed is the donor's full postal address and the number of the receipt. The donor's National Insurance number is not required. The Gift Aid Declaration can relate to a specific donation or to all donations made after the date of the declaration, provided the donor clearly informs the Trust that further donations have been made. It is however vital that the donor themselves sign the form otherwise the Trust will not be able to reclaim tax. If a donation is from a couple it is important that both parties sign the declaration.

Payroll giving

Under the Payroll Giving scheme, any employee can authorise their employer to deduct charitable donations from their pay before calculating Pay As You Earn tax. This way, the employee automatically gets tax relief at his or her top rate of tax.

From 6 April 2000, the £1,200 per year ceiling on the amount that an employee can give was abolished. There is no limit on the amount that can be given under the scheme.

If any employee is interested in this method of donation they should contact the Payroll department of their employer who can supply a form for completion.

Additionally, payroll giving can be directly requested, simply by completing the **Payroll Giving in Action form** on line. Just link to <https://www.givingonline.org.uk/>

Charity Aid Foundation (CAF) Voucher

If a voucher is received, it should be sent to The Charity Head of Finance and Governance as the voucher is not a cheque and cannot be paid into a bank account. The Charity Head of Finance and Governance will process the voucher and arrange payment into the appropriate charitable fund.

Just Giving

The Trust commissions a “Just giving” website, <https://www.justgiving.com/bucksnhs/donate/>, which allows donors/fundraisers to make donations over the internet. This is extremely useful for fundraisers who may receive donations from all over the country or world. Details of the website are provided on the donations poster and the Trusts external website.

Donations using Mobile Phones

General public and staff are able to donate from £2 to £10 using their mobile phones by texting BEST22 £2, £3, £5 or £10 to 70070. The Charity receives 100% of the donation.

d) Private Patient Fees and Medical Report Income

Gross **Fees Earned by individuals** (e.g. hospital clinical consultants) **MUST NOT BE** allocated directly to NHS Charitable Funds. Instead, if the fee earner (e.g. Consultant /Clinician) wishes to make a charitable donation:

1. **The monetary donation** should be made directly to the charity of the consultant’s choice at any time during the tax year.
2. The fee earner (e.g. Consultant) should declare the total amount paid over to all charities on his/her self-assessment tax return (form SA 100).

The income generated from signing medical reports, **CANNOT** be paid into the charitable funds. If this work is undertaken in Trust time, the income must be paid into the departmental revenue budget where the doctor is charged. If work is undertaken in the individual’s private time, and wishes to make a charitable donation, the related income should be treated in the same way as **Fees Earned by individuals**.

If fees are donated then the donor can restrict the donation to particular limited purposes. However it will be up to the Trustees to decide whether to accept the donation and, if accepted, how it is to be spent. Although the donation may be passed on to medical staff who donated it to administer (e.g. because the specified purposes is in that person’s area of responsibility) **the decision on spending is the Trustee’s and not the donor’s**.

If a donor were to provide a gift to a charity effectively under a gift aid arrangement and then gain personal benefit by the way in which that gift was used, this could invalidate the gift aid arrangement and therefore a taxable benefit for the donor would result.

Under current legislation, **it is unwise for a charity to enter into an arrangement whereby a third party (e.g. a patient) makes a payment directly to a charity for services provided by another party (e.g. a member of staff).** The payment is the taxable income of the service provider and must be declared by them to HM Revenue and Customs.

e) Staff approaching an outside organisation

A member of staff should not approach an outside organisation for financial/non-financial support/sponsorship to undertake charitable activities without prior approval of the Trustees. This approval may be gained by :-

- a) Contacting The Charity Head of Finance and Governance who will require detailed information concerning the request for support.
- b) The Charity Head of Finance and Governance will satisfy himself as to the charitable nature of the request, that it fits in with the charitable objectives of the individual fund concerned or the overall charitable objectives of the Trust.
- c) The Charity Head of Finance and Governance may refer the request to the Chief Executive if appropriate.
- d) The Charity Head of Finance and Governance will ensure that the request for approval is placed on the next Charitable Funds Committee agenda, if appropriate.

f) Organisations approaching staff

A member of staff who is contacted by an outside organisation should refer the organisation to The Charity Head of Finance and Governance, who is responsible for ensuring that:

- the offer is of a charitable nature,
- that it meets the charitable objectives of the individual fund and the overall Charity,
- that it does not impose any legal requirement on the Charitable Funds.

The Charity Head of Finance and Governance will ensure that the request is placed on the next available Charitable Funds Committee agenda, if appropriate.

g) Non-Cash Gifts

Small gifts of a personal nature e.g. boxes of chocolates, bouquet of flowers, where the whole ward or department is to benefit need not necessarily be refused. However, gifts given specifically to an individual for their sole use should be politely declined. Gifts may be offered to a ward to be used for instance, in a raffle.

Any ward/department wishing to hold a raffle should contact The Charity Head of Finance and Governance for advice.

All staff should ensure they follow the Trust's policy relating to Code of Conduct which is available on the intranet.

h) Legacies and Bequests

A significant level of income to the Charitable Funds arises from legacies or bequests, where a hospital or department is specified as a beneficiary in a Will.

The types of legacy gift are:

- Pecuniary legacy: this is a specific amount of money, decided by the donors.
- Residuary Legacy: this legacy means that after the donor's gifts to family and friends and other expenses, they can leave the remainder of their estate to be divided between their favourite charities. This is the most flexible option – They don't have to decide on an exact amount and it keeps pace with inflation.
- Reversionary legacy: this is a gift which is only paid after the death of someone else. If the donor has a spouse or partner, the donor may want to leave his/her entire estate to him/her on the donor's own passing, but the donor can specify that after their death, all or part of the remaining estate is paid to his/her favourite charities.

If any member of staff is approached by, or receives correspondence from, a solicitor/the Executors of a Will concerning a legacy they **MUST** refer the information to the Director of Finance who will ensure the legacy/bequest is passed to The Charity Head of Finance and Governance to administer and reclaim tax where applicable. **Only the Director of Finance can extinguish liability and discharge a legacy.**

Appropriate records of all legacies received, together with information on potential legacies must be kept by The Charity Head of Finance and Governance. The Charity Head of Finance and Governance will provide advice in respect of the wording of Wills.

Legacies are recognised and accounted for when it is probable that it will be received. This will be once:

- There has been grant of probate,
- The executors have established that there are sufficient assets in the estate, after settling any liabilities, to pay the legacy; and
- Any conditions attached to the legacy are either within the control of the charity or have been met.

The Charity adopted a policy of discounting the value of legacies where:

- The expected receipt date is more than 12 months after the balance sheet date
- AND the expected nominal value of the legacy is over £1 million or the expected receipt date is more than 3 years after the balance sheet date
- AND the effect of discounting is material.

Material legacies which have been notified but not recognised as incoming resources in the Statement of Financial Activities are disclosed in the balance sheet notes.

The discount rate will be the prevailing rate in line with the Trust's General Discount rate disclosed in the Department of Health Group Accounting Manual

i) Investment Income

The principal source of dividends and interest are those derived from the Charitable Funds Investment Portfolio held with the Trust's investment manager.

The Director of Finance is responsible for the recovery of tax from the HM Revenue and Customs Charities Division in appropriate cases where such interest is received net of tax.

Interest is also received from funds held in the Trust's Charitable Funds bank account.

Distribution of Investment Income to individual Charitable Funds is made quarterly, based on the average monthly balance of each fund over this period.

Details of the Charitable Funds Investment Policy are included at section 3 (page 26) of these procedures.

j) Fund-raising

Fund-raising traditionally includes activities such as jumble sales, bazaars, fetes, lotteries, raffles and special appeals.

Fund-raising for the general purposes of an existing Charity does not create a new charity and fund-raising is not a charitable purpose in itself. It has to be carried out in support of charitable purposes (see section 3 of these procedures for the definition of a charitable purpose).

The Trust as Trustee to the Charitable Funds, is responsible for ensuring that:

- a) Fund-raising is properly carried out in line with the current Fundraising Regulator guidance;
- b) Expenditure is properly validated;
- c) All funds raised are properly accounted for;
- d) They are not seen to be speculating with charitable funds and that the costs of fund-raising are not excessive
- e) Fund raising is not prejudicial and does not harm the reputation of the Charity or Trust
- f) It is being carried out for purposes that the Charity considers meet its objectives
- g) To ensure that the charity does not need to purchase additional insurance cover.

In order that the conditions set out above are achieved, The Charity Head of Finance and Governance deals with all matters relating to fund-raising throughout the Trust. **Any member of staff who is proposing to carry out a fund-raising project must, in all instances, contact The Charity Head of Finance and Governance prior to any action being taken.**

For all fund-raising activities The Charity Head of Finance and Governance will need the following information:

- a) name and designation of the fund-raiser
- b) the name of the Ward/Department/Group or organisation
- c) contact address, telephone/fax number
- d) purposes, nature and period of the fund-raising
- e) the estimated cost of the fund-raising activity
- f) the amount expected to be raised

No commitment to fund-raising should be made until approval has been given by The Charity Head of Finance and Governance.

Under Charity regulations any donations received as a result of fund-raising or an appeal must be used for the purposes that the fund raising advertised. If the proceeds of the fund raising cannot be used for the advertising purpose, or more funds are raised than required, then under Charity regulations they are required to be returned. All fund raising literature should also include the caveat of 'for the purpose of XXXXX except where this is not possible or practical, where they will be used for an alternative charitable purpose within Buckinghamshire Healthcare'.

Members of staff and other organisations who wish to fund-raise independently of the Trust Charitable Funds **must make clear to potential donors that they are doing so independently**

and not on behalf of the Trust. Members of staff must comply with the conditions detailed above.

More detailed information about the issues relating to fund-raising for charitable funds is contained in the Charity Commission Guide number CC20 and the Fundraising Regulator guidance. A copy of these Guides are kept by The Charity Head of Finance and Governance.

The Charity Head of Finance and Governance should be contacted for advice regarding the running of a raffle in accordance with the Lotteries and Amusements Act 1976, as amended by the National Lotteries Acts of 1993 and 2006.

k) Trading

Charity law does not permit charities to exercise a trade on a substantial or regular basis simply for the purpose of raising funds. Trading is only allowed if it is undertaken in pursuance of the principle charitable objectives of a charity, for example training and education by a school run as a charitable foundation. **The principal objective of the BHT charity is the relief of those who are ill; therefore we are NOT permitted to trade.**

The following will generally be regarded as the exercise of a trade:

- a) the provision of services for reward
- b) the sale of goods which have been bought in
- c) donated goods which have been altered or improved prior to sale

The straight forward sale of donated goods will not generally be regarded as the exercise of trade.

Members of staff should therefore, seek advice from The Charity Head of Finance and Governance before considering any form of Charitable Fund activity which could be regarded as trading.

HM Revenue and Customs is the primary arbiter of what constitutes a “trade” for tax purposes and the fact that all profits or surpluses are to be used for charitable purposes is irrelevant. A tax liability arises if any surplus/profit results from the trade.

l) Income from other NHS organisations

Where income is generated from **non-charitable activity**, this income must be credited to the Exchequer funds of the Trust and **NOT** to Charitable Funds.

Income from other NHS Organisations will usually relate to Exchequer funds, as NHS organisations are not able to make charitable donations.

If a member of staff is in any doubt about the source of such an item of income generated to the Trust, they should contact their Finance Manager or The Charity Head of Finance and Governance for clarification.

m) Rebates

Where income is generated from Exchequer **rebate activities**, this income must be credited to the Exchequer funds of the Trust and **NOT** to Charitable Funds.

n) Grants

Where members of staff are aware of any grants received from **government and public bodies** which are attributable to Charitable Funds (i.e. for a charitable purpose) these grants must be identified as charitable and not included in Exchequer funds of the Trust. The Charitable Funds Annual Accounts must identify separately all such grants and it is therefore essential that members of staff make this information available to The Charity Head of Finance and Governance.

Grants that are received from **non-public bodies** for a charitable purpose are treated as Charitable Fund **donations**, and therefore should be identified as such.

o) Gains on disposal of Intangible and Tangible Fixed Assets

The Annual Accounts of the Charitable Funds must record all gains on the disposal of Intangible and Tangible Fixed Assets.

Based on current definitions there are no intangible or tangible fixed assets held within the BHT Charitable Funds.

The only examples of Intangible Fixed Assets so far identified are copyrights and logos.

p) Charging for services to Patients

The HFMA current guidance states that NHS charitable funds considering to charge for part or all of their services, should bear in mind important considerations whether to charge, and if so, how much.

This guidance also states that the fees charged can more than cover the cost of the relevant services or facilities, provided that the charges are reasonable and necessary to carry out the charity's aims. However, where the amount charged means that the benefits are NOT available to a sufficient section of the public, this may cause difficulties. Charging **MUST NOT** result in the people with less resources being excluded and if the Trustees consider that charges are too high, provision must be made so that the people with less resources can benefit and such provision **MUST BE** more than minimal.

Making a charge without first properly considering the issues may jeopardise the fund's charitable status and be a breach of trust. Therefore, in order to ensure the compliance with this guidance, the Committee requires that these activities are assessed before implementing any recharge to patients in order to ensure that the appropriate provisions have been considered and the charges are justified.

2. EXPENDITURE

a) General

Charitable expenditure must be for the public benefit and cannot be for the benefit of a specific individual or group of individuals. It must have a direct or indirect link to actual benefit for the public or a wider group of individuals. Given that the principle purpose of the NHS is to deliver services to patients, then, in simple terms, the outcomes to be achieved using charitable funds should always be patient focused.

The Charity's funds are held as two main types:

- Unrestricted funds comprise those funds which the Trustees are free to use for any purpose in furtherance of the charitable objects. Unrestricted funds include designated funds, where the donor has made known their non-binding wishes or where the trustees, at their discretion, have created a fund for a specific purpose.
- Restricted funds which also have to fall within the purpose of the Charitable Funds, but which may have further restrictions placed upon them e.g. for the benefit of certain areas or departments or for certain types of expenditure e.g. training. The fund holders of these funds are expected to have a clear understanding of what restrictions are to be applied to those funds and ensure that the restrictions are complied with.

The statutory purpose of the Charitable Funds is defined as:

Any charitable purpose or purposes relating to the National Health Service wholly or mainly for Buckinghamshire Healthcare NHS Trust.

In addition for all funds, further criteria should be applied before expenditure can be approved:

- Is the proposed expenditure for the public benefit/patient benefit?
- Does it fit with Buckinghamshire Healthcare's own priorities?
- Will it incur additional costs e.g. staffing, training, consumables?
- What arrangements are in place for when the funding ceases – is there an “exit” strategy?
- As a charity the activities are open to scrutiny by the public and all expenditure should be capable of being robustly defended in case of any query from a donor, the Charity Commission or the media.

If these criteria can be met, expenditure can be authorised if it falls into one of the following categories and is compliant with the fund purposes (e.g. a member of staff should not be paid from an equipment fund).

Charitable Funds can be used to supplement or subsidise public services when:

- They are within the charitable objects;
- They are in the interest of the Charity and its beneficiaries; and
- There is a clear justification for doing so.

The Trustee must be able to demonstrate that, before applying charitable funds towards service delivery, there has been a clear, independent and open decision-making process.

Benefits to Patients

- Improvements in the patients' physical conditions while in hospital over the level that would normally be expected to be provided in an NHS hospital
- Improvements in the patient's clinical care through:
 - Research (see section b.5 below for further information)
 - Education
 - Introduction of new technologies
 - New equipment
 - Advances in diagnosis
 - Advances in management

Benefits to Staff

For expenditure on staff to be charitable it should have a direct or indirect link with improving the level of care provided to patients. The Charity Commission accepts that, so long as a direct benefit to staff translates demonstrably to relief of sickness of NHS patients, it is a legitimate use of the unrestricted charitable funds to provide such a benefit. This may include, in certain circumstances, expenditure to improve staff recruitment, retention and morale.

- Improved conditions of work and welfare. As a rule this must be for a whole group of staff and not for specific individuals.
- Support for research
- Support for education
- Support for training

In deciding how to spend funds available for staff welfare purposes the Trustees need to consider:

- To what extent the intended charitable outcome from a particular payment can be measured and demonstrated.
- How effective the particular payment used will be in delivering the ultimate outcome.
- How strong the connection may be between the particular payment used and the charitable outcome intended.

This approach does not rule out funding to individual member of staff where there is a clear link to the care of patients.

b) Detailed Areas of Expenditure

1. Equipment

Charitable funding should normally be seen to be used to supplement the Trust's usual activities, which benefit the patients that are, were or will be treated at Buckinghamshire Healthcare NHS Trust.

Medical or other equipment can be purchased through the Charity if it meets the tests outlined above, the direct benefit to patients can be demonstrated and its compliance with the charity's objectives and purposes.

Under special circumstance and with approval of the Committee, Equipment replacements will be considered by the charity when the expenditure is focused only on the patient benefit and it will have an immediate and direct effect in the services that are provided to the patients within the Trust.

Trust procedures on the procurement of medical and IT equipment will apply. This includes infection control procedures.

The purchase of medical equipment must be approved by the Medical Equipment Panel and Capital Management Group before any order is placed. The Charitable Funds Bid should be submitted to this panel before being passed to The Charity Head of Finance and Governance for him to seek the required level of authorisation. Any bid or request for the purchase of medical equipment will be returned if approval has not been given.

The Medical Equipment Panel and/or Capital Management Group should indicate the equipment priorities that need to be considered, in the financial year, to the Charitable Funds Committee.

The Charitable Funds Committee may call fund holders to attend a Committee meeting to provide information in how the charitable funds monies are being used in line with the objective of the fund and for the benefit of patients that are/were treated by the Trust.

In most cases IT equipment is now seen as essential equipment and should usually be purchased through the Trust. IT equipment can only be bought through charitable funds where the equipment is going to be used primarily for charitable purposes e.g. direct patients activities or services, research, education and training or where it is necessarily, included as part of a larger project undertaken by the charity.

Only IT equipment which has been authorised by the Trust's IT department will be purchased to ensure that it is compatible with Trust systems. Therefore requisitions for IT equipment will be passed to the IT department for approval before any order can be placed.

Equipment for individuals e.g. Phones, laptops or other mobile devices, will not be funded unless it can be demonstrated that it will be used for charitable purposes or is in the public benefit.

The Charity will not fund the upkeep of such equipment or any consumables such equipment requires.

2. Employment of Staff

The Charity does not directly enter into contracts of employment with staff. Any members of staff, whether working directly for the Charity or on projects paid for by the Charity, enter into contracts of employment with Buckinghamshire Healthcare NHS Trust and the costs are recharged to the Charity.

In order to consider whether to fund staff costs the Charitable Funds Committee will need to take into account:

- The project to be funded and whether the aims of that project meet charitable objectives. The Charity will not fund staff costs on an ongoing basis for undefined general purposes e.g. 'research'.
- Whether the fund has restrictions applied to it that prevent the funding of staff costs e.g. equipment only funds
- Whether the particular fund has sufficient monies to cover all the costs associated with staffing over the lifetime of the project . As well as salary costs, the total cost will include Employer's National Insurance and Pension Scheme contributions.
- Whether an 'exit strategy' has been considered for the staff costs. Either staff will need to be seconded into posts and their substantive post filled with temporary staff or staff will need to be recruited on a 'fixed term' basis. However fixed term contracts which are extended past a certain period can confer permanent employment rights so HR should be contacted for further information. The Charity will not cover any type of severance pay.

All bids sent for approval must include consideration of all the points above for it to be presented for approval.

Costs of employing Trust staff cannot be recharged to the Charity except in the circumstances above. For example the staff advertising is not a charitable purpose in itself and should not be paid for by the Charity in cases where the Trust will not fund the advertising.

24.4

3. Patient Amenities

Expenditure that improves the patient experience or the patient's environment meets one of the Charity's key purposes. Some issues that may need to be considered are:

- Is the proposed expenditure over and above the level that would normally be considered reasonable for an NHS Trust to provide?
- Is the level of expenditure proportionate with the number of patients that are likely to benefit from it? The larger the expenditure the greater the number of patients that could be expected to be able to benefit.
- Are there any ongoing running or maintenance costs associated with the initial expenditure? These will need to be considered as part of the approval for expenditure. For example the installation of a water cooler in an outpatients department will have ongoing costs of supply and maintenance.
- Are there any issues with infection control or security, or any other health and safety issues. The Trust's normal policies will need to be complied with.
- Could the expenditure adversely affect other patients' experiences or the Trust's reputation? Equality and diversity guidelines should be taken into account. Also people's perceptions of artwork etc. may vary if this is purchased when rooms are being refurbished.

4. Staff Amenities

What constitutes appropriate expenditure on staff amenities is a far more complex and problematic area. The overriding principles of expenditure leading to public benefit and being in line with the Charity's objectives should always be borne in mind. This can be translated into whether a donor, the Charities Commission, a patient or other stakeholder would consider the expenditure to be fair and

reasonable and in the public interest. Areas of expenditure and issues that need to be considered are outlined below:

- **Training and Education**

The Charity will fund staff training and education **where it can be shown that there is a direct or indirect benefit to the patients or staff of Buckinghamshire Healthcare NHS Trust**. The member of staff who is to attend the training event/course/conference must have the approval of their line manager or Head of Service and the fund holder before approval for the expenditure can be given. Attendance at a training event or conference, the subject of which, however commendable, **is not likely to benefit the health of the people of Buckinghamshire, cannot be funded**.

- Charitable Funds should have confirmation from the applicant and fund holders that this petition for Training/Conference/Courses support has been previously requested to the Trust and cannot be covered by:
 - Statutory and Mandatory training - BHT
 - Health Education England funded training
 - Apprenticeship levy funds

The benefit of the training or education must be available for some time after it is undertaken i.e. members of staff on rotation or who are due to leave the employment of the Trust would not normally be entitled to be funded through the Charity.

Travel and subsistence expenses will be reimbursed in line with the Trust's normal expenses procedure, although the claim should be made to the Charity. For the avoidance of doubt:

- Travel expenses will be refunded for standard fares on trains or economy flights. First class or business class tickets may only be partially reimbursed to the extent that the member of staff pays any premium above standard or economy fares for these tickets themselves.
- Reasonable subsistence and accommodation expenses will be refunded. Although it is recognised that costs vary according to geographical location, claims for reimbursement must be capable of being defended and information on costs of accommodation in that location should be able to be provided. Again members of staff may choose to 'upgrade' but any additional costs will need to be met by themselves.
- Travel or subsistence for any person accompanying the member of staff will not be refunded.
- If attendance at a conference is extended to cover a period before or after the conference days as a holiday the additional costs will be payable by the member of staff. The Charity will not fund any additional costs of 'open-ended' tickets and will only refund a scheduled return journey.
- Reimbursement claims must be submitted within three months of the expense being incurred. Failure to submit by the deadline will result in the expense claim being rejected.

Where the costs of attending a training event or conference have been significant the member of staff benefitting from this event may have to provide a presentation on their learning to the Trustees, demonstrating that it benefits the Trust's patients or staff.

Individual membership of professional organisations will not be reimbursed. Subscriptions to any magazines, journals or other information sharing sources should benefit a number of individuals and must not be of personal interest of one member of staff.

Books, leaflets, posters, newsletters etc. that are used to educate or inform patients over the level that may be expected to be provided by the Trust is an appropriate use of Charitable monies.

- **Conferences, special events and support by visiting speakers arranged by the Trust**

Training events, conferences and dinners are sometimes arranged using charitable funds. Where these are modest events e.g. a lunchtime or evening lecture, it is reasonable to make small payments or reimburse reasonable expenses to the speaker. Any lunches and dinners arranged can only be attended by professional colleagues and must be directly relevant to the speaking event. The reputation of the Trust and the Charity must be taken into account when arranging such events and the venue and cost of meal must be carefully considered and seen to be appropriate.

Where the event is opened up to outside attendees as a method of fund raising (as opposed to meeting a part of the cost) then the income and expenditure must be separately accounted for, and the guidance on fund-raising above taken into account.

Where there is a major event to be organised The Charity Head of Finance and Governance may need to be contacted in advance for advice.

- **Entertaining and Social events**

Staff entertaining (even if funded by the Charity) is a taxable benefit except when specific criteria are met. In order for a taxable benefit not to be incurred the event needs to be open to all staff, or those in a specific department or location. These events cannot be open to guests without a taxable benefit occurring, unless the guests are paying the full cost of the event. In addition the costs of these events, including those available to all staff, cannot exceed £150 per annum.

When arranging staff events the reputation of the Trust and the Charity should be considered. Events that may be seen to be 'stunts' or lead to disrepute will not be supported by the Charity. The Charity will not fund the costs of alcohol.

Routine expenditure on general benefits for staff, such as tea, coffee, milk or water will not be funded by the charity. Occasional events such as modest departmental team events may have a strong motivational impact on staff and indirect benefit to patients. These can be supported at the discretion of the fund manager. The provision of water coolers is only appropriate if they are primarily for the use of patients.

- **Retirement and long service awards**

The Charitable Funds Committee has enjoyed supporting these activities for several years. However in order to comply with the guidance and regulations from regulatory bodies, it is necessary that all funds should be spent in activities that directly benefit the patients of the Trust and translate demonstrably to relief of sickness of patients. Therefore the Charitable Funds Committee is no longer able to support expenditure related to retirement and long service awards.

Retirement functions will not be funded through the charity.

- **Other gifts**

Routine expenditure on gifts for staff will not be supported.

5. Research

Medical research financed from Charitable Funds may only be commenced when there is the intention at the outset that the results will be published, for example as an article in a professional journal.

Medical research is not always successful, and therefore there would be no point in publishing the results unless it is likely to assist future research. However the Research and Development Department will monitor and review the progress of all research and the planned programme of payments.

The support by a charity of private commercial research is not permitted.

A research project funded by Charitable Funds must be for the public benefit and not for the benefit of a private individual or organisation (i.e. where the results are owned by the sponsoring drug company). Such research projects are exchequer income generation schemes.

Details of any proposed research to be met from Charitable Funds must be approved by the Research & Development Department prior to commencement. All intellectual property rights arising from any research must accrue to the benefit of the Trust.

The Research and Development Department will be pleased to advise and assist on any proposed research projects.

Below is an excerpt from the NHS Executive's Funds held on Trust guidance

Where charitable funds are used to provide grants or other funding for research, the Trustees have a duty to ensure that they have power to do this and that the research they are funding is charitable.

In any case of charitable research to which the charity devotes any resources, the basic duties of Trustees are to ensure that:

- a) *the research falls within the scope of the charity's purposes and its powers, and is an effective way of fulfilling those charitable purposes*
- b) *the research is well managed and cost effective*
- c) *the research is good quality and*
- d) *the research is used with the aim of achieving public benefit.*

These duties are onerous and should not be undertaken lightly.

Charitable purposes are those that the law acknowledges as carrying a public benefit in their fulfilment. It is important to understand that there is nothing charitable, and no inherent public benefit, in conducting research or in paying someone else to conduct it. A body whose purpose is merely to conduct or fund research in a particular field is not a charity. The charitable element, and the realisation of public benefit, lies in the use of research and its products to achieve the broader purpose, recognised as charitable. The task of charity trustees is to ensure that the useful products of the research which the charity has resourced are devoted to the active fulfilment of their charity's purposes and, thus, to the realisation of a public benefit.

When a drug company contracts with a researcher to undertake a clinical trial on its behalf, the contract, which is made between the researcher and the drug company, invariably makes it clear that the results are owned by the drug company. Therefore, even if in due course the results are made available to the public, it is the drug company that receives the results first in order to see if they are capable of being exploited commercially. This is therefore a business service undertaken

by the researcher or by the NHS trust (depending on who signed the contract) and not a charitable activity.

*If such research is being undertaken on NHS premises, using NHS resources, then the NHS Trust may be entitled to recover its costs – dependant on the terms of the agreement between researcher and NHS Trust. Any such income should be accounted for within its **exchequer** funds as income generation and should not pass through NHS charitable funds – even as a matter of convenience.*

If it is the researcher rather than the NHS trust which signed the contract then at the end of the drugs trial, and after deducting any allowable costs including those due to the NHS, the researcher may be left with an amount of “profit”. This clearly has tax implications for the researcher. They can defray some (or all) of this tax liability by making an outright gift of the amount into one of the charitable funds registered with the NHS trust – the donation should follow the tax rules e.g. gift aid.

The practicalities of carrying out the research must be considered, especially with regard to staff costs and the guidance contained in this document on the Charity funding staff costs should be complied with.

6. Fund-raising/Publicity

All proposed fund-raising schemes for Charitable Funds must be approved by The Charity Head of Finance and Governance (see Section 2)

Any proposed fund-raising scheme application must clearly identify all estimated costs in carrying out the scheme, including those of publicity and give an indication of anticipated income.

All publicity in respect of Charitable Funds must be approved in advance by the Communications Department and The Charity Head of Finance and Governance.

7. Trading

The BHT Charity is not set up to undertake trading activities. If any member of staff is proposing any fund-raising activity, which could be construed as trading, to provide for Charitable Fund income, they must in the first instance consult The Charity Head of Finance and Governance.

8. Expenditure approved by another Charity

Where another Charity (for example Scannappeal) has agreed to fund or part-fund a purchase this needs to be marked clearly on the paperwork in order that a recharge invoice can be raised to that Charity.

The charitable funds will proceed to purchase this equipment or service, only when a “Mandate” has been received from the external charity authorising this transaction and when a charitable funds authorised non-stock requisition is received from the department/ward that requested the funding.

The charitable funds will raise a recharge invoice to the external charity for the equipment or service provided. A recharge invoice will not be raised, until the supplier invoice and the goods received notification, have been received and paid for by the charity.

Invoices are raised with a 30 day payment terms and are chased accordingly when these terms are exceeded.

9. Management and Administration

Management and Administration costs incurred by Charitable Funds includes central management and administration costs, which include the costs of legal advice, audit fees, payroll, creditors, financial information etc.

Costs are recharged to each fund on a quarterly basis, in proportion to fund balances. This is achieved by netting the costs against the Investment Income due to each fund. (See section 2). Distribution of Investment Income to individual Charitable Funds is made quarterly at the end of March, based on the average monthly balance of each fund over the past financial year.

10. Brokers Fees

Brokers fees are charged for the management of the investments within the Charitable Funds Investment Portfolio. These costs are billed separately on a quarterly basis in arrears. Therefore Investment Income shown in fund balances is net of these costs.

c) Procedures for the committing of expenditure

The Trust's usual Requisitioning, Ordering, Receipt and Payment for Goods and Services procedures apply to both Charitable Funds and Exchequer funds. They must be complied with on all occasions charitable funds are to be committed. **In all cases, The Charity Head of Finance and Governance must be aware of orders being placed against Charitable Funds. All expenditure from Charitable Funds must be within the terms of any general and specific restrictions placed upon the relevant funds. All requisitions, payment requests etc. must be verified by The Charity Head of Finance and Governance following authorisation by one fund signatory.**

After receiving all the appropriate and authorised documentation, the Charitable Funds department requires **at least 10 clear working days** to process and pay expenditure. This is to enable the charity to process the paperwork in a timely manner for the BACS weekly pay run. Please note the charity no longer pays by cheque, unless in exceptional circumstances.

Purchases should not be undertaken until The Charity Head of Finance and Governance has seen and authorised the proposed expenditure.

In instances where The Charity Head of Finance and Governance is not sure that the expenditure meets the definition of being charitable he may request further information from the fund holder. In cases where the expenditure does not meet the appropriate threshold for being charitable it will be refused.

1. Authorisations

The current Limits of Delegation Policy sets out the authorisation limits for Charitable Funds.

Where proposed expenditure on an item exceeds £5,000, a Charitable Funds Bid form must be completed (see appendix 2) and the appropriate levels of authorisation must be obtained.

2. Value Added Tax (VAT)

Certain purchases from charitable funds require completion of a VAT Exemption Declaration form. The VAT Exemption Declaration forms are held by The Charity Head of Finance and Governance, who will complete the form, where applicable, and ensure that it is attached to the order.

There is no general relief from VAT for charities. However, zero rating can be obtained on the purchase of medical, scientific, computer, video, sterilising, laboratory or refrigeration equipment which will be used in medical research, training, diagnosis or treatment. The equipment must be purchased wholly from charitable funds in order to obtain the relief.

3. Charitable Funds Orders

Once the appropriate level of approval has been given a non-stock requisition should be completed, signed by the fund holder and forwarded to the Charitable Funds department, together with any

supporting paperwork or quotations.

The Charitable Funds department will raise a Charitable Funds order and record the proposed expenditure as a commitment against that fund. Where goods have been ordered a copy of the order will be sent to Stores to receipt delivery.

Invoices will be paid against the order once receipt of the goods/services has been recorded, so it is important that this is notified to the Charitable Funds Department as soon as the goods or services have been provided.

There may be some instance, for goods that that are over and above what the Trust should supply (in order to benefit the patients and staff), where companies require payment of goods before delivery and therefore will not accept an official Charitable Funds order. When this occurs and there is a clear cost benefit and best value for money in procuring the goods directly from recognised high street/on line retailers/wholesalers (e.g. Ikea, DFS, Amazon, etc) the charity will give written authorisation to the department/fund holder for these goods to be purchased via the Trust using their computerised ordering system. These items will then be recharged to the Charity.

4. Charitable Fund Payment Requests

Payment requests are only to be used in an emergency when an urgent cheque is needed. Charitable Funds orders should be used in normal circumstances.

A Payment Voucher should be sent to The Charity Head of Finance and Governance (Appendix 1) containing details of the reason for the request (with supporting documentation) and signed by one fund signatory, will ensure a cheque is raised.

Receipts/supporting documentation **must** be provided for reimbursements. Where payment is made in a currency other than British Pounds, using a credit card, the reimbursement will take place on production of the credit card statement showing the exact sterling amount charged. For foreign currency payments not made on a credit card, the exchange rate on the day the reimbursement request is received by The Charity Head of Finance and Governance will be used to calculate the amount owed.

Travel/mileage must be claimed using the Trusts travel and subsistence form as the amount reimbursed is calculated by Payroll, based on vehicle size and distance travelled.

Claims for reimbursement to a fund holder cannot be signed by that fund holder. In normal circumstances the fund holder's direct line manager should be asked to countersign the reimbursement. Where that line manager is not themselves a fund holder another fund holder on that fund may be requested to confirm that the expenditure is charitable.

5. Cheque/Payment with Order

In normal circumstances payments should be made only on the receipt of goods and services. However in some instances, such as training courses, payments need to be made in advance. **Payments in advance for goods are not usually acceptable.** On receipt of the requisition marked "Cheque with Order" The Charity Head of Finance and Governance will request a cheque to be raised.

All payment requests must be verified by The Charity Head of Finance and Governance.

6. Petty Cash

Petty Cash should only be used for payments under £50.

Disbursements from Petty Cash may be made for Charitable Funds expenditure when adequate supporting documentation is provided i.e. receipts. The fund holder will need to sign and code the documentation before the recipient of the payment takes it to Cashiers.

3. INVESTMENT OF FUNDS

The Charitable Funds policy related to the investment of funds is covered separately within the Charitable Funds Investment Policy (BHT Pol 147)

- Investment fixed assets are shown at market value.
- Quoted stocks and shares are included in the balance sheet at mid-market price, excluding dividends.
- Other investment fixed assets are included at trustees' best estimate of market value.

4. BANKING

All banking arrangements for Charitable Funds must be in line with the procedures set out in the Standing Financial Instructions.

All income to the Charitable Funds must be deposited in accounts held with the Government Banking Service.

The Director of Finance is responsible for ensuring that bank account balances do not become overdrawn or excessively high. Surplus funds are invested in the investment portfolio.

Under no circumstances should a separate bank account be held or operated for any fund or appeal sitting within the Umbrella charity.

The Director of Finance is responsible for ensuring the secure operation of all Charitable Fund bank accounts.

5. REPORTING

a. Monthly Statements

All Fund Holders will be issued with monthly statements of income and expenditure.

It is the responsibility of all authorised officers to review the accuracy of Account Statements and to raise any queries with The Charity Head of Finance and Governance.

A written record should be kept of all agreed amendments that are required to be made in order that these amendments can be checked against subsequent Statements.

b. Statement on Unrealised Gains and Losses

Unrealised gains and losses on investments of Charitable Funds are allocated quarterly, based on the average monthly balance of each fund over this period. Any significant unrealised loss on the value of the investments may require specific action by the Trustees to temporarily curtail any further expenditure on all the charitable funds

c. Accruals and Commitments

While the Charitable Funds team try to ensure that commitments are recorded for all orders processed by the department, Account Statements may not currently include the value of all requests for payment placed or where goods and services have been received but not yet paid. It is imperative that fund holders take into account any outstanding commitments before placing further orders that would place their fund in an overdrawn situation.

d. The Reserve Policy and annual spending plans

The Trustees are under a legal duty to apply charitable funds within a reasonable time of receiving them but should also hold some money in reserve. The appropriate level of those reserves (the reserve policy) should be considered and reviewed regularly by the trustees. This policy should be available to any fund advisers and other NHS staff dealing with charitable funds.

Trustees are required to have a formal reserves policy, review this regularly and report on it in their annual report (Refer to CC19).

In the trustees' annual report should be reported:

- why you need to keep money aside instead of spending it on your charity's aims
- how much your charity holds in reserve
- why your charity needs to hold this amount in reserve

The Trustees consider that reserves should be set at a level which is equivalent to estimated planned commitments' in the next financial year covering a period of three months. At this level, and in the event of a significant reduction in charitable funding, Trustees feel that they would be able to continue with the current programme of activity for such time as is necessary to allow for a properly planned and managed change in the activity programme and/or the generation of additional income streams. (Refer to Charitable Funds Reserve Policy)

The reserves are maintained in a readily realisable form within the Portfolio Investments.

The Trustee is expected to ensure that charitable funds are spent, on the purpose for which they were donated, within a reasonable timescale, unless funds are being amassed for a large piece of expenditure. Delays in spending funds may result in a breach of trust.

Account balances are continuously monitored. The Charity Commission can hold the trustees in breach of trust if they accumulate funds without good reason.

Fund Managers are required to forward their spending plans for the next financial year to The Charity Head of Finance and Governance by 31 March, for collation and presentation to the Charitable Funds Committee.

e. Risk Management Report and registry

Due to the Adoption of the 'FRS 102 SORP' by The Charitable Funds Committee (CFC), an Analysis of Risks and a Risk Register are required. This risk register should provide a description of the principal risks and uncertainties as identified by the Trustees, together with a summary of their plans and strategies for managing them and this information should be disclosed on the charity annual report (Balance Sheet notes).

The risk register should be monitored by the Charitable Funds Committee, periodically, to ensure actions are taken in the areas that have been identified to strengthen the position of the Charity. This is to ensure that the Trustees are covered for liability in line with the Charity Commission and SORP expectations.

f. Annual Accounts & Annual Report

The Trust must submit an Annual Report and the Director of Finance is responsible for producing Annual Accounts for Charitable Funds. These reports must be submitted to the Charity Commission to the deadline set and must comply with all charity law and the Statement of Recommended Practices issued by the Charity Commission.

6. AUDIT

a. External Audit

The Charity Commission requires that our charity has an independent audit. The auditor appointed for the Buckinghamshire Healthcare NHS Trust Charitable Fund is Grant Thornton.

External auditors are now required to report separately to the Charity Commission on any matters of concern.

b. Internal Audit

All systems within the Trust relating to Charitable Funds are subject to continuous internal audit. All records within Divisions relating to Charitable Funds should be made available whenever required by internal audit staff.

c. Monthly Analysis

All charitable income and expenditure is reviewed on a monthly basis. If you are asked to provide further information about income or expenditure you must do so. If any transaction (income or expenditure) appears to be non-charitable and no explanation is provided to the Charitable Fund Accountant, the transaction will be removed from the funds and coded to the department's exchequer budget.

7. TRAINING

Training is available from the Charity Head of Finance and Governance at the request of the Charitable Fund Managers.

BUCKINGHAMSHIRE HEALTHCARE NHS TRUST

CHARITABLE FUNDS

PAYMENT VOUCHER

PLEASE PAY

NAME OF PAYEE
ADDRESS
POSTAL CODE

DATE	DETAILS	£	P

Certified for Payment.....(Name)(Signature)

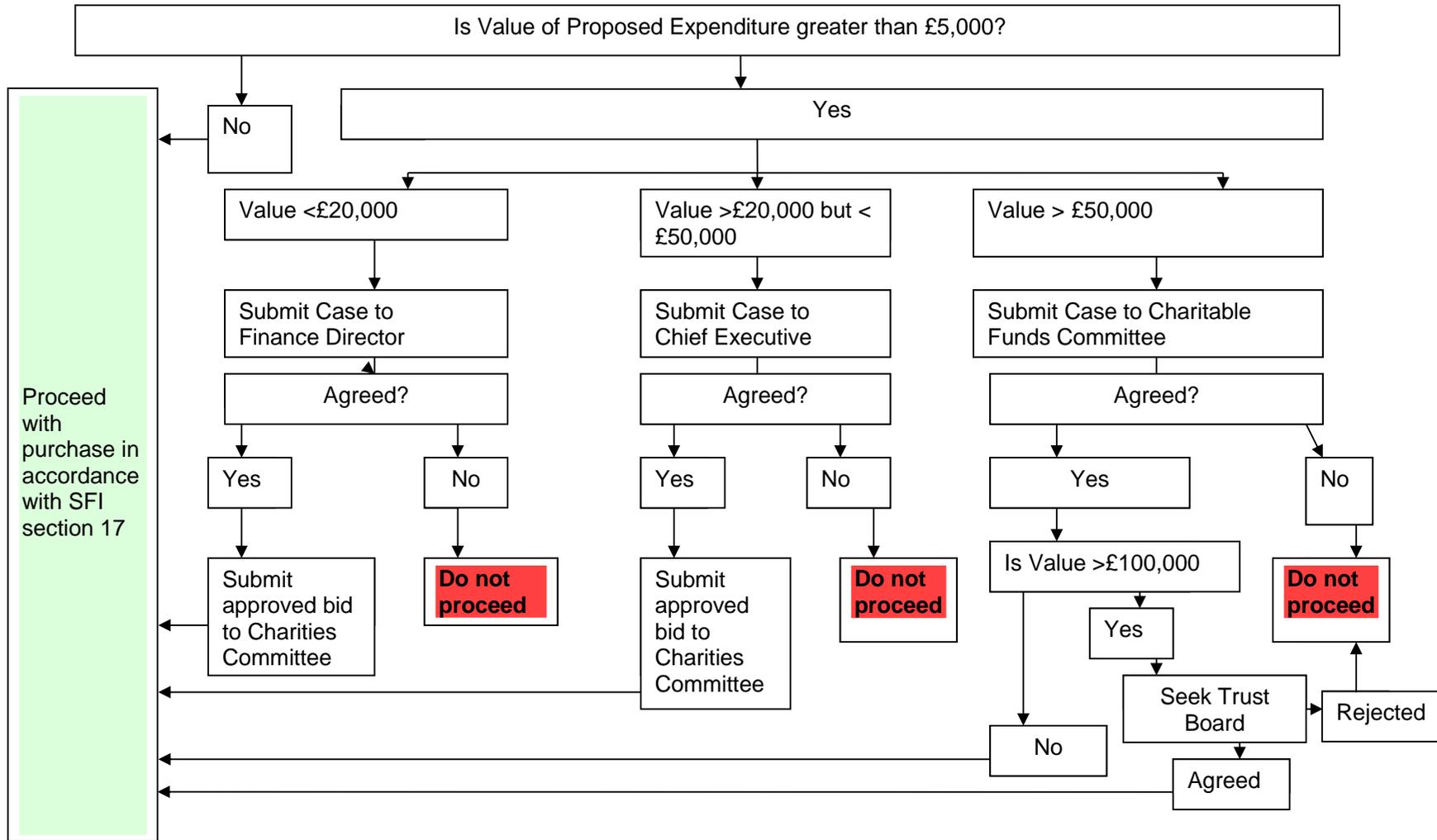
Payment Approved.....(Name)(Signature)

TRUST DIVISION REQUESTING PAYMENT (Compulsory Information)	
---	--

Fund Number	Ledger Code	£	p
Total Cost			

24.4

APPENDIX 2



APPENDIX 3

Examples of expenditure that is not charitable or which does not have the Committee's approval

Routine expenditure on gifts for staff will not be supported.

Expenditure which may be seen as inappropriate for a health organisation such as alcohol;

Routine expenditure on general benefits for staff, such as tea, coffee, milk or water will not be funded by the charity. Occasional events such as modest departmental team events may have a strong motivational impact on staff and indirect benefit to patients. These can be supported at the discretion of the fund manager.

Expenditure on events which may have a poor effect on the Charities' or the Trusts' reputation such as "stunts";

Attendance at a conference, the subject of which, however commendable, was not likely to benefit the health of the people of Buckinghamshire

Attendance at any event, accommodation or travel for a spouse or other person not employed by Buckinghamshire Healthcare NHS Trust. If an event has been arranged that other people can attend they must contribute the full cost of the event;

Items essential to the structure of the hospital

This would be refused as it is a clear case where an item should be provided by the Bucks Healthcare Trust and constitutes exchequer funding

Purchase of a PC that is incompatible with BHT Trust equipment.

A study day when the individual concerned is leaving the employment of BHT

Membership of professional organisations for the benefit of an individual will not be supported by the charity. Where the membership has a clear group benefit in terms of access to publications or training at preferential rates, such that the cost is outweighed by the financial benefits of avoided costs, the fund manager will have the discretion to support the membership.

Expenses incurred when normal purchasing guidelines have not been adhered to (e.g. express delivery charges, maintenance agreements on equipment) unless there are valid reasons.

These guidelines will be reviewed regularly. If you have any comments or questions please do not hesitate to contact The Charity Head of Finance and Governance, on 01494 734777 or on the Trust's e-mail system.

VAT AND CHARITIES

Purchases made by the Trust

Certain goods purchased or hired by eligible bodies, which include Regional, District and Special Health Authorities, and NHS Trusts using funds provided by a charity or from voluntary contributions are eligible for zero-rating by the supplier. (Throughout this section the term Health Authorities should be taken to mean also NHS Trusts).

The relief covers "relevant goods", as follows:-

- Medical, scientific, computer, video, sterilising, laboratory or refrigeration equipment for use in medical or veterinary research, training, diagnosis or treatment. Zero-rating is also available for parts and accessories for use in or with these items. Please see below for further details.
- Computer services by the way of provision of computer software solely for use in medical research, diagnosis or treatment.

These items must be purchased or hired using money **wholly** from charitable funds or voluntary contributions to qualify. Health Authorities cannot pay in part for the purchase or hire of such items. When goods are being bought or hired out of such funds it is worthwhile ensuring wherever possible that the goods being purchased will be eligible for zero-rating under these rules to maximise the relief available.

Examples of articles, which are eligible for relief as medical, scientific, computer, video, sterilising, laboratory or refrigeration equipment, or as parts and accessories.

Anaesthetic apparatus	Graduated medicine measures
Bandages and dressings	Hoists and other patient lifting devices
Highly specialised beds, designed to prevent deterioration in a patient's condition or materially assist recovery (e.g. net suspension beds, medical waterbeds)	Laboratory glassware and plastic ware Patients' stretchers and trolleys
Adjustable hospital beds, which have either a tilting action or a variable height feature	Physiotherapy apparatus (including specialised play equipment designed for sick or handicapped children) Refrigeration equipment
Centrifuges	Resuscitation equipment
Clinical thermometers	Sphygmomanometers (blood pressure equipment)
Computers and peripheral units	Stethoscopes
Drip poles	Surgical gloves

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First aid boxes and medical kits containing both eligible and ineligible items provided they are only supplied as single pre packed units

Surgical instruments
Tapes and disks specially designed for computer use

Video equipment (including cameras and tapes)

X-ray equipment and X-ray films

Computer equipment includes any computer, its peripherals and parts and accessories. This includes disks and tapes specially designed for use with the computer, but general purpose tapes or items such as paper are not included.

Refrigeration equipment includes both freezing and cooling equipment and parts and accessories designed solely for use with such equipment.

Video equipment includes all types of video equipment and systems including accessories and tapes.

Examples of articles, which are ineligible for relief as medical, scientific, computer, video, sterilising, laboratory or refrigeration equipment, or as parts and accessories.

Air conditioners

Drugs

Amenities for patients or staff (e.g. television or radio sets, tape recorders, soft furnishing, easy chairs)

Drug Trolleys

Handicraft materials for occupational therapy

Blankets and towels

Medical stationery

Catering equipment

Over bed tables and patients lockers

Standard camera equipment and films

Tapes and disks not specially designed for computer use

Closed circuit television systems

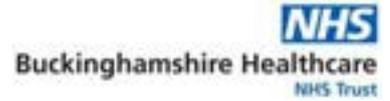
Toys (unless specially designed for sick or handicapped children)

Consumable items for use in with medical, scientific or computer equipment (e.g. chemicals, gas cylinders, paper, ink and cleaning fluids)

Training equipment e.g. first aid dummies

Tape recorders

24.4



APPENDIX 4 PAGE 3

Amersham Hospital

Whielden Street
Amersham
Buckinghamshire
HP7 0JD
Tel: 01494 434 411
www.buckshealthcare.nhs.uk

DONATED MEDICAL AND SCIENTIFIC EQUIPMENT ETC.
PURCHASING BY AN ELIGIBLE BODY

Buckinghamshire Healthcare NHS Trust
Charitable Funds
Amersham Hospital
Whielden Street
Amersham
Bucks HP7 0JF

01494-734783

Declare that the above named organisation is buying from:
[Supplier name]
[Supplier address]

the following services:
[description of good or service]

And is paying for this supply with funds provided by a charity or from voluntary contributions.

I also declare that the goods are to be used in medical research, training, diagnosis or treatment.

I claim that the supply is eligible for relief from Value Added Tax under Group 15 of the Zero Rate Schedule to the Value Added Tax 1994 – VAT Notice 701-6

Signature: Date:

Buckinghamshire Healthcare NHS Trust
Charitable Fund Order No ... Date:

Registered Charity Number 1053113

Signature: Date:

Buckinghamshire Healthcare NHS Trust
Charitable Fund Order No..... Date:

Registered Charity Number 1053113

24.4

APPENDIX 5

24.4



The Trustees for the Buckinghamshire Healthcare NHS Trust Charitable Fund

A registered Charity No. 1053113

Finance Department
 Trust Headquarters
 Amersham Hospital
 Whielden Street
 Amersham
 Bucks HP7 0JD
 Telephone 01494 734783 / 734557

Receipt No.....
 (Cashier Dept. Only)

I,.....Address:.....
, Post Code:....., UK.

Give to Buckinghamshire Healthcare NHS Trust Charitable Fund, The sum of £....., which I wish to be used for (Please select one):

- The General Purposes of the Charity Patients Staff Research

Or without imposing any special restriction, it is my wish that my donation should be used for:

Special Purpose

This Donation has been given in:

- Cheque (No/(s))..... Cash

Donor's Signature..... Date: / /

Donor's e-mail Address.....

Staff Member Receiving Donation..... Date: / /

Gift Aid Declaration

I would like the charity to reclaim tax on my donation and confirm that I am a UK tax payer. (Please tick).

(Please note that you must pay an amount of Income Tax and/or Capital Gains Tax for this tax year at least equal to the tax that the charity will claim from HM Revenue & Customs on your Gift Aid donation.)

Please, ensure that your address and postcode are correct, without this information the charity will not be able to claim Gift Aid.

Signature: Date: / /

Thank you

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Finance Department Amersham Hospital Whielden St. Amersham Bucks HP7 0JD

CHARITABLE FUNDS
Reg. No. 1053113

Telephone 01494 734783

Gift Aid declaration

I want the charity to treat

*the enclosed donation of £.....

*the donation(s) of £.....which I made on/...../.....

*all donations I make from the date of this declaration until I notify you otherwise

*all donations I have made since 6 April 2000, and all donations I make from the date of this declaration until I notify you otherwise as **Gift Aid donations.**

*Delete as applicable

Details of donor

Title.....Forename(s).....Surname.....

Address.....

.....

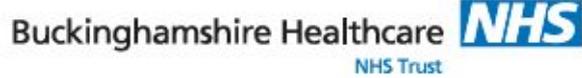
Post Code.....

Signed.....Date.....

Notes

- 1** You must pay an amount of Income Tax and/or Capital Gains Tax at least equal to the tax that the Charity reclaims on your donations in the tax year (currently 28p for each £1 you give).
- 2** You can cancel this declaration at any time by notifying the charity
- 3** If in the future your circumstances change and you no longer pay tax on your income and capital gains equal to the tax that the charity reclaims, you can cancel your declaration (see note 1).
- 4** If you pay tax at the higher rate you can claim further tax relief in your Self-Assessment tax return.
- 5** If you are unsure whether your donations qualify for Gift Aid tax relief, ask the charity. Or ask your local tax office for leaflet IR 65.
- 6** Please notify the charity if you change your name or address.

24.4



Donate now

To help your local NHS deliver the best patient care

At Buckinghamshire Healthcare NHS Trust we have a charity dedicated to improving our patients' care, in our hospitals and in our community, through extra funding for equipment, research, staff and patient welfare.



Find out how you can make a difference with Buckinghamshire Healthcare NHS Trust Charitable Fund at:

www.buckshealthcare.nhs.uk/charity



Donate right now, just text BEST22 £2 to 70070. You can donate £1, £2, £3, £4, £5 or £10 by text



Make a donation via Just Giving at: www.justgiving.com/bucksnhs/donate



Opt for payroll giving and every pound you give will only cost you 80p. Just look for the form on our website



Want to cycle the length of Great Britain, climb Mount Kilimanjaro or cycle to Paris? Look up our charity challenges online



Find out how to leave a legacy of outstanding health facilities for 500,000 people

Scan this code to find out more:
Buckinghamshire Healthcare NHS Trust Charitable Fund Registered charity 1053113
www.buckshealthcare.nhs.uk/charity



Safe & compassionate care,
every time

24.4

Charitable Fund

APPENDIX 8

REF:

BUCKINGHAMSHIRE HEALTHCARE NHS TRUST

BID FOR CHARITABLE FUNDS EXPENDITURE OVER £5,000

GENERAL INFORMATION	
1.- BUSINESS CASE TITLE:	
<input type="text"/>	
2.1- DEPARTMENT:	2.2- TRUST BUSINESS CASE NUMBER:
<input type="text"/>	<input type="text"/>
3.- BUSINESS CASE PREPARED BY:	
<input type="text"/>	
4.- BUSINESS CASE SPONSORED BY:	
<input type="text"/>	
5.- UNIQUE BUSINESS CASE NUMBER <small>(This information Must be obtained from Charity's Finance Department – Amersham / Ext 4557 and 4783)</small>	6.- PROPOSAL TOTAL EXPENDITURE:
<input type="text"/>	<input type="text"/>
7.- FUND NAME: <small>(This information has to be provided) :</small>	8.- FUND NUMBER: <small>(This information has to be provided:</small>
<input type="text"/>	<input type="text"/>
9.- FUND BALANCE: <small>(This information Must be obtained from Charity's Finance Department – Amersham / Ext 4557 and 4783)</small>	10.- FUND BALANCE DATE: <small>(This information Must be obtained from Charity's Finance Department – Amersham / Ext 4557 and 4783)</small>
<input type="text"/>	<input type="text"/>
11.- OBJECTIVE OF THE FUND (S): <small>(This information Must be obtained from Charity's Finance Department – Amersham / Ext 4557 and 4783)</small>	
<input type="text"/>	

24.4

Safe & compassionate care,
every time

PUBLIC / PRIVATE / SEMINAR / BOARD MEETING
31 / JULY / 2019

Details of the Paper

Title	BHTPOL147 - Charitable Funds Investment Policy
Responsible Director	Wayne Preston, Interim Director of Finance
Purpose of the paper	<ul style="list-style-type: none"> To ask the Board to Note and Approve the propose ranges of asset allocations indicated in this policy. To endorse the changes in this policy.
Action / decision required (e.g., approve, support, endorse)	The Board is asked to ENDORSE proposed changes in the Charitable Funds Investment Policy.

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

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

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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.	<i>Non-Financial Risk: N/A</i>
	<i>Financial Risk: N/A</i>

LINK TO CARE QUALITY COMMISSION ESSENTIAL STANDARDS OF SAFETY AND QUALITY

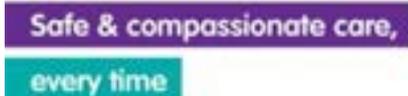
Which CQC standard/s does this paper relate to?	<i>(if you need advice on completing this box please contact the Director for Governance)</i>
---	---

Author of paper: Nelson Garcia- Narvaez (Charitable Funds Head of Finance and Governance)

Presenter of Paper: Wayne Preston (Interim Director of Finance)

Other committees / groups where this paper / item has been considered:
Charitable Funds Committee and Executive Management Committee.

Date of Paper: 26/06/2019



Introduction

The Charitable Funds Investment Policy (BHT Pol 147) was presented and approved by the Charitable Funds Committee and the Executive Management Committee. These Committees authorised submission to the Board in order to be endorsed.

This policy was thoroughly scrutinised and amended last year (2018) by the Director of Finance, the Charitable Funds Committee and endorsed by the Board.

The only modifications being introduced in this policy are:

- Amending the proposed asset allocations presented by Cazanove Capital and agreed by the Charitable Funds Committee in order to have additional flexibility in the management of the investments. (Refer to page 7 of the policy)

In line with this investment policy, the propose ranges of asset allocations should be approved by the Board.

- Formalising the process for Ethical Investment screening requested by the Committee. (Refer to page 5 of the policy)

The Charitable Funds Committee requested to present this policy to the Board in order to be ratified.

Recommendation

The Board is asked to **ENDORSE** proposed changes in this policy.



Once printed off this is an uncontrolled document. Please check the intranet for the most up to date version.

February 2018 Version 8.3

CHARITABLE FUNDS INVESTMENT POLICY

24.4

Summary of Changes:

This version has been significantly revised to take into account the Trust's requirements on the writing of Policies

Version:	8.3
Approved by:	Charitable Funds Committee
Date approved:	February 2019
Ratified by:	Trust Board
Date ratified:	TBC
Consultation:	TPSG
Name of originator/author	Revision: Nelson Garcia-Narvaez / Charities Head of Finance Original Policy: Nelson Garcia-Narvaez / Charities Head of Finance
Lead Director	Caroline Trevena – Director of Finance
Name of responsible committee/individual	Charitable Funds Committee / Charitable Funds Head of Finance
Document Reference	BHT POL 147
Date Issued:	February 2019
Review date:	February 2021
Target Audience:	Directors, Non Executive Directors and Fund managers
Equality Impact Assessment:	June 2016

Charitable Funds Investment Policy, BHT Policy 147 V8.3 February 2019
Final

Document History

Version	Issue	Reason for change	Authorising body	Date
1	0	New Document-Issued		
2	0	Update		
3	0	Formal Review		Nov 2008
4	0	Formal Review		July 2010
5	0	September 2012	Charitable Funds Committee 08.08.12 Trust Board 29.09.12	Sept 2012
6	0	Formal Review – Sept 2014	Charitable Funds Committee Trust Management Committee Trust Board	29.07.14 Sept 14
7	0	Formal Review – July 2016	Charitable Funds Committee Executive Management Committee	25/05/16 22/07/16
8	0	Formal Review – August 2016	Charitable Funds Committee Executive Management Committee	25 th August 2016
8.1	0	Update	Charitable Funds Committee Executive Management Committee Board	May 2017
8.2	0	Update	Charitable Funds Committee	28/02/2018
8.3	0	Update	Charitable Funds Committee Board	05/02/2019 TBC

Associated Documents

BHT Ref	Title	Location/Link
n/a	Investing charity funds: regulatory perspective	https://www.gov.uk/government/publications/investing-charitable-funds https://www.gov.uk/government/publications/charities-and-investment-matters-a-guide-for-trustees-cc14
n/a	Trustee Act 2000	http://www.legislation.gov.uk/ukpga/2000/29/contents
n/a	Charity Act 2011	https://www.legislation.gov.uk/ukpga/2011/25/contents
n/a	Charity Act 2016	www.legislation.gov.uk/ukpga/2016/4/contents/enacted
n/a	SORP 2015 – FRS 102	https://www.gov.uk/government/publications/charities-

Charitable Funds Investment Policy, BHT Policy 147 V8.3 February 2019
Final

		sorp-2005
n/a	Regulations 2008	www.legislation.gov.uk/ukSI/2008/629/contents/made

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Charitable Funds Investment Policy Document

1. Introduction

This policy governs the investment strategy of the Trust's charitable funds.

Under the Trustee Act 2000 it is a legal requirement that, if the investment function is delegated to an investment manager, the Trustees have a written investment policy which is kept formally under review.

The Health Services Act 1977 gives NHS bodies the authority to hold charitable funds. The Trust's charitable funds are derived from donations, legacies and investment returns. The charity's objectives are to utilise the charitable funds for the benefit of the National Health Service rather than to accumulate funds with which to achieve investment returns.

For some time, new gifts of a charitable nature have been encouraged to be made to a general fund, which can be used for any general charitable purposes of the Trust. However there are some funds which have specific 'restricted' purposes. These general and restricted funds are held under one 'umbrella' charity for Buckinghamshire Healthcare NHS Trust. Although there is a distinction between the funds for administrative purposes, from an investment perspective the assets of all underlying funds are pooled and then managed as a single coherent whole.

Charitable fund trustees are under a duty to ensure that the funds are appropriately utilised and this means that the funds should not remain unused for a long period of time, particularly when there are no future plans for spending. However, in relation to the Trust's charitable funds, as with most NHS charitable funds, resources are only expended slowly. After allocating funds that are likely to be required to fund identified expenditure ('short term monies') the balance will be invested in an investment portfolio designed to be long term in nature ('long term monies').

This policy should be read in conjunction with the Management of Charitable Funds Policy (**BHT Pol 063**) to cover complementary information regarding the way in which the Trust's charitable funds are managed and utilised.

2. Scope and Purpose

This policy applies to the investment of all funds of the Buckinghamshire Healthcare NHS Trust Charitable Fund.

The purpose of this policy is to facilitate effective management of funds, whether these are invested or held as liquid assets, to achieve the objectives of the Charity in the immediate and longer term in conjunction with identification and understanding of the risks to the Charity.

3. **References and Definitions**

The main Charities Commission website provides further details on the responsibilities of Charities and Trustees for investment policies and can be found at www.charity-commission.gov.uk/Charity_requirements_guidance/Charity_governance/Managing_resources. Only elements of the guidance that is relevant to this Charity have been produced here.

Legal requirements covered within this Policy are outlined in the Charities Act 2011 as amended by Charity Act 2016 and the Trustee Act 2000.

Definitions:

The Charity: the Buckinghamshire Healthcare NHS Trust Charitable Fund, registered charity number 1053113, a separate legal entity from Buckinghamshire Healthcare NHS Trust NHS Trust.

Trustee: Charity Trustees are responsible for the general control and management of the administration of the charity. The Charity has a corporate trustee – the Board of Buckinghamshire Healthcare NHS Trust.

Investment Manager: an individual or corporate body appointed by the Charity's Trustees to advise and make investment decisions on behalf of the charity.

Charitable Funds Committee: a sub-committee of the Board whose responsibility it is to oversee the management of Charitable Funds.

Common Investment Fund: an arrangement whereby the money invested by a number of charities is pooled and invested in a range of investments in accordance with the published policy of the scheme. The size of each share is determined by the number of 'units' each contributor owns and investment returns (or losses) are allocated in the same proportion.

'Umbrella' Charity: a charity registered under a single name and number under which several funds are held and administered. These funds may have separate purposes and objectives and the balance will be managed by different fund holders. Income and expenditure is allocated to these fund balances individually, whereas investment returns will be allocated in proportion to the fund balances held.

Volatility of returns: there is a link between the rate of return that can be expected on an investment and the risk inherent in that type of investment. This is separate from the systematic or market rate of return, where a whole class of investments will be affected by an upturn or downturn in the market caused by macro-economic trends. The more risky an investment is seen to be the higher the return that would be expected to be achieved. However there is also a potential for large losses on this type of investment, where safer investments would have much lower rates of returns. This link between levels of risk and the rate of returns is known as the volatility of returns.

4. Roles and Responsibilities

4.1 The Board

The Board as corporate Trustee of the Charity has the overall responsibility for setting the investment policy for the Charity through setting an overarching set of objectives that need to be taken into account when deciding on specific investment allocations. It is responsible for appointing the investment manager. It has delegated responsibility for monitoring and making amendments to the portfolio of investments to meet the overarching objectives to the Charitable Funds Committee.

4.2 Charitable Funds Committee

The Committee has the responsibility to monitor performance of the portfolio of investments through the receipt and review of reports from the investment manager. The investment manager will attend each quarterly Charitable Funds Committee in order to give the members the opportunity to raise questions about the performance of the investments and the appropriateness of moving investments into other areas. The Committee will update the Board with regard to significant changes or issues with performance of the investments.

4.3 Investment Manager

The investment managers appointed will be responsible for investing the available funds as far as possible to fulfil the investment objectives laid out below. They will provide quarterly reports to the Charitable Funds Committee. They will take into account any concerns raised by the Committee in the allocation or performance of the funds. They will take into account the Trustees stance on ethical investment.

4.4 Trust finance staff

The Trust, through its finance staff, carries out financial administration of the Charity. It is the responsibility of the appropriate finance staff to ensure that the invitations to attend the Committees are sent to the investment manager and that investment information provided is passed onto the Committee members. It is their responsibility to ensure that the Charity keeps accurate records of its investments, properly accounts for investment returns and movements in the value of investments.

5. Consultation and dissemination

This Policy has been formulated by taking into account the guidance issued by the Charities Commission as well as the previously documented objectives of the Trustees in achieving investment returns. It was presented to the Charitable Funds Committee on TBA for their comments before they ratified it.

The Policy will be published on the Trust's intranet within the Finance Policies section.

6. Monitoring compliance with the Policy

The Trustees wish to monitor the performance of the investments carefully and will seek quarterly valuations and reviews of performance. Whilst the precise mechanics will depend on the independent professional advice given to the Trustees, it is proposed that performance should be measured against one of the industry standard measures such as the WM Charity Survey.

The Charitable Funds Committee will provide information in its Annual Report to the Board on its actions in managing the investments. If the Committee identifies that there are shortfalls in the performance of its investments, and that these shortfalls are not being remedied by the investment manager, the Committee will report this to the Board together with its proposals on remedying the situation. This may include a change of investment manager.

The Committee will, in turn, monitor compliance with this Policy by the investment managers and finance staff.

7. Investment Strategy

7.1 Investment Objectives

As stated above, it is not the Trustee's primary aim to accumulate funds and the investment strategy set out below is written with this in mind. Accordingly, a portion of the total funds will be held back as short term monies or working capital (assets which are capable of being released to generate cash quickly, or cash) with the rest constituting the investible portfolio (long-term monies), which is the subject of this policy paper, being invested.

The Trustees objectives are:

- To maintain the value of the capital in real terms over the medium term (3-5 years).
- To realise capital gains (i.e. returns on the investments achieved) only if there is a bona fide charitable purpose for them
- To receive dividends and interest from the investments as income to the charity and utilise it as such.
- To reinvest capital gains where no immediate charitable purpose exists
- To take normal charitable expenditure from ongoing donations and interest from investments that is surplus to administrative expenditure
- To fund unusual major capital projects on a case-by-case basis from one-off reductions in investment capital.

That part of the portfolio which must, as a minimum, be kept in liquid funds should be sufficient to cover three months of anticipated charitable expenditure. However the investment advisers have discretion to increase the liquid element of the portfolio if market conditions should so dictate.

Subject to the recommendations of our independent adviser, the funds will be invested on a discretionary basis by the purchase of pooled funds, ordinarily Common Investment Funds [CIFs] or others where they are not available.

The investment principles of the Trustees are to ensure: -

- (a) A balance between income (interest or dividends) and capital growth whilst adopting an appropriate medium to long-term risk profile, accepting that this will impose a *degree of volatility* in performance (*A)
- (b) The maintenance of the 'real' value of the capital within the portfolio after allowing for the effects of inflation but before any strategic change in historic expenditure levels.
- (c) That they are prepared to realise capital gains if achieved and if there is a bona fide charitable purpose for them.
- (d) An income of approximately £250,000 p.a. from the portfolio, which is currently equivalent to a yield of about 3.39% p.a.
- (e) That the administrative burden on the Trustees is kept to an acceptable minimum.
- (f) That they receive independent professional advice on the set up and monitoring of the performance of the investments.

7.2 Risk Profile and asset allocation

The Trustees are bound by the rules for Charities on investments and have adopted a strategy, which avoids speculation and high risk, while accepting a *reasonable degree of volatility of returns* (*B). They will spread the investments over a number of different investment classes such as UK Equities, overseas Equities, Bonds, Property and cash and have considered and agreed a limited amount of exposure to non-traditional assets like hedge funds and absolute return funds, subject to clear restrictions.

The trustee will define a range for each asset class as set out in annex 1. Within that range the Charitable Funds Committee will agree with the Investment Manager the actual allocation to each class. Movements outside of the range will be explicitly approved by the trustee.

7.3 Ethical Considerations

The Trustees have considered whether to impose any ethical restriction on the investment of the Trust's assets by their investment managers and are mindful that their primary duty is to seek the best returns within the limits of the overall investment policy.

The Trustees have decided to avoid direct investment in certain types of stocks and to this end they will specifically avoid direct investment in stock adverse to health (e.g. Tobacco). They will also seek to minimise investments in areas where conflicts of interest could be seen to occur, such as with pharmaceutical companies.

The Trustees accept that the investment in common investment funds (and similar products) may give the charity indirect exposure to such stocks. Any indirect exposure is monitored biannually and will not exceed 5% of the total portfolio value.

The Ethical Screening Analysis is benchmarked using the revenue screens selected by the Church of England’s Ethical Investment Advisory Group (EIAG) screened at 100%.

Should the indirect exposure through funds reach a total of 4%, based on the restricted list published by the Church of England’s Ethical Investment Advisory Group (EIAG), each individual investment will be assessed with regard to its adverse exposure and this may lead to a reduction or complete sale.

7.4 Investment Powers

The appointed fund managers or funds will be given discretionary powers and empowered to buy and sell securities on behalf of the trustees, subject to the overall investment policy as set out in this document. All such transactions must be reported to the Trustees in the next quarterly review.

7.5 Review of Policy

The Charities Committee will review this policy annually and the Trustees will approve any proposed changes.

- A* This is defined as movements in performance of 5%
- B* This is defined as movements in performance of not more than 10%

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8. Related Policies

The following related policies & guidance are available on the Trust Intranet and external websites

	Document
(a)	Standing Orders / Standing Financial Instructions (BHT Pol 089)
(b)	Limits of Delegation Policy (BHT Pol 061)
(c)	Code of Conduct (BHT Pol 019)
(d)	Standards of Business Conduct (Corporate Policies)
(e)	Charitable Funds Committee Terms of Reference
(f)	Management of Charitable Funds (BHT Pol 063)

Annex 1**Currently Approved Range of Asset Allocations**

In line with the current professional advice to the Charitable Funds Committee, the agreed ranges for each asset allocations are as follows:-

	Asset Type	Agreed %
1	UK Equities	31.5% – 51.5%
2	Global/Overseas Equities	11% – 31%
3	Fixed Income	0 % – 30%
4	Alternatives	5% – 25%
5	Property	0% – 20%
6	Cash	0% – 10%

These approved ranges of asset allocation are approved by the trustee (Trust board) and can only be amended by the Board. Within each range the Charitable Funds Committee can agree specific asset allocations upon advice from the Investment Manager.

The Committee takes the view in order to cover eventualities regarding a variation in the asset allocations agreed with the investment manager to accept a margin of fluctuation of 2% of the % stated in each category, where there is a proven benefit to the charity.

In any case this variation should be corrected in a period no longer than 6 months without formally changing the investment policy. The decision to vary must be reconsidered and the case represented at each meeting of the committee."

The Committee requires that any fluctuation to the agreed asset allocations is reported as soon as the information is disclosed by the Investment Management.

Safe & compassionate care,
every time

PUBLIC BOARD MEETING 31 JULY 2019

Details of the Paper

Title	Charitable Funds Terms of Reference
Responsible Director	Wayne Preston, Interim Director of Finance
Purpose of the paper	<ul style="list-style-type: none"> To ask the Board to Note and Ratify the Charitable Funds Terms of Reference
Action / decision required (e.g., approve, support, endorse)	The Board is asked to RATIFY the updated Charitable Funds Terms of Reference

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: N/A
	Financial Risk: N/A

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)
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Author of paper: Nelson Garcia- Narvaez (Charitable Funds Head of Finance and Governance)

Presenter of Paper: Wayne Preston (Interim Director of Finance)

Other committees / groups where this paper / item has been considered:
Charitable Funds Committee and Executive Management Committee.

Date of Paper: 26/06/2019



Introduction

In order to comply with the Charitable Fund annual business cycle, the Charitable Funds Terms of Reference (ToR) is reviewed annually. This document was presented and approved by the Charitable Funds Committee.

These Terms of Reference were thoroughly scrutinised and amended by the Director of Finance, the Charitable Funds Committee and endorsed by the Board in March 2018. Therefore, further significant amendments for this financial year (2019) were not required.

However, following the recommendation from the Charitable Funds Committee, this document was updated in order to state that there are now “**Two Honorary Independent Members**” - one Honorary Independent Member for the interest of the donors and one Honorary Independent Member for the interest of the patients (both are non-voting members).

Please refer to page 4 of the terms - sections 4.2 and 4.3.

The Charitable Funds Committee requested to present this Terms of Reference to the Board in order to be ratified.

Recommendation

The Board is asked to **RATIFY** the update to the Terms of Reference.

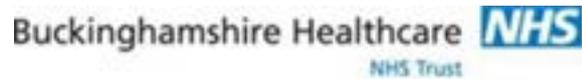
Buckinghamshire Healthcare NHS Trust

Charitable Funds Committee Terms of Reference (ToR)

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Charitable Funds Committee

Terms of Reference

1. Background

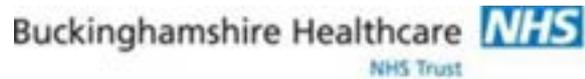
- 1.1 The Charitable Funds Committee (CFC) has been established to exercise the Trust's functions as sole corporate trustee of Buckinghamshire Healthcare NHS Trust Charitable Fund (registered charity number 1053113).
- 1.2 The Trust Board is regarded as having responsibility for exercising the functions of the Trustee. The Trust Board delegates these functions to the CFC, within any limits set out in these Terms of Reference and the charitable funds section of Standing Financial Instructions.

2. Purpose

- 2.1 The overall purpose of the Committee is to assist the Board as the Corporate Trustee in the performance of their duties through providing assurance the Trust's charitable activities are within the law and regulations set by the Charity Commissioners for England and Wales, the Charities Act 2011 *as amended by* Charity Act 2016, the Statement of Recommended Practice on Accounting and Reporting for Charities (SORP), the Charity's Trust Deed and applicable United Kingdom guidance and regulations for NHS charities.
- 2.2 The Committee will approve charitable funds expenditure in accordance with standing orders and standing financial instructions as well as approve investment policy and monitor investments on a regular basis.
- 2.3 These terms of reference establish formal and transparent arrangements for the oversight of the appropriate use of charitable funds within the Trust and provide a vehicle to ensure the independence of the decision-making process for the Charity from that of the Trust as a whole.

3. Constitution

- 3.1 The Board resolves to establish a standing Committee of the Board to be known as Charitable Funds Committee (the Committee). The Committee is a Non-Executive committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference.
- 3.2 The Trust was appointed as corporate trustee of the charitable funds by virtue of Statutory Instrument 2002 (2271) and that its Charitable Funds Committee serves as its agent in the administration of the charitable funds held by the Trust. The Committee has been formally constituted by the Board in accordance with its Standing Orders, with delegated responsibility to make and monitor arrangements for the control and management of the charitable funds and will report through the Board.



4. **Membership**

4.1 The Committee shall be appointed by the Board from amongst the non-executive or executive directors of the Trust and shall include up to three directors who have the personal and professional characteristics necessary to be effective.

4.2 The CFC comprises:

- (Two) non-executive Directors, where one of them preferably should be financially literate.
- (One) executive Directors, normally the Director of Finance.
- (Two) Honorary Independent Members.

4.3 The CFC's structure is:

- Chair: a Non-Executive Director.
- Finance Director.
- Non-Executive Director.
- Honorary Independent Member for the interest of the donors. (Non – voting member)
- Honorary Independent Member for the interest of the patients.(Non-voting member)
- Operational Leads: Trust's Head of Financial Controls and Head of Charities Finance. (non-voting)
- CFC Administrator: Head of Charities Finance. (non-voting)

4.4 When a member is unable to attend a meeting they may appoint a deputy to attend on their behalf. The nominated deputy of a Board member will have the same voting rights as the member; any other deputies will have no vote.

4.5 Other Charity and/or Trust officers may be asked to attend when the CFC is discussing areas that are the responsibility of that individual. The CFC may also invite external advisors to attend for appropriate items, especially if items require detailed knowledge in areas such as investments.

5. **Quorum**

5.1 The quorum necessary for the transaction of business shall be two voting members, and at least one of them should be a non-executive director. 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 Chairman and/or an appointed Deputy, the remaining non-executive members present shall elect one of themselves to chair the meeting.

- 5.2 Where a Committee meeting is not quorate under paragraph 5.1 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 time, place and date as may be determined by the members present.

6. Meetings

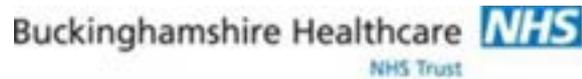
- 6.1 The Committee shall meet at least two times per year and at such other times as the Chairman of the Committee shall require. Meetings of the Committee shall be summoned by the CFC Administrator of the Committee at the request of the Chairman of the Committee.
- 6.2 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, 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 seven days ahead of the date of the meeting.
- 6.3 The Committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities.

7. Authority

- 7.1 The Board of Directors has delegated to the Committee the authority to deal with the matters set out in paragraphs below.
- 7.2 The Charitable Funds Committee is an advisory body with no executive powers; it is not the duty of the Committee to carry out any function that properly belongs to the Board of Directors or the Management Board.
- 7.3 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 employee, who are directed to co-operate with any request made by the Committee.
- 7.4 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 Chairman of the Committee and shall be within any budgetary constraints imposed by the Board of Directors.
- 7.5 The Charitable Funds Committee has the authority to require any member of staff to attend its meetings.

8. Duties

- 8.1 The Charitable Funds Committee shall be responsible for the following duties:
- Ensure the Charity complies with current legislation;
 - Determine the charitable fund's investment policy, including the selection of appropriate investment advisers and banking service provider;
 - Review the performance of the Charity's investments;
 - Set and review an expenditure policy, including the use of investment gains;



- To monitor the Trust's scheme of delegation for expenditure for the levels:

Up to £5,000	Fund Holders
Over £5,000 up to £20,000	Finance Director
Over £20,000 up to £50,000	Chief Executive
Over £50,000 up to £100,000	Charitable Funds Committee
Over £100,000	Trust Board
- Approving expenditure over £5,000. This responsibility may be discharged by the Chair of the Committee and Director of Finance acting together. All approved expenditure of over £5,000 will be reported to the next meeting of the Committee.
- Review individual fund balances within the overall Charity on a regular basis;
- Review a regular report of all expenditure from charitable funds
- Agree guidance and procedures for fundraising and expenditure;
- Agree expenditure plans from individual fund holders in accordance with funds objectives.
- Review and ensure audit recommendations are actioned;
- To approve annual accounts for the Charity and ensure relevant information is disclosed;
- Produce an annual report for the Charity in accordance with section 45 of the Charities Act 1993 and Charities Act 2011 *as amended by* Charity Act 2016;
- Encourage where appropriate a culture of fundraising and raise the profile of the Charity within the Trust and local population;
- Develop and approve promotional material of the Charity on behalf of the Trustees to ensure that material used will promote the charitable funds purposes and not place the Charity's reputation at risk;
- To ensure that all fund raising and expenditure is clinically and ethically appropriate;
- To ensure funding decisions are appropriate and consistent with objectives, and to ensure said funding provides added value and benefit to patients and staff above those afforded by income for commissioned services;
- To receive regular reports on the Charitable Trust fundraising activities;
- To provide regular Internal and External Audit reports to the Audit Committee to enable it to provide assurance to the Board that the Charity is properly governed and well managed across the full range of activities; and
- To implement appropriate policies and procedures to ensure that accounting systems are robust, donations received are acknowledged and that all expenditure is reasonable and in accordance with donors wishes.

9. Reporting

9.1 The minutes of all meetings shall be formally recorded and a summary report regarding the Committee's activities should be submitted, together with recommendations where appropriate, to the Board of Directors.

9.2 The Charity's Annual report shall include a section describing the work of the Committee in discharging its responsibilities.

10. Review

10.1 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.

11. Support

11.1 The Committee shall be supported administratively. This support shall ensure:

- The Agreement of the agenda with Chairman and attendees and collation of papers. Papers will be distributed seven days before the meeting electronically. 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.

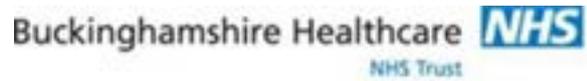
12. Monitoring Compliance and Effectiveness

In order to support the continual improvement of governance standards, sub-committees of the Trust Board are required to annually:

- Complete a self-assessment of the effectiveness of the CFC
- Prepare an annual work plan, where appropriate
- Maintain an up to date Risk Register
- Present a written report to the Trust Board.

13. Document Control

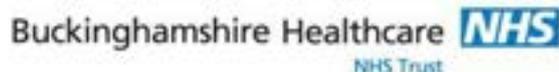
Version	Date	Author	Comments
1.0	1 Dec 2013	E. Hollman	Draft for Committee Chair
2.0	30 th Jan 2014	Nelson Garcia-Narvaez E. Holman	Approved by CFC and the Board
3.0	29 th May 2016	Nelson Garcia-Narvaez	Approved at EMC 22/07/16



4.0	12 th January 2017	Nelson Garcia-Narvaez	Approved at CFC 12 th January 2017 Approved at Trust Board 31 st May 2017
5.0	28 th February 2018	Nelson Garcia-Narvaez	Approved at CFC 28 February 2018 Approved at Trust Board 28 March 2018
8.0	23 th November 2018	Nelson Garcia-Narvaez	Approved at CFC 28 November 2018 Approved at Trust Board TBC

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Agenda item: 24.5
 Enclosure no: TB2019/095



**BOARD COMMITTEE ASSURANCE REPORT FOR PUBLIC BOARD
 31 July 2019**

Details of the Committee

Name of Committee	Strategic Workforce Committee
Committee Chair	Hattie Llewelyn-Davies
Meeting dates:	4 June 2019
Were the meetings quorate?	Yes
Any specific conflicts of interest?	No
Author of the paper	Bridget O'Kelly

4 June 2019

Apologies: Mr David Williams, Mrs Carolyn Morrice

KEY AREAS OF DISCUSSION:

The key areas of discussion were:

- Head of Midwifery staffing report
- An update on two of the people programmes from the Corporate Objectives – Making BHT a great place to work; Developing teams, talent and an inclusive workforce
- 2018-19 Annual report from the Guardian of Safer Working Hours
- 2018-19 Annual report from the Freedom to Speak up Guardian
- 2018 Staff survey update
- Integrated Performance Report – people metrics

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

- The nurse vacancy rate remains over the target of 12%

ANY EXAMPLES OF OUTSTANDING PRACTICE OR INNOVATION:

- The work being carried out by the Trust Freedom to Speak Up Guardian

24.5

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every time

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