Safe & compassionate care, every time

NHS Buckinghamshire Healthcare NHS Trust

Meeting: **Trust Board Meeting in Public**

Date: **Wednesday, 27 November 2019**

Time: **9.00am – 12 noon**

Venue: **Hampden Lecture Theatre, Wycombe Hospital**

Dial in:

Start Time	Item	Subject	Purpose	Presenter	Encl.
09.00		CARE AWARD PRESENTATIONS			
	1.	Chair's Welcome to the Meeting and Meeting Guidance Apologies for absence:	Select from list	Chair	Yes
	2.	Declaration of Interests	Select from list	Chair	
General Business					
09.15	**3.**	Patient Story :	Approval	Chief Nurse	Yes
	4.	Minutes of last meeting (25 September 2019)	Approval	Chair	Yes
	5.	Actions and Matters Arising	Approval	Chair	Yes
	6.	Chief Executive's Report	Assurance	Chief Executive Officer	Yes
Quality and Performance					
10.00	**7.**	Integrated Performance Report • Quality • Workforce • Finance	Assurance	Chief Operating Officer	Yes
		QUESTIONS FROM THE PUBLIC			
	8.	Infection Prevention & Control Monthly Report	Assurance	Medical Director	Yes
	9.	Care Quality Commission Plan	Assurance	Chief Nurse	Yes
	10.	Patient Experience Annual Report	Assurance	Chief Nurse	Yes
	11.	7 Day Working Board Assurance Framework	Assurance	Medical Director	Yes
		COMFORT BREAK			
Strategy					
11.00	**12.**	Corporate Objectives	Assurance	Director of Strategy & Business Development	Yes
Risk and Governance					
11.20	**13.**	Fit and Proper Persons Test report	Assurance	Director of Workforce and	Yes

			Organisational Development	
14.	Appointment of a NED to the Charity Committee	Approval	Director for Governance	Yes
15.	Board Assurance Framework	Assurance	Director for Governance	Yes
16.	Corporate Risk Register	Assurance	Director for Governance	Yes
17.	Risk Management Policy	Assurance	Director for Governance	Yes
18.	Board attendance record	Information	Director for Governance	Yes
19.	Private Board Summary Report	Information	Director for Governance	Yes
20.	Board Committee Reports • Quality and Clinical Governance Committee • Finance and Business Performance Committee • Strategic Workforce Committee • Audit Committee	Information	Committee Chairs	 Yes Yes Yes Verbal
21.	Risks identified through Board discussion	Discussion	Director for Governance	
	ANY OTHER BUSINESS			
	QUESTIONS FROM THE PUBLIC			
	Date of Next Meeting: Wednesday 29 January 2020, 9am, Hampden Lecture Theatre, Wycombe Hospital Report Submission Date			

The Board will consider a motion: "That representatives of the press and other members of the public be excluded from the remainder of the meeting, having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest" Section 1 (2) of the Public Bodies (Admission to Meetings) Act 1960.

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

Safe & compassionate care, every time

NHS
Buckinghamshire Healthcare
NHS Trust

3

Meeting: Trust Board Meeting in Public

11 November 2019

Agenda item	Patient & Staff Story
Board Lead	Chief Nurse
Type name of Author	Charlotte Moss, Head of Physiotherapy
Attachments	Video outlining the development & benefits of the new Therapy & Nursing Led Unit (Stoke Mandeville previously W8)
Purpose	Discussion
Previously considered	Type in Board / Committee or Group and date considered, minute number

Executive Summary

Key points:

- Importance of staff engagement and involvement in service improvement
- Strong therapy leadership, innovative Multi-Disciplinary Team (MDT) ward model with nurse consultant overview
- New pathways triaging patients ready for rehabilitation to the ward through Daily Facilitated Meetings (DFMs) with patients selected once medically optimised and clear rehabilitation goals identified
- Effective discharge pathways established

The video outlines:

- The ethos of the unit – shared goals of patients and staff, promoting regaining of function & independence - celebrating success
- Joint working with community services & partner agencies to expedite timely & safe discharge
- Patients & staff working on the ward and gymnasium

Decision	The Board / Committee is requested to support the further development of the Therapy & Nursing Led Unit

Relevant Strategic Priority

Quality ☒	**People ☒**	**Money☒**

Implications / Impact

Patient Safety	Improved care/reduced harm
Risk: link to Board Assurance Framework (BAF)/Risk Register	BAF 2 – Implement new workforce models
Financial	Value for money
Compliance Select an item. Select CQC standard from list.	Person Centred Care

Partnership: consultation / communication	Interdisciplinary Care
Equality	Equal access
Quality Impact Assessment [QIA] completion required?	Not required

1 Introduction/Position

A Therapy & Nursing Led Unit (TNLU) was developed up December 2018 on Ward 8 at Stoke Mandeville Hospital in line with National Guidance. The aim of the unit is to improve rehabilitation and outcomes for patients, including safe and effective discharge - providing a focus for rehabilitative care in a non-medical environment.

2 Problem

Patients requiring Rehabilitation were scattered over a number of different ward areas with other acutely unwell patients, leading to a lack of focus on the right care and environment. Therapists (who are in short supply) often had difficulties in locating these patients across a number of different wards including escalation areas.

3 Possibilities

The TNLU has provided the opportunity to develop a focus on rehabilitation, strengthening Nursing and Therapy joint working and collaboration. This has maximised the patient's involvement, experience and outcomes as well as supporting a safe & timely discharge

4 Proposal, conclusions recommendations and next steps.

To continue to develop and strengthen this model of care

5 Action required from the Board

The Board is requested to support the continued development of the Service

APPENDICES

Appendix 1:Video presentation

Agenda item:
Enclosure number: TB2019/

Buckinghamshire Healthcare NHS Trust

4

Minutes of the Trust Board Meeting in Public on Wednesday 25 September 2019 at 9.00am in the Hampden Lecture Theatre, Wycombe Hospital

Present:

Voting Members:	Ms H Llewelyn-Davies	Chair
	Mr N Macdonald	Chief Executive Officer
	Dr D Amin	Non-Executive Director
	Mr D Gibbs	Chief Operating Officer
	Mrs N Gilham	Non-Executive Director
	Mr R Jaitly	Non-Executive Director
	Mr B Jenkins	Director of Finance
	Dr T Kenny	Medical Director / Director of Infection Prevention and Control
	Mrs C Morrice	Chief Nurse
	Mr T Roche	Non-Executive Director
Non-Voting Members:	Mrs B O'Kelly	Director of Workforce and Organisational Development
	Prof D Sines	Associate Non-Executive Director
	Ms A Williams	Commercial Director
	Mr D Williams	Director of Strategy and Business Development
In Attendance:	Mrs S Manthorpe	Director for Governance
	Mrs E Jones	Senior Board Administrator (minutes)

127/2019	**CARE AWARDS** The Chief Executive Officer presented the Care Awards given to staff nominated by patients and colleagues for demonstrating the Trust's CARE values: Collaborate, Aspire, Respect and Enable. The winners able to be present were: Lisa Finnis, Yvette MJukandori, Kirsty Johns, Neuro Ward Team, Paige Johnson and Christopher Ibberson.
128/2019	**CHAIR'S WELCOME AND OPENING REMARKS** The Chair welcomed everyone to the meeting in particular those attending to receive a Care Award and the members of the public. In addition the Chair welcomed, Nicola Gilham, Non-Executive Director, Dan Gibbs, Chief Operating Officer and Barry Jenkins, Director of Finance who were attending their first public board meeting as new members of the Board. The Chair thanked the Communications Team for organising a fun day at the Open Day and AGM the previous Saturday.
129/2019	**APOLOGIES:** Apologies had been received from Graeme Johnston.
130/2019	**DECLARATIONS OF INTEREST** There were no new declarations of interest.

DRAFT

131/2019	**PATIENT STORY** The Chief Nurse introduced Marteene Pringle, a patient, who was joined by Dee Irvin Engagement & Events Officer to present to the Board on raising awareness of the challenges the transgender population within Buckinghamshire face. There are over 300 transgender people in the Aylesbury area, many of whom are afraid to access healthcare when they need it. The Board were advised of the activities taking place to reach out to this community to improve their experience and health outcomes. The Board heard the Trust had held an inclusion conference for staff to raise awareness of the challenges faced by this group of the population. The Chair thanked Marteene Pringle for sharing her experiences and working with the Trust to help tackle inequalities in the local community. The Board **SUPPORTED** the report.
132/2019	**PHARMACY PRESENTATON** The Medical Director introduced a team from the Pharmacy Department including; Claire Brandish, Bee Yean Ng, Kate Russell-Hobbs and Dr Jean O'Driscoll who presented the work being undertaken in health partnership to strengthen antimicrobial stewardship with a university hospital in Uganda. Dr Freddy Kiritimati, from the university in Uganda informed the Board of the shared learning gained from the Trust's infectious diseases pharmacists who had visited Uganda earlier in the year. The Medical Director thanked the team and described them as a fabulous integrated leadership team who had brought back international learning for the benefit of the Trust. The Board **SUPPORTED** the report.
133/2019	**MINUTES OF THE MEETING HELD ON 25 SEPTEMBER 2019** The minutes were accepted as an accurate record of the meeting after a correction for the initial for Mr T Roche.
134/2019	**MATTERS ARISING AND ACTION MATRIX** There were no matters arising on updates on the action matrix.
135/2019	**CHIEF EXECUTIVE OFFICER'S REPORT** The Chief Executive Officer presented his report asking the Board to note the organisational plans, integrated care plans for the county and system plan in the context of the long term plan including the long term financial plan for the county which included the structural strategic approach to fixing the healthcare financial deficit in the county. The Chief Executive Officer extended his welcome to the new executive directors and in addition thanked Carolyn Morrice for her work with the Trust's improvement journey over the last six years as this would be her last public Board meeting. Mr Roche questioned the challenges around the shortage of capital and whether the Executive Directors had found a way to overcome some of these challenges. The Chief Executive Director explained the long-term strategic challenge, and the lack of investment in estates and IT continued to be a risk and focus for the Board. Dr Amin queried how the Trust was trying to mitigate these risks before the year end. It was explained this was through a variety of things including reducing expenditure, capping cost pressures, commercial work and restructuring workforce. There were pressure demands and a wide range of things to do including structural changes to achieve this.

	Mrs Gilham queried the cancer metrics and resources and how these were managed. The Chief Executive noted the pressure on diagnostics, imaging and pathology and links with tertiary cancer centres and system challenges around timeliness of pathways. Professor Sines noted the cancer metrics were considered regularly at the Quality and Clinical Governance Committee. The Board **NOTED** The Chief Executive's report.
136/2019	**INTEGRATED PERFORMANCE REPORT** The Chief Operating Officer provided the Board with an update on the integrated performance reports, noting in particular the emergency and acute care pressures over the last few months with deterioration in performance due to high demand. There had been an increase in patients seeking primary care type services and an increase in very ill patients. The Trust had seen its highest admittance over the previous few days. It was a challenge managing the demand which had ultimately affected planned care. The Trust was working in partnership with the CCG to seek a resolution, focussing on the winter resilience plan and primary / urgent care across the community. In addition managing post-operative care was being worked through with partners, managing the discharge operating model in integrating with social care. Cancer pathways were an area of focus and the business model was being reviewed with resourcing for diagnostics and working with the Quality Improvement team looking at best practice models. This was work in progress and would be reported back to the Board in future. The Chief Executive Officer queried if the Chief Operating Officer had, during his first few weeks working at the Trust, identified if there were areas suitable for immediate improvements. It was explained that initial rapid changes would be around Service Development Unit leads in integrated medicine, managing the medical model, reaching out into the community, working with the public in how they used services and working with care homes. There were big opportunities in medical and surgical services and the Trust needed to allow services to be as successful as they could be across the 7 day and 24 hour services. Professor Sines queried the deterioration in readmission rates and whether the Trust had been discharging patients prematurely. The Medical Director noted there had been an improvement and this needed to continue. In addition, Professor Sines encouraged greater working together with the care home sector, targeting education programmes noting the link between readmissions and care homes. Mr Jaitly noted the length of medical stay had flat lined. This was due to the general rise in acuity and seeing more sick people who were being admitted. It was explained the delayed transfer of care was driving up the length of stay and there was focussed work in reducing this looking at medical pathways in the hospital. The Chief Nurse commented on the pressure ulcers and falls levels noting the improvement team were driving change during handover of care and safety huddles. It was important to protect frail people in the Trust's care and the new deputy chief nurse was looking at the issues to reduce harm in all areas across the partnership as well as just the Trust. Mr Jaitly queried if 'small change big difference' was making a difference. The Medical Director explained the 'small change big difference' initiative, was a social movement to drive efficiencies and improve quality trust wide. It was a long term project which would be evaluated with help from the University in trying to cost it.

	The Director of Workforce and Organisational Development updated the Board on the work being undertaken to drive down the nursing vacancy rate including employing overseas graduates, growing our own through apprenticeships and retention work, focussing on staff due to retire. This reduction in vacancy rate had reduced temporary staffing spend. Tight grip and control with close working between the clinical teams and the corporate services teams working together for the best use of money. The Strategic Workforce Committee monitors the apprenticeships and spend against the levy; reports around staff sickness especially going into the flu season and appraisals which were better than last year but need to reach a level of 90%. In addition, the Guardian of Safe Working Hours provides quarterly report on exception reports by Junior Doctors. Dr Amin queried the appraisal level. This was explained by sickness, maternity leave and takes account of short-term contracts and those who leave halfway through the year. It was explained the Trust would get to 90%. Closer link with appraisal and moving up through the increments was being brought. The real motivator was for staff to have a good conversation with their line manager around staff engagement and improving care for the patients. Mr Roche noted the great work in temporary staffing however, however he asked for further information on the staff retention paper. It was explained that the Trust was doing well and were overachieving on nurse turnover and were above the national average. The Finance Director informed the Board the Trust was on plan at month 5 and had reported a £2.1m deficit with the regulators. There were risks for the end of year which would need managing. There were pressures emerging within Medicine, Surgery, Specialist Services and Property Services however recovery and mitigation plans were in place and working on a granular level on the forecast outturn. In addition, improvements had been made with Finance Team procedures. The Board **REVIEWED** and **NOTED** the Integrated Performance Report.
137/2019	**QUESTIONS FROM THE PUBLIC** Mr Alan Barnard, a member of the public, queried how the Trust recovered finance from non-EU citizens who received NHS care. The Commercial Director explained the role of the overseas visitors' team who asked questions of patients and work was being done to see how robust this was. Mr Roche noted he was impressed by recent reviews to tighten processes around the recovery of costs for the treatment of non EU citizens.
138/2019	**INFECTION PREVENTION AND CONTROL REPORT** The Medical Director presented the Board with the Infection Prevention data for July 2019 noting the great work being undertaken with line infections. Dr Amin questioned the rates of colostrum difficile to date. It was explained the Trust was currently on target and noted all incidents were subject to a panel hearing for investigation and categorised. Additionally, the Medical Director noted MRSA numbers were reported however there was no target. The Board **NOTED** the Infection Prevention Control report for July 2019.
139/2019	**NURSING WORKFORCE – SAFE STAFFING, APPRENTICESHIP SUPPORT AND EFFICIENCY PLAN** The Chief Nurse presented the Nursing Workforce – safe staffing, apprenticeship support and efficiency plan which outlined the proposed skill mix to ensure appropriate staffing levels to provide high quality and safe care through an effective and efficient nursing

	workforce. The financial recovery programme would monitor efficiencies against the plan and cost pressures around the run rate. Professor Sines noted the Quality and Clinical Governance Committee had reviewed the plan and there would be a funding request for acuity. Chartridge and Waterside wards would depend on the future model of care for skill mix and mitigation of risk. There were specialist nurses on ward rosters working across acute and community sites. It was necessary to understand the role of these nurses, to have visibility and clarity and challenge model of care. There were links to income and outcomes with focus on a hospital setting for a model of care across pathways. This would be monitored going forward for quality and money purposes in a systematic and predicted way with skill expertise and meaning. Great links between the education team and the nursing workforce team helped to successfully support nursing apprenticeships which was praised. Professor Sines commented on skill mixing and whether the Trust was continuing to focus on supervision and reflection of skill mix as competence grows. It was explained this was now part of the nursing preceptorship and education with nurses was ongoing. There would be internal measures and testing. The Director of Workforce noted the apprentice model needed a backfill pathway, and to ring fence funds for training posts. Mr Roche questioned if the Trust was celebrating these staff, the Chief Nurse noted this was being promoted and a presentation would be brought to a future Board Seminar. Mr Roche asked for the number of people under apprenticeships, it was explaining this was building and was a good success story. The Board **APPROVED** the plan.
140/2019	**END OF LIFE CARE STRATEGY UPDATE** The Chief Nurse provided the Board with an progress update on the end of life care strategy and highlighted the outstanding rating received for end of life care from the Care Quality Commission (CQC). Mrs Gilham expressed how impressed she with maternity bereavement care processes following her induction walkabout around the Trust. The Chief Nurse commented on the need for identifying end of life and having early conversations with families which was linked with confidence in clinicians. Targets would be brought back to the Board in March. It was highlighted the end of life care strategy was inclusive to all parts of the community not just in a hospital setting. The Board **NOTED** the report.
141/2019	**RESEARCH AND INNOVATION REPORT** The Medical Director presented the Research and Innovation Annual Report 2018-2019 to provide reflection on 2018-19 successes; update on research and innovation activity and to look ahead to 2019-2020. Dr Admin admitted to not realising how much research and innovation work goes on within the Trust and that it would be great to share this work more widely both inside and outside the Trust. It was suggested this could be publicised during corporate induction and to raise

	the profile in communication bulletins. Mr Jaitly queried how the Trust decided which areas of research were decided on for work. There was a local network which was in line with national benchmarking. More needed to be done in the area of cancer research in the entire region and more work with Thames Valley. The contribution of the Trust was being stepped up. Mr Jaitly queried if the Trust was involved in stem cell research and the Medical Director noted Oxford was the lead for trial work in this area. We do not have the patient group to link into this research area. The Medical Director noted she was very confident the innovation hub would be open by the end of the financial year. The Board **NOTED** the report.
142/2019	**PEOPLE STRATEGY** The Director of Workforce and Organisational Development presented the Buckinghamshire Healthcare Trust People Strategy 2019-2021. There were 5 people priorities which were aligned to deliver corporate objectives in Buckinghamshire and in the wider system. Mr Roche believed retention needed to come out more in the strategy. Dr Amin queried what outcomes the non-executive directors should be looking out for in the year ahead. The focus would be on nursing, cultural work and leadership work. Equality, diversity and inclusion were also a focus. The Chief Executive noted the Trust was a people business it was critically important to manage people through the changes and the corporate objective was linked to quality improvement. The Board **ENDORSED** the strategy.
143/2019	**BUCKINGHAMSHIRE, OXFORDSHIRE AND BERKSHIRE WEST INTEGRATED CARE SYSTEM (BOB ICS) LONG TERM PLAN (LTP)** The Director of Strategy and Business Development presented the Board with an update on progress and plans for developing the BOB ICS LTP. The aim of the plan was to improve the health and well-being cross the system and to meet the challenges patients faced. Work was being undertaken with partners to provide a long-term plan by the end of November which reduced health inequalities and tackled mental health and long term conditions. There were issues with infrastructure, staffing and a rise in demand in A&E, however, the plan would give a sense of where the system was headed over the next 5-10 years. In answer to a query from Dr Amin, the Director of Strategy noted the plan was based on a national template. In addition Dr Amin queried if there would be a focus on prevention in the plan. It was explained this would be a significant part of the plan with links with public health and a focus on preventative health. In addition there would be a focus on respiratory care and on the challenges between the poorer and wealthier areas. The Chief Executive Officer noted there was a legal duty to share the plan with the public through patient experience groups and community hubs as part of the ongoing narrative. The Board **NOTED** the report.
144/2019	**EQUALITY DIVERSITY & INCLUSION ACTION PLANS** The Director of Workforce and Organisational Development presented the Equality

	Diversity & Inclusion Action Plans for approval. The Chief Executive Officer noted the action plans should be viewed as a 'moment in time' and would continue to be updated. It was noted the metrics had been uploaded in August and the plans published and noting the disability standard was new. The Director of Strategy noted the oversight framework would include the actions. In answer to a query from Mrs Gilham, it was confirmed that non bias training was included in recruitment training. The Board **APPROVED** the action plans.
145/2019	**QUESTIONS FROM THE PUBLIC** David Peplar, district councillor for South Bucks queried what a Death Café was. The Chief Nurse explained they were a national initiative that provided what was often an uplifting opportunity for the local community to get together to discuss all sorts of worries about end of life. It was noted the concept was a good one however the name of the group did not entice members of the public to attend. A review of who attended these cafes would be looked at. Mr Jaitly asked for the cultural implications to be considered.
146/2019	**BOARD ASSURANCE FRAMEWORK** The Director for Governance presented the quarterly Board Assurance Framework (BAF) to the Board which had been reviewed by the Audit Committee and highlighted the top risks and how they were being managed. These were the Financial Recovery and Workforce Plans and how the Trust was mitigating these risks going forward. Mr Roche commented on the document being difficult use and it was explained that a new user friendly document was being considered. The Board **CONFIRMED** the top risks.
147/2019	**CORPORATE RISK REGISTER** The Director for Governance presented the Corporate Risk Register to the Board noting there had been some updates discussed at the Executive Management Committee since publication in the Board Papers. These included some risks being removed and included on divisional risk registers. It was noted the internal auditors would be reviewing the risk management processes. A new electronic system was being investigation to allow a more timely and manageable system across the divisions. Dr Kenny commented on the risk regarding cleaning, noting audits since April have improved, including strengthened contract management meetings. Mr Jaitly noted that the register required updating in terms of what was there and what might be missing. The Director for Governance explained updates were being provided by each Executive Director. The Board **APPROVED** the risk register.
148/2019	**BOARD ATTENDANCE RECORD** The Board **NOTED** the attendance record noting the attendees of the Charitable Funds Committee should be included in future reports.
149/2019	**PRIVATE BOARD SUMMARY REPORT** The Board **NOTED** the summary of the private board held in July 2019.

150/2019	**QUALITY AND CLINICAL GOVERNANCE COMMITTEE** The Board **NOTED** the Quality and Clinical Governance Committee Chair's report.
151/2019	**FINANCE AND BUSINESS PERFORMANCE COMMITTEE CHAIR'S REPORT** The Chair of the Finance and Business Performance Committee updated the Board on the meeting held the previous day which had focussed on finances, outcomes for the end of year, CIPs and the financial recovery plan. The Board **NOTED** the Finance and Business Performance Committee Chair's report.
152/2019	**AUDIT COMMITTEE CHAIRS REPORT** The Board **NOTED** the Audit Committee Chair's Report.
153/2019	**CHARITABLE FUNDS COMMITTEE CHAIR'S REPORT** The Chair of the Charitable Funds Committee expressed disappointment at the lack of bids the committee had received. The Chief Executive Officer noted an action for the Executive Directors to look at utilising charitable funds for public and patient's benefit. Mr Roche asked for evidence of what had been received previously to be widely communicated. The Director of Finance commented on working more with associated charities of the Trust. The Board **NOTED** the Charitable Funds Committee Chair's Report.
154/2019	**STRATEGIC WORKFORCE COMMITTEE CHAIR'S REPORT** The Board **NOTED** the report.
155/2019	**RISKS IDENTIFIED THROUGH BOARD DISCUSSION** The Director for Governance set out the risks identified through Board discussion as follows: • A&E and cancer targets • Nursing workforce retention • End of life care, and learning from process • Inclusion agenda and access to services • Financial risk • Changing landscape and being proactive in managing risk • EU exit
156/2019	**ANY OTHER BUSINESS** There was no other business.
157/2019	**QUESTIONS FROM THE PUBLIC** Mr Alan Barnard expressed concern over the slow progress in uptake of CAT's services in local community hubs. The Chief Nurse and Director of Strategy and Business Development would look to review what blocks there may be to making greater use of services so valued by local communities.
158/2019	**DATE OF NEXT MEETING** Wednesday 27 November 2019, 9am, Hampden Lecture Theatre, Wycombe Hospital There being no further business the Chair recited the motion to bring the meeting in public to an end.

	Signed ……..... Trust Chair Dated……......

ACTION MATRIX

Minute		Lead	Timescale	Update November 2019
065/2019	Examples of wider learning to be brought to Board	Chief Nurse	September 2019	Therapy led ward patient and staff story November Board
067/2019	More information on the performance metrics for the community sites in future reports	Chief Operating Officer	November 2019	
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
092/2019	Clinical Psychology report to come back to Board on how the pilot was being taken forward.	Chief Operating Officer	November 2019	
097/2019	Patient Experience Strategy to come to Board in the Autumn	Chief Nurse	Autumn 2019	Bi annual update
098/2019	Board Seminar Session on understanding unconscious bias to be scheduled	Director for Governance	September 2019	
111/2019	Digital Strategy : update on milestones and finances	Director of Strategy and Business Development	September 2019	
112/2019	Board Assurance Framework : Dates to be provided on the red rated risks	Director for Governance	September 2019	Completed
136/2019	Cancer pathways and diagnostic best practice models to come to Board	Chief Operating Officer	TBC	
139/2019	Presentation to Board on apprenticeships	Chief Nurse	TBC	
153/2019	Executive Directors to look at utilising charitable funds for public and patient benefit	All	TBC	

Buckinghamshire Healthcare NHS Trust

TRUST BOARD MEETING IN PUBLIC
27 NOVEMBER 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.

Learning

We recorded four instances of *clostridium difficile* infection in September, and six in October; we had no reports of MRSA bacteraemia infection in the last two months. Disappointingly, we recorded one fall causing severe harm in September; none in October. Regarding pressure ulcers, we recorded one in September, and six in October, and this continues to be a focus area for the teams. We had no never events in the last two months. We recorded 415 births in September and 413 in October. The number of deaths recorded was 88 in September and 121 in October.

We received 57 formal complaints in September and 47 in October. Our target is to respond to 85% of complaints within 25 days. In September we achieved this in 79% of cases and we are working hard to improve the response time. We received 1125 accolades in August and 1062 in September.

We continue to encourage staff to submit excellence reports so that we can learn from great practice, and we received 56 and 63 excellence reports in September and October respectively. The example shared below is a heart-warming demonstration of compassion from a member of our staff during a gentleman's end of life care:

"After her caseload was complete SLT* spent time with a dying patient.
This patient was well known to our team and had no family present.
She took time to hold his hand, play music and sing to him too offer comfort in his final hour.
She showed respect, compassion and care for this man at the end of his life to ensure he was not alone."

*speech & language therapist

Quality improvement

I am pleased to share an example of a quality improvement project in the maternity department. Between 2017 and 2018, 19% of women in the UK who had given birth had a post-partum haemorrhage (PPH). Recognising this as an issue for our local population, a multidisciplinary project team was established, including midwives, obstetricians, and anaesthetists. The first work stream was to design and introduce a process for more accurately recording measured blood volume, and as a result this has improved to over 90% within the last three months. The principle impact of this project is to improve the experience for mothers, including a reduction in length of stay.

Quality and performance

Winter has officially started for the NHS, with key schemes designed to support the provision of care in the right place for patients commenced. The falls and frailty vehicle we piloted in conjunction with South Central Ambulance Service is now running five days per week, supporting patients who have fallen or are frail to remain at home following a rapid intervention from a specialist occupational therapist and paramedic. We have brought together the adult social care and hospital discharge teams to provide one cohesive team to support the acute wards, and provide more timely discharge. We have also simplified the referral process for patients requiring ongoing care.

The volume of patients attending Accident & Emergency (A&E) continues to increase, with an extra 160 patients each week compared to last year. Despite this, we are working hard to keep non-elective admissions at a similar level to last year through the provision of same day emergency care services for both adults and children.

Consistent with the national picture, our A&E performance against the 85% four-hour standard has deteriorated over the last few months, and we are currently reporting 81.5%. This is clearly disappointing but significant effort and attention is being dedicated to improving this situation for our patients and our staff.

Regarding cancer performance, our weekly reporting data suggest a positive shift in patients' waiting times as a result of a new pathway to expedite diagnostic pathology; we will continue to monitor this progress.

Our campaign for staff flu vaccination is well underway and we reported 46% of front-line staff at the end of October; our latest figure at the time of writing this report is 52.3% of front-line staff vaccinated. Our target this year is 80%, and we continue to work hard to encourage staff to be vaccinated to protect themselves, their families and our patients.

People
October was national "Speaking Up Month". Our Freedom To Speak Up Guardian was raising awareness in a variety of different ways across the Trust. Our theme this year was to promote the Trust saying "Thank you to staff" for raising concerns, which has been demonstrably supported by our Chair, CEO and members of our executive and non-executive teams. Nationally, the campaign has already been reported as a success with increased activity compared with last year.

October was Black History Month and once again the Trust celebrated this throughout the month. I was pleased to attend the Trust BAME Network's celebration on 29 October, hosted by the new chair of our network, Isabel Sánchez Wilson.

Together with Sodexo, we are hosting an internship programme for seven students with learning disabilities from Stoney Dean School. The programme started in September 2019 and runs until June 2020 and is supported by Bucks County Council. It will provide the interns with valuable skills and experience that will support them in gaining employment.

I am delighted to welcome the first cohort of 16 nurse cadets to the Trust. This is a partnership programme with Bucks College Group; the cadets are studying a Level 3 health and social care course and have expressed a particular interest in undertaking pre-registration nursing in the future. The programme comprises four days per week in college and one day per week placement across community and acute settings, with students 'buddied' with an experienced healthcare support worker who will provide support, guidance and mentorship.

The nurse cadet scheme will provide a pipeline of future NHS support staff; we anticipate a further cohort joining in January 2020. The intention of the scheme is to provide opportunities for nurse cadets to be recruited at the end of their college programme onto a career pathway from Healthcare Support Worker to Registered Nursing Associate to Registered Nurse.

Our nurse vacancy rate has reduced to 13.8%, the lowest since March 2016. There is still more to do but this represents significant efforts in this area and I am pleased to see that these efforts are paying dividends. Since the start of the financial year, we have increased the number of registered nurses and midwives by just less than 80. This autumn we have welcomed newly registered nurses from the UK, in particular from our partner universities – University of Bedfordshire and Bucks New University – as well as from the EU and further afield. We continue to invest in our nursing workforce at all stages of their career, supporting both newly qualified and more experienced colleagues.

I would like to take this opportunity to formally welcome Jenny Ricketts to the Trust Board, who joins as Interim Chief Nurse.

Money
At the end of month seven of the financial year, the Trust is reporting a £12.5m normalised deficit year-to-date; the in-month position for October is £3.1m deficit. The year-to-date position includes receipt of quarter 1 and 2 Performance Sustainability Fund (PSF), Financial Recovery Fund (FRF) and Marginal Rate of Emergency Threshold (MRET) of £7.1m in total. The Trust's current end of year forecast is in line with the breakeven plan. A detailed assessment of divisional forecasts and financial risks have been considered.

We have started the process of budget setting for the 2020–21 financial year and will be reporting to Trust Board in the last quarter of the current financial year.

Strategic view
Our Trust corporate objectives for 2019–21 have now been in place for about six months, and I am pleased to see the first of our regular reports on progress to Trust Board, highlighting some significant achievements in each of the three objectives. Our Small Change, Big Difference campaign is in full swing; one of the examples is changing our printing paper to recycled paper, which is estimated to produce a £25,000 saving over the course of a year.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (BOB ICS)
The BOB ICS has submitted a response to the NHS Long Term Plan which outlines the aspirations and detailed plans for improving the health and well-being of the residents of Buckinghamshire, Oxfordshire and Berkshire West. Plans are currently being assessed and are likely to be publically available in the New Year.

Clinical Commissioning Groups in Buckinghamshire, Oxfordshire and Berkshire West have outlined proposals for the future arrangement of NHS Commissioning in the BOB ICS area. The Board will have the opportunity to consider its response before the deadline on 01 December. The engagement pack is available here: https://www.buckinghamshireccg.nhs.uk/wp-content/uploads/2019/10/2019-BOB-Commissioning-Architecture-Engagement-Pack-v-FINAL.pdf

The BOB ICS held its first Chairs Forum on 23 October; meetings will be held bi-annually. Topics included the System Financial Recovery Plan. The BOB ICS Senior Leaders Group discussed the implications of housing growth on health and social care services at its last meeting and the opportunity for the system to influence and plan for these changes.

Buckinghamshire ICP
The ICP is developing a strategic case for change linked to the NHS Long Term Plan and to the quality and sustainability of services in the county in the next five years. As part of this process, the Trust hosted a Clinical Leadership Seminar to shape future models of care in rehabilitation, acute, outpatients, diagnostics and community services, which will contribute to the plans.

The ICP held a number of important events in November including a Senior Leaders Event for colleagues across the system. The day was an opportunity to agree key values and ways of functioning to improve joint working across the local health and care system. The outputs will be developed into an Organisational Development Plan for the ICP.

The ICP Board received an update on progress towards a single unitary council for Buckinghamshire. The new Council will have 147 elected members and elections to the new council will take place in May 2020. The new council will deliver all local government services for Buckinghamshire, both county and district, from 01 April 2020.

Outstanding practice
£34k of Pathway Transformation Funding has been awarded to the Urology department. This NHS England funding was made available to help providers overcome practical obstacles to deploying innovation. This money will help transform the Lower Urinary Tract Symptoms Service, paving the way for one-stop Urology services in Amersham.

BHT's Children and Young People's services were rated 8th out of 66 Trusts overall in a patient experience survey by Picker. This is a fantastic representation of all our speciality teams that interact with children who come in to our hospitals.

The Bucks Skills Show is an annual event for young people to discover different sectors and career paths available in Buckinghamshire and further afield, attended by 30 schools and c. 3000 children. I gave a short presentation and led a discussion about careers in healthcare, and colleagues hosted stalls on various parts of our Trust. The Research and Innovation team had a particularly heart-warming interaction with a boy with cerebral palsy who visited their stand and, with the support of an occupational therapist, tried out a soft extra muscle (SEM) glove, which had recently been an intervention in one of the studies in the National Spinal Injuries Centre. The boy was able to use it to form a tight grip on an object. This illustrates the potential benefits of research into improving patients' lives.

Proud to be BHT
- Huge congratulations to Liz Monaghan, matron at the Florence Nightingale Hospice at Stoke Mandeville Hospital, who has been named 'Best Nurse' for The Sun's Who Cares Wins national awards. Liz was nominated by Elaine Trump, a member of the Patient Experience Group, for her dedication to the Purple Rose initiative which aims to improve the care for patients in the last days of their life. This is an enormous achievement and we are very proud of Liz and the team.
- I was delighted to spend the evening this month with representatives of the community team and Freedom To Speak Up Guardian at the HSJ awards. Congratulations to all involved, and particularly to the community teams for being awarded Highly Commended for 'Acute or Specialist Service Redesign Initiative – London

and the South'. We were also shortlisted for 'Community or Primary Care Service Redesign – London and the South' and 'Freedom to Speak Up Organisation of the Year'.

- Congratulations to Shaun Appleton, Consultant Surgeon, who has been successful in securing the role of Vice Lead for National Selection, and subsequently in 2021 and 2022, Lead for National Selection for Higher Surgical Training in General Surgery. This is an excellent achievement for which he should be rightly proud.
- Congratulations to Yasmeen Rabindranath who won the Trust Bake Off Final in October, and thank you to all who entered and helped raise money for Macmillan Cancer Support.
- Staff and visitors to Wycombe General Hospital will see the newly installed 'lift wraps' encouraging people to join the Organ Donor Register.
- Earlier in November we celebrated World Quality Day with activities to raise the profile of quality improvement, including talks and stalls showcasing examples of projects at the Trust from clinical audit, voluntary services and library services.
- It was fantastic to attend the official opening of the doctors' mess at Stoke Mandeville Hospital earlier this month – this is an important space for the doctors to have on the site.
- Congratulations to one of our amazing volunteers, Trevor Hudson, who was shortlisted for the Helpforce Volunteer of the Year Award. Although Trevor didn't win, he was highly commended for his achievements as an A&E Buddy.

Neil Macdonald
Chief Executive

Appendix – Financial Recovery Board and Executive Management Committee

Appendix 1 – Financial Recovery Board and Executive Management Committee

Financial Recovery Board

Financial Recovery Board (FRB) continues to meet on a weekly basis, attended by Executive Directors and chaired by the Chief Executive. The agenda covers cost improvement/savings plan (CIP) performance, the overall financial performance, progress towards achieving recommendations to improve our financial governance processes, ideas generated by our Small Change Big Difference campaign.

Our CIP is currently £16m against a target of £15m; aiming above target is to help manage the risk of schemes not delivering to plan. We are also now looking ahead to the 2020–21 financial year, starting to plan potential CIP opportunities. FRB is also focusing on the financial performance management of four particular areas requiring support: Property Services, Surgery & Critical Care, Integrated Medicine, and Specialist Services divisions. Overseen by the Director for Governance, delivery of the Financial Governance Action Plan is on track and is now reporting by exception following scrutiny by NHS England & Improvement earlier this month.

Executive Management Committee 20 September 2019 to 15 November 2019

Executive Management Committee meets 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 clinical and corporate services. The following provides an overview of some of the key areas considered by the committee since 20 September 2019.

Corporate objectives

Quarterly reports for the following programmes:

- Continue to improve our culture
  - Listening to the patient voice
  - An organisation that learns
  - Small Change Big Difference
  - Culture of quality improvement
- Implement new workforce models
  - Innovate with new models of care
- Tackle inequalities and variation
  - Build new community partnerships
  - Modernise outpatient services
  - Embed use of accurate data across the Trust
  - Getting it Right First Time and reduce clinical variation
- Enablers
  - Clinical strategy
  - Digital strategy
  - Commercial services

Six-monthly progress summary for Trust Board

Money

Monthly capital, cash and key performance indicators report
Efficiency programme 2019/20
Capital programme quarterly report
Procurement strategy quarterly update
Contract activity and income quarterly report
Drugs expenditure report
Forecast 2019/20
Budget setting 2020/21
Buckinghamshire Integrated Care Partnership financial position
Care Quality Commission Use of Resources update
BHT Charitable Funds proposal
Draft finance strategy

Strategy

Buckinghamshire, Oxfordshire & Berkshire West (BOB) Integrated Care System (ICS) long term plan
BOB ICS growth agenda
BOB ICS population health
BOB ICS digital report

People

CARE value awards
Freedom To Speak Up Guardian quarterly report
Guardian of safer working hours quarterly report
Bank rates review
Staff survey 2019
Pensions update
Locum rates
Notice period proposal

Quality and Performance

Patient/staff story
Patient voice annual report
Patient experience quarterly report
Medicines optimisation annual report
Women, Children & Sexual Health Services division report
Infection Prevention Control report
Flu vaccination plan 2019/20
NHS Improvement learning disabilities improvement standards report
Care Quality Commission action plan
EU Exit preparations
Integrated Performance Report and exception reports
Endoscopy update
NHS Oversight Framework
Maternity quarterly safety and staffing reports
Seven day services
Community inpatient wards update
Serious incidents report
Non-elective performance update
Endoscopy five year strategy

Governance
Board Assurance Framework
Corporate Risk Register
Summary of internal audit work
List of policies due to lapse in next 6 months
Caldicott & Information Governance Committee
Report writing templates

The following policies have been approved:

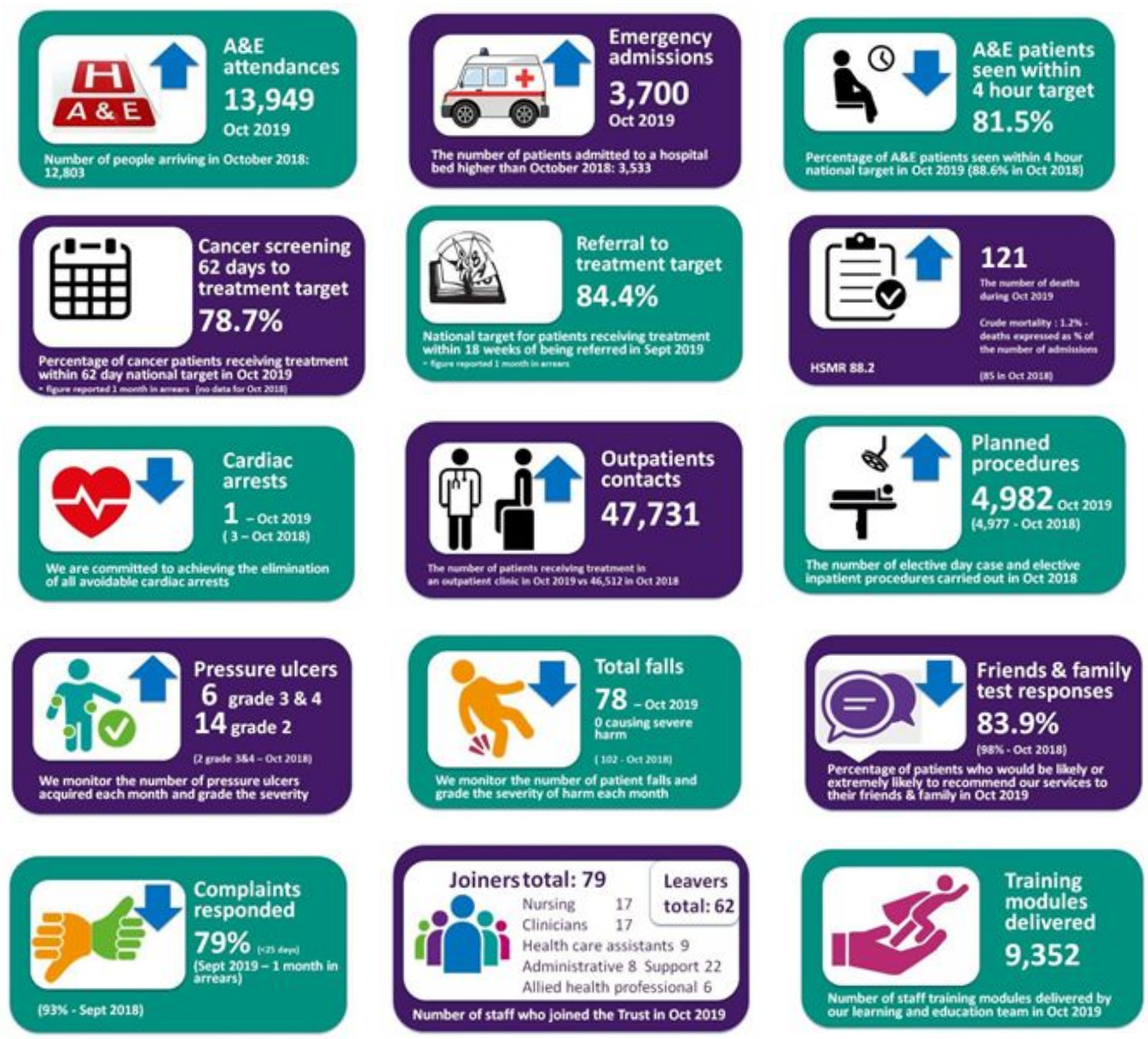
- Blood transfusion policy
- Capability policy and procedure
- Safeguarding adults policy
- Safeguarding children policy
- Temporary staffing
- Clinical excellence awards policy
- Policy for the use and release of Person Identifiable Data

Meeting minutes of the following:

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

NHS
Buckinghamshire Healthcare
NHS Trust

Month in numbers
November 2019 with October 2019 data



Please note: arrows show comparison with October 2018 data (figures going up or down) unless stated otherwise and are not intended as an indication of performance

Safe & compassionate care, every time

Safe & compassionate care, every time

Buckinghamshire Healthcare NHS Trust

Meeting: Trust Board Meeting in Public

27 November 2019

Agenda item	Integrated Board Report
Board Lead	D.H.R. Gibbs – Chief Operating Officer
Type name of Author	Wendy Pocknell
Attachments	None
Purpose	Assurance
Previously considered	EMC 22/11/2019, F&BP 26/11/2019

Executive Summary

- Summary report of KPIs related to quality, people and money with exception reports for designated areas.
- Illustrates BHT compliance against operating framework standards, quality metrics and financial overview.

7

Decision	The Board / Committee is requested to be updated with current position

Relevant Strategic Priority

Quality ☒	**People ☒**	**Money☒**

Implications / Impact

Patient Safety	Yes – KPIs related to patient safety contained herein.
Risk: link to Board Assurance Framework (BAF)/Risk Register	BAF2A Delivery of constitutional standards
Financial	Yes – financial reports contained herein.
Compliance CQC Standards Safeguarding	Yes – KPIs related to patient safety contained herein.
Partnership: consultation / communication	No.
Equality	Yes – related KPIs herein.
Quality Impact Assessment [QIA] completion required?	No

NHS
Buckinghamshire Healthcare
NHS Trust

Integrated Performance Report

September 2019

CQC rating (June 2019) - *GOOD*

Safe & compassionate care,
every time

Executive summary

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

Actions/Emerging Risks

A&E: Performance against the A&E four hour standard has deteriorated from 82.68% in September to 81.5% in October. Attendance remain higher than planned, particularly at weekends when attendances were in excess of 500 on occasions. Minors breaches continue to post significant problems out of hours and contribute 18-22% of overall breaches. Actions to revamp streaming processes are to be introduced to mitigate continued risk of increased breaches.

RTT: September Referral to Treatment compliance deteriorated from 85.3% in August to 84.4% in September. Surgical specialties are under increasing pressure to reduce elective capacity to meet emergency demand. The waiting list saw a significant rise but more patients have booked appointments from electronic referrals. The diagnostic pathway continues to be compliant with less than 1% waiting more than 6 weeks, and there are no 52 week breaches.

Cancer: Cancer 62 day performance deteriorated from 83.4% in August to 78.7% in September. Actions to expedite pathology reporting and active patient tracking are underway to improve performance.

Quality and Safety

Celebrate success: 'We would like to say a BIG thank you to all staff from triage/labour ward and not last neonatal unit for the level of care , quality of service and all the effort to help my wife deliver our daughter at 31 weeks and 4 days . We felt like our own family was there to help . We can't thank you enough. I hope you receive from life the same type of treatment you offer to your patients. ' Anonymous.

Complaints: The trust target for the 25 day response rate in September was 79%. Out of the 38 complaints received, eight breached. Five breaches were attributed to Trauma and Orthopaedics (T&O). The unexpected loss of a laminar flow orthopaedic trauma theatre in October and the operational impact of this has contributed to increased number of in month breaches in this speciality. A QI plan is in place to support the team to recover their position in November.

Pressure ulcers: There were six pressure ulcers for October

Falls: Falls performance has improved this month with no falls causing severe harm.

Workforce

Our Nurse vacancy rate has improved to 13.8%, the lowest reported figure since March 2016. This is due to our international recruitment pipeline (in particular supporting individuals in preparing for the Occupational English Test (OET) and in their subsequent applications for UK registration). This, alongside our retention initiatives that stabilise turnover, has had a positive impact on our overall nurse vacancy rate.

Our flu campaign achieved 46% vaccination rate of front line staff by the end of October. The flu CQUIN target is for 80% of front line staff to be vaccinated by Jan 2020. We are refreshing our campaign (following a delay in the delivery of the second batch of vaccines), using data collected to have a more targeted approach in key areas utilising peer vaccinators in clinical areas.

The annual NHS National staff survey went live to all 6015 staff members for 8 weeks from 2 October 2019. To date we have achieved a response rate of 39% (2289 staff) a 4% increase in the response rate for the same period last year. Our target is for at least 55% of staff to complete the survey

Finance

The trust is off plan by £3.1m at Month 7 YTD delivering a £5.1m deficit position versus plan of £2.0m. 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 £7.4m. Also included is benefit of £3.0m non-recurrent ICP income risk phasing from Buckinghamshire CCG (reduced from £4.5m at Month 6). The £3.1m variance to plan at month 7 is due to two key factors (1) repayment of £1.5m of ICP income risk funding and (2) the loss of £1.5m PSF and FRF funding in month 7. The YTD month 7 normalised position excluding receipt of PSF, FRF and MRET is a £12.5m deficit, and without the ICP income risk phasing would be £15.5m deficit. Cash balances at the end of the month were £0.4m ahead of plan. This includes revenue support loan cash draw downs made in previous months and additional £0.5m PSF receipt in respect of the prior year. A £2.8m revenue support loan cash draw down is planned for December 2019 and this will need to be repaid once funding flows to the organisation or when the trust begins to deliver a surplus.

Content of the Integrated Performance Report

The Integrated Board report consist of two components

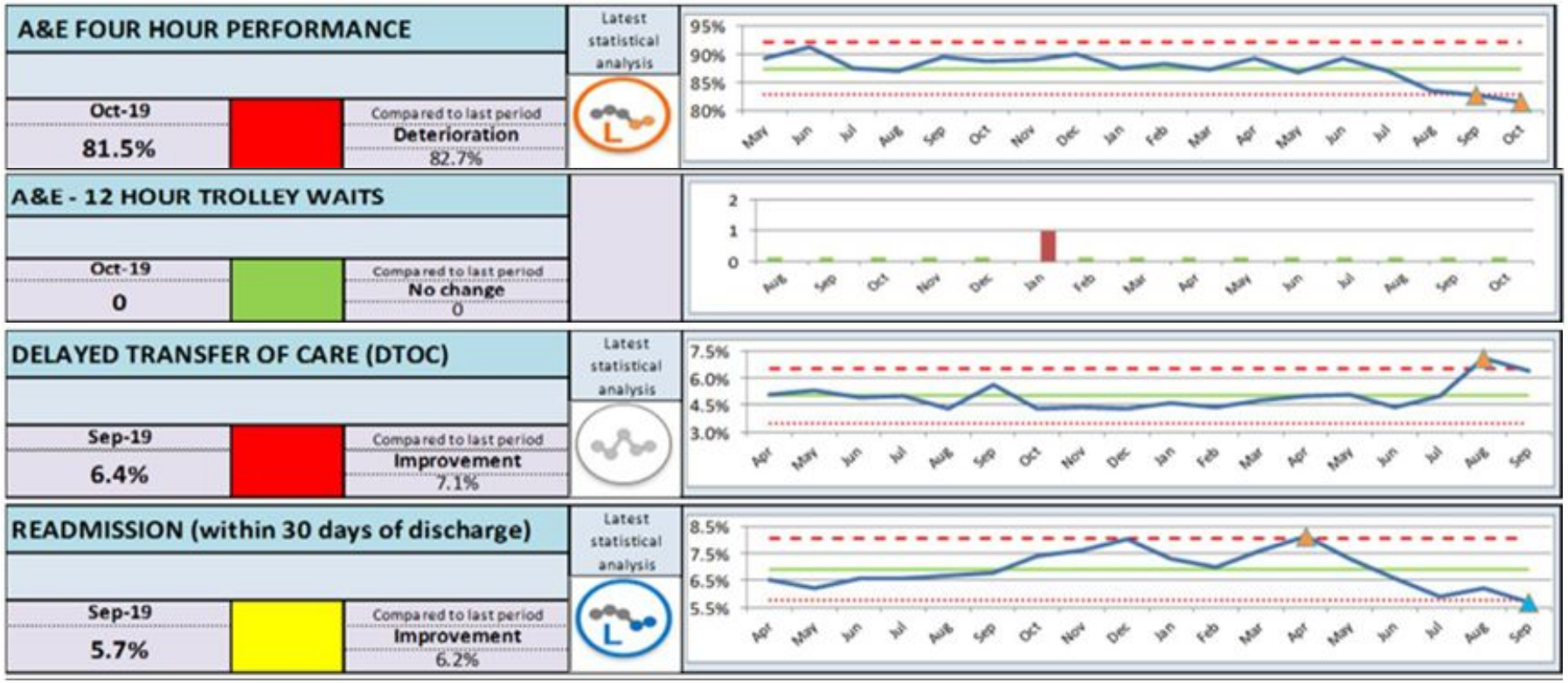
- **Charts that show the Trust's performance across a large number of important areas, known as Key Performance Indicators (KPI's)**
- **Commentary on these charts together with other reports about key aspects of the Trust's performance, strategy and financial position**

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 areas:

- **Referral to Treatment, Cancer and Acute Care Performance – which shows the Trust's compliance with National Constitutional Standards and supporting KPIs. These show the current value for a KPI, how it meets the targets (based on a "traffic light" system) and an SPC analysis (more information about SPC analysis is given on the following page)**
- **Efficiency/Performance – 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**
- **Quality and Safety – 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**
- **Workforce –**
- **Finance -**
- **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.**

A&E 4 Hours Waiting Time

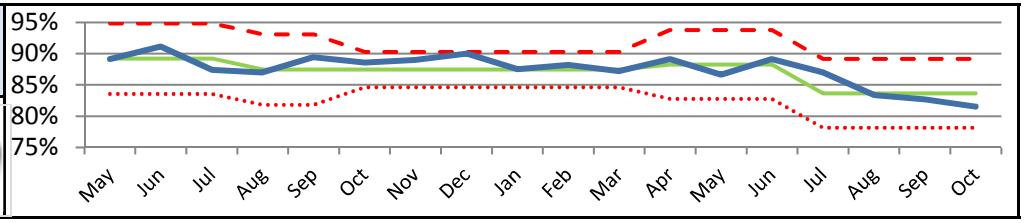


Performance Overview:

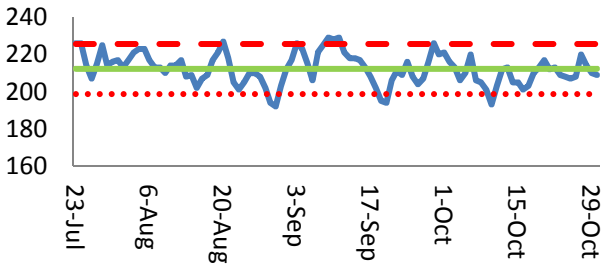
- A&E performance remains challenging due to the number of attendances and delayed flow through and from the department.
- Discharges from ward remain challenged for patients requiring social input.

A&E 4 Hours Performance

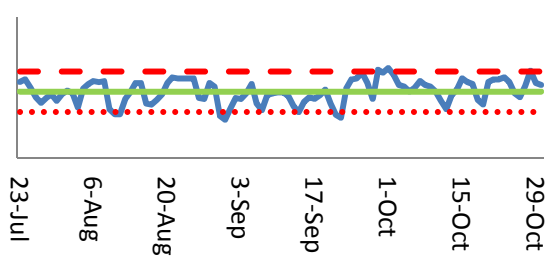
A&E FOUR HOUR PERFORMANCE			Latest statistical analysis
Oct-19		Compared to last period	
81.5%		Deterioration	
		82.7%	



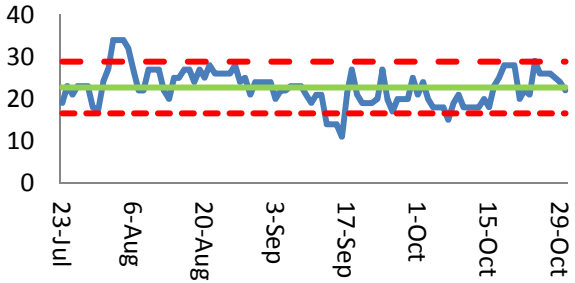
Stranded Patients - 7 days (number)



Beds Occupied (number)



DToC



Performance Overview:

Performance of the Emergency Department (ED) constitutional standard of patients seen or discharged within 4 hours has continued to see more variation throughout October and in particular weekend performance has been continued to be challenged. In October the ED attendances were in excess of 500 on 5 occasions. The highest recorded day was 542 patients.

Type 1 A&E performance continues to be a challenge and there was an even further reduction in performance in October at 65.41%.

Minors breaches continue to contribute to 18-22% of the overall breaches

A visit from NHSi to support performance was undertaken on 11th November 2019.

There was agreement to focus on;

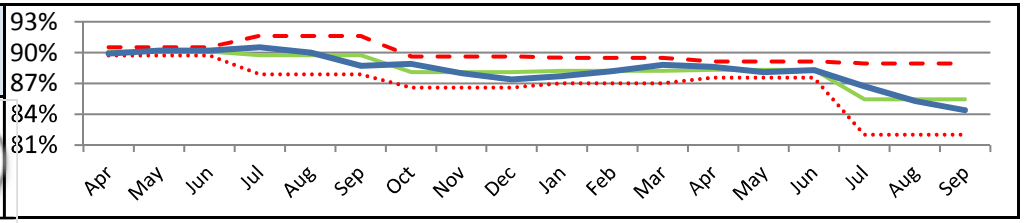
- ED huddles
- Nurse in charge/EPIC roles
- RAG rated operational sheets
- Band 7s – development
- Triumvirate development
- Streaming – options

DToC

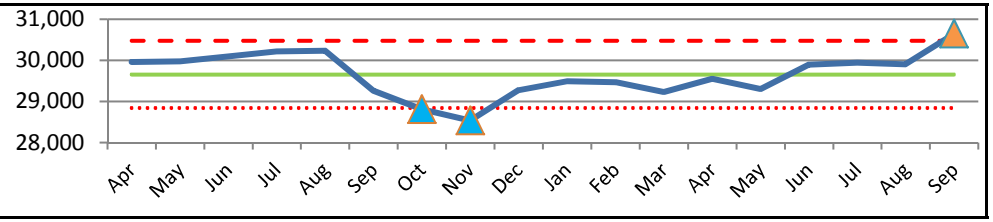
The number of DToC remain stable between 22 & 25 and work continues with system partners to reduce this.

Referral to Treatment Performance

RTT - OPEN PATHWAY PERFORMANCE			Latest statistical analysis
Sep-19		Compared to last period	
84.4%		Deterioration 85.3%	



RTT - NUMBER OF OPEN PATHWAYS			Latest statistical analysis
Sep-19		Compared to last period	
30,640		Deterioration 29,901	



Summary

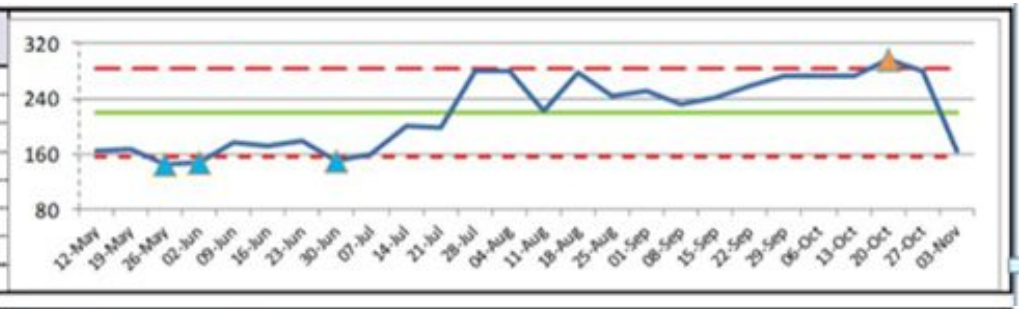
- September experienced the largest rise in patients added to the waiting list and this was as a result of more patients receiving appointments through the electronic referral channel.
- Less patients waiting without an appointment
- Elective surgical capacity was restricted due to emergency demand and this contributed to a decline in the number of patients treated
- The Trust continue to look at moving capacity across sites to maintain elective service
- Business planning commenced with focus on RTT performance and delivery

Cancer Performance

CANCER - PATIENTS WAITING MORE THAN 62 DAYS FOR TREATMENT TO COMMENCE

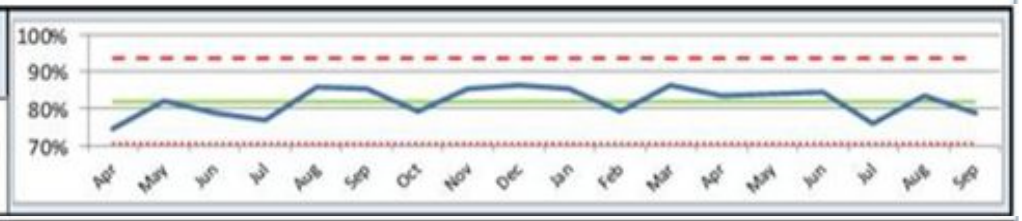
On a weekly basis, the number of patients who had waited more than 62 days for treatment including delays due to patient choice

Week ending	Patients waiting
03-Nov	165
27-Oct	281
20-Oct	296
13-Oct	272
06-Oct	272
29-Sep	272
22-Sep	259
15-Sep	242



CANCER - TREATMENT IN 62 DAYS (2 ww)

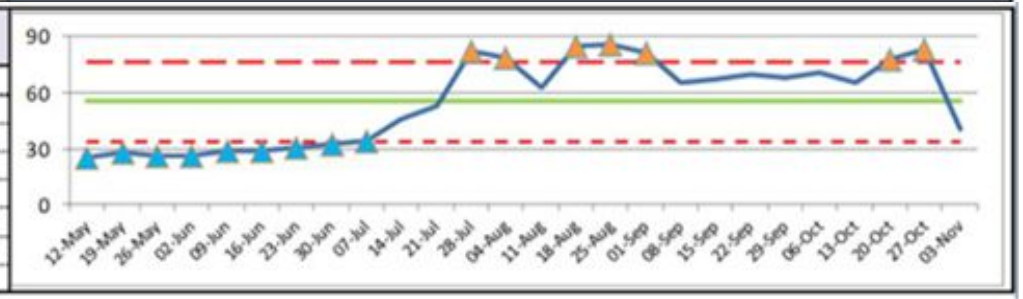
Sep-19	Compared to last period	Latest statistical analysis
78.7%	Deterioration 83.4%	



CANCER - PATIENTS WAITING MORE THAN 104 DAYS FOR TREATMENT TO COMMENCE

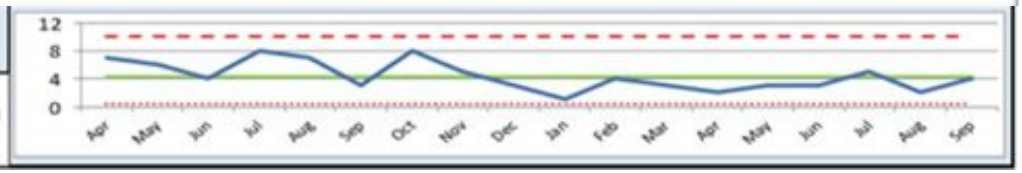
On a weekly basis, the number of patients who had waited more than 104 days for treatment including delays due to patient choice

Week ending	Patients waiting
03-Nov	40
27-Oct	83
20-Oct	78
13-Oct	65
06-Oct	71
29-Sep	68
22-Sep	70
15-Sep	67



CANCER - 104 DAY WAITS (2 ww)

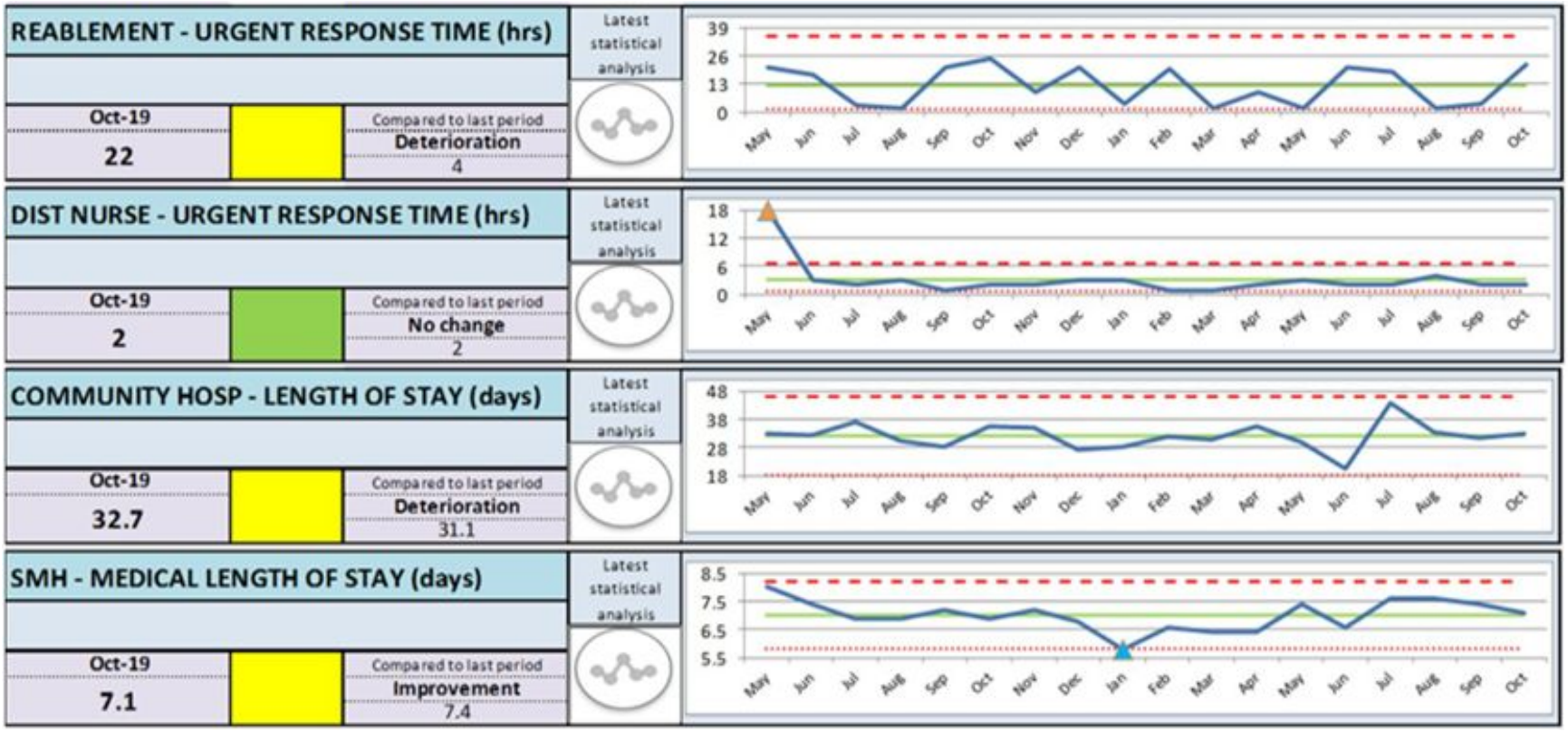
Sep-19	Compared to last period	Latest statistical analysis
4	Deterioration 2	



Summary

- Tertiary delays remain a significant factor in cancer non-compliance
- Capacity affected by lack of radiology support
- Initiation of new pathway to expedite diagnostic pathology to improve performance and clinical care
- Plans to share of information and increased involvement of clinicians

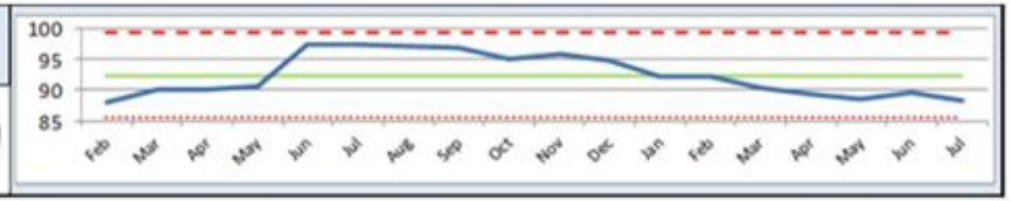
Efficiency/Performance

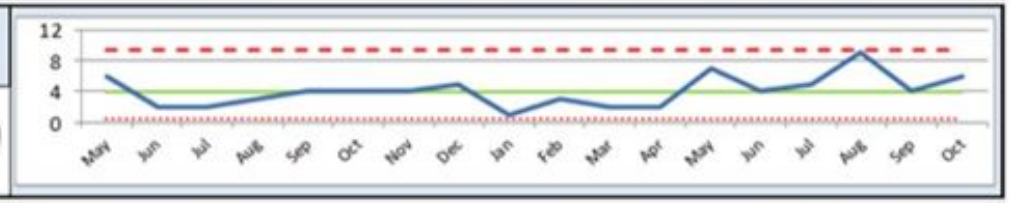


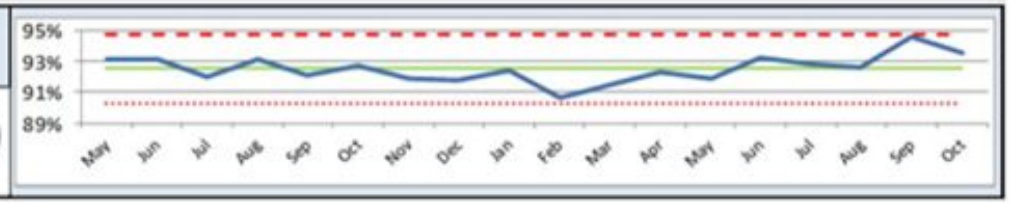
Summary:

Rapid Response and Intermediate Care (RRIC) – shows normal variation – urgent response times are being maintained. The increase in lead time in October is attributed to: bridging packages of care for adult social care which hampers capacity, holding patients at the end of the six weeks RRIC when they need onward Adult Social Care and staffing shortages.

Quality and Safety

HSMR (Hospital Standardised Mortality Ratio)			Latest statistical analysis	
Jul-19		Compared to last period		
88.2		Improvement 89.5		

C DIFF (Clostridium Difficile)			Latest statistical analysis	
Oct-19		Compared to last period		
6		Deterioration 4		

HARM FREE CARE			Latest statistical analysis	
Oct-19		Compared to last period		
93.5%		Deterioration 94.5%		

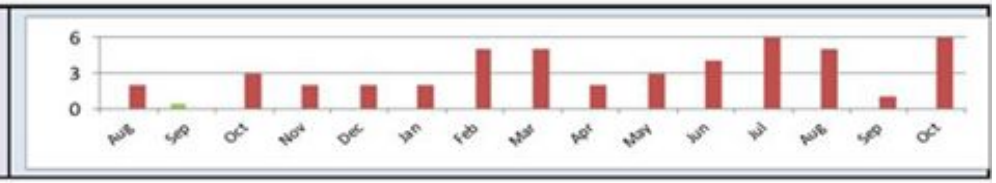
MRSA BACTERAEMIA			
Oct-19		Compared to last period	
0		No change 0	

Summary

Harm Free Care:

- This is the best performance in the last 12 months at 94%. The two areas that contribute to this score relate predominantly to pressure ulcers that have been acquired outside of BHT and new VTE's (0.45%) although numbers are small.
- A review of the areas with a % of HFC under 90% will be used to inform ongoing work.

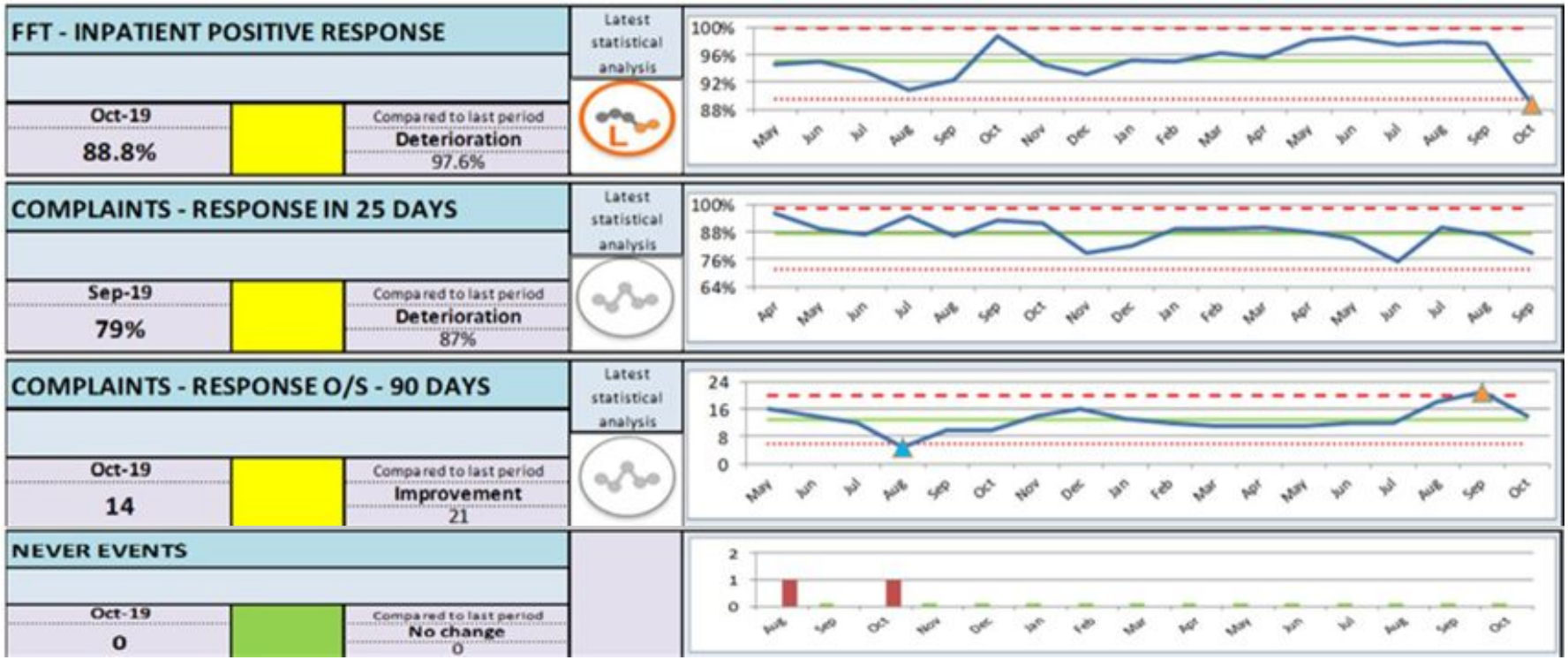
Quality and Safety

FALLS (causing severe harm)	Oct-19: 0	Compared to last period: Improvement 1	
MEDICATION ERRORS (with severe harm)	Oct-19: 0	Compared to last period: No change 0	
O/S PATIENT SAFETY ALERTS	Oct-19: 0	Compared to last period: No change 0	
MIXED SEX BREACHES	Oct-19: 0	Compared to last period: No change 0	
PRESSURE ULCERS (deep tissue damage)	Oct-19: 6	Compared to last period: Deterioration 1	

Pressure Ulcers

There have been an increase in the number of deep tissue pressure ulcers for October, five unstageable and one category three. The data indicates an increase in pressure ulcers all within the Integrated Medical and the Integrated Elderly and Community Division. All were acquired at BHT, but only one of these has been declared a Serious Incident (i.e sub optimal care provided), for which an RCA is underway.

Quality



Summary
The speed of 25 day complaint responses was a challenge this month, particularly for Trauma & Orthopaedics and therapies leading to a 79% Trust total (target is 85%). Key complaint themes for all complaints in September (59) were around delays and cancellations (11) poor behaviour and attitude of staff (10) and diagnosis (10)

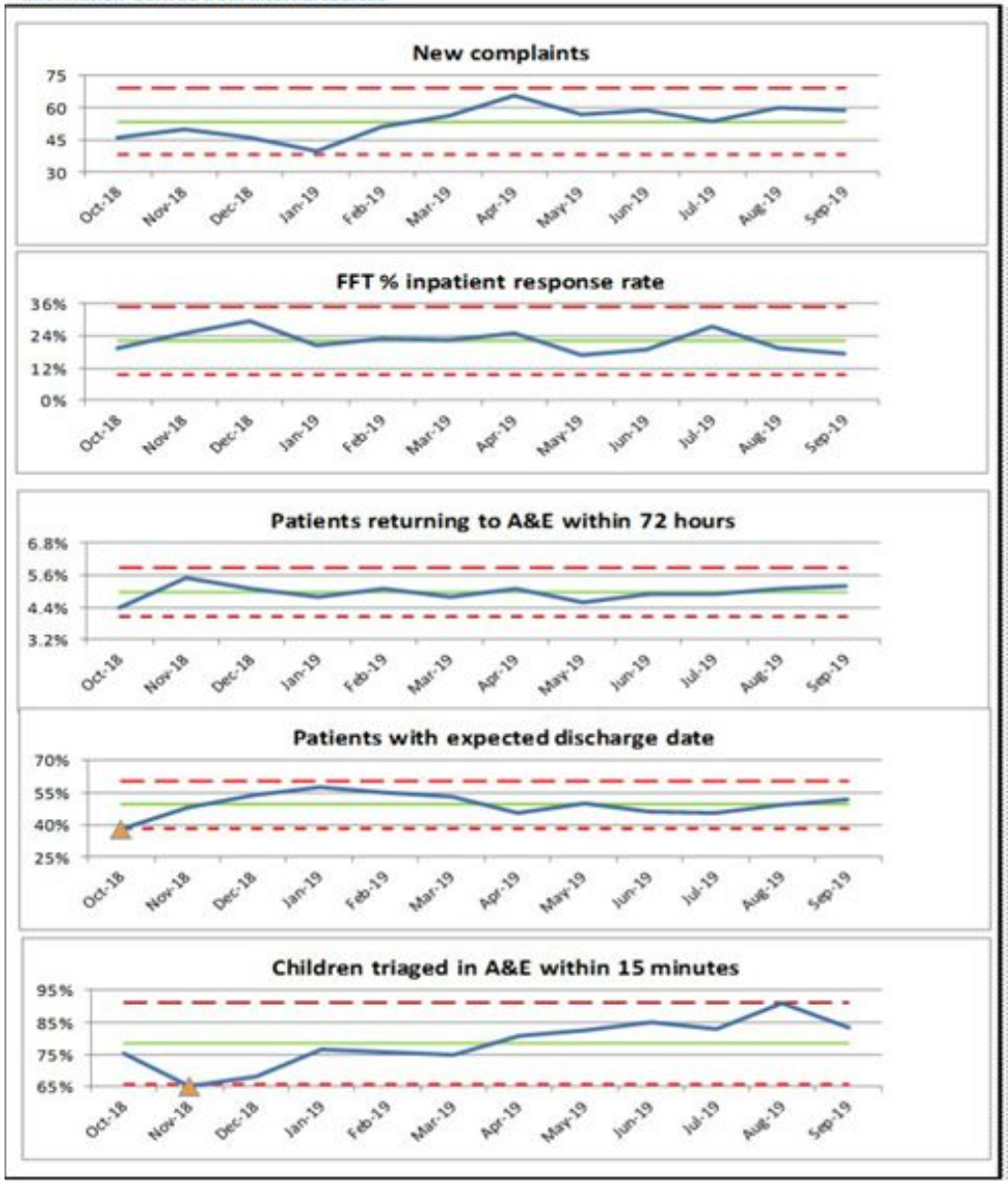
There has been a reduction in complaint responses over 90 days from the September peak of 22 down to 14 in October. This was attributed to the hard work of the complaints team working collaboratively with the Divisional teams - raising the profile of 90 day complaint responses.

Quality: patient experience

PATIENT EXPERIENCE - LEADING INDICATORS (SPC)

Lead - Quality Committee

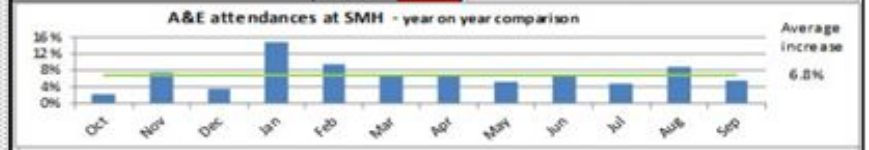
Information derived from internal sources

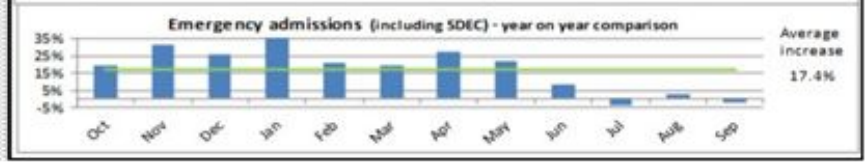


PATIENT EXPERIENCE - TREND INDICATORS

Information derived from internal sources

Diagnostic waits - patient seen within six weeks	This period 99.7% Sep-19		100% 97% 94%
Outpatient appointment disruption	This period 17.9% Sep-19		21% 18% 15%
Outpatient letters to GP within 14 days	This period 73% Sep-19		80% 70% 60%
Elective operations cancelled on the day	This period 38 Sep-19		70 35 0
Friends and Family - % positive (Maternity)	This period 100% Sep-19		100% 95% 90%
Friends and Family - % positive (A&E)	This period 80.9% Sep-19		100% 85% 70%
Patients over 12 hours in A&E	This period 565 Sep-19		600 400 200
Cancer - two week wait for first appointment	This period 96.0% Aug-19		100% 95% 90%
Cancer - 31 days to first treatment	This period 94.2% Aug-19		100% 95% 90%
Cancer Screening - 62 days to first treatment	This period 57.1% Aug-19		100% 75% 50%





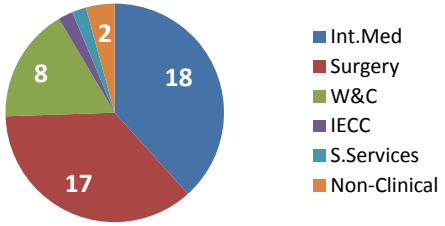
Quality: patient experience

Accolades

Division	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Grand Total
Corporate/Non-Clinical Support Services	2	4		5	9	10	32
IECC	490	159	591	556	563	517	2876
Integrated Medicine	105	101	68	48	67	55	448
Specialist Services	267	264	147	184	158	86	1107
Surgery	120	224	216	225	250	252	1293
Women & Children	194	119	119	162	78	142	814
(blank)							
Grand Total	**1178**	**871**	**1141**	**1180**	**1125**	**1062**	**6570**

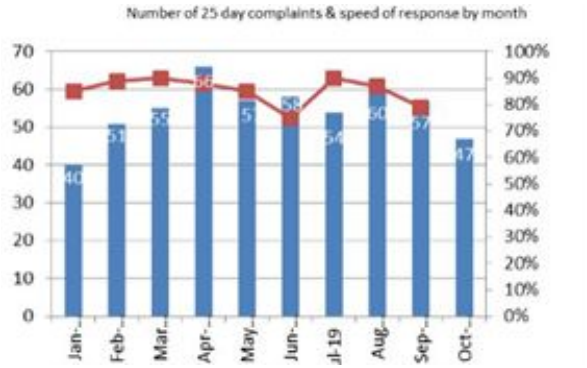
Complaints

47 Trust Complaints received in Oct 2019



The number of new formal complaints received was the lowest since January 2019 at 47. However, A&E received almost double their average number of formal complaints at 12. The most commonly cited themes for A&E included incorrect diagnosis; delays in diagnosis & treatment and sub-optimal care of deteriorating patients.

The remaining 35 formal complaints were spread across 18 other specialties and were low in numbers for those specialities



Month	Total %	IECC	Intmed	Surgery	Wmn & Child	Spec-Serv	Non-Clin
Sep-19	79%	60%	100%	40%	100%	100%	100%

Top themes for October:

Themes	Coded to
Treatment/Procedure	15
Communication with patient or visitor	14
Delays/Cancellations	11

Family and Friends Test (FFT)

In October 2019 the Trust expanded the Envoy digital platform for FFT to include inpatients, outpatients and day cases, in addition to the original pilot sites of A&E, Community and Maternity. As a result response rates for FFT have risen considerably in the last month from 3439 responses in September 2019 to 14,558 in October 2019. This includes an increase in outpatient responses from 301 in September 2019 to 8761 in October 2019.
The Trust reported response rate required by NHS England includes A&E, Maternity and Inpatient data only. This reported rate increased from 23.2% in September 2019 to 27.8% in October 2019.

A&E:

- September 2019 to October 2019 showed an increase in the FFT response rate from 30.5% to 32.5% This is a significant improvement from this time last year where we were at an 8% response rate.
- September 2019 to October 2019 showed a decrease in the FFT approval rating from 80.9% to 77.7%. The reduction in our approval related to waiting times, staff attitude and behaviour, and environment. The A&E team are working hard to improve the patient experience through an identified action plan including training, better patient communications and information.

Inpatients

- September 2019 to October 2019 showed an increase in the FFT response rate from 17.4% to 28.1%
- September 2019 to October 2019 showed a decrease in the FFT approval rating from100% to 88.8%. The introduction of Envoy has enabled many more patients to respond to FFT and initially it is not unusual to see a decline in approval ratings. As a result of now having more patient feedback available to us it will provide the opportunity to develop more targeted improvements to the patients experience of care.

Maternity:

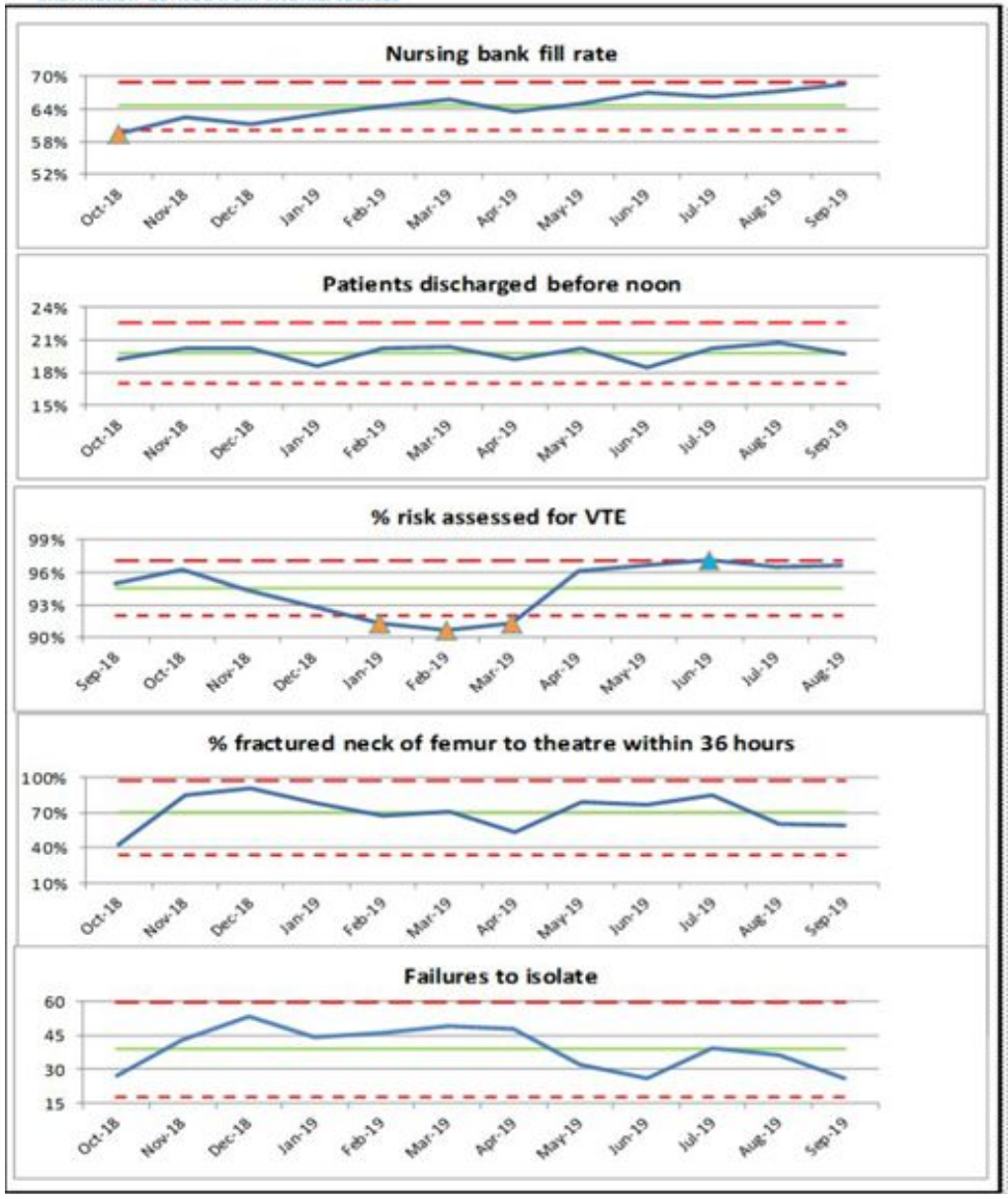
- September 2019 to October 2019 showed an increase in the FFT response rate from 5.9% to 7.8%. Though the Maternity service has been part of the Envoy pilot it is not yet utilising the SMS text messaging part of the platform due to the additional requirements resulting from Maternity having four touch points for FFT. The Information team expect to have systems in place to allow for Maternity join the SMS service in December 2019. We would expect response rates to increase considerably.

Quality: patient safety

PATIENT SAFETY- LEADING INDICATORS (SPC)

Lead - Quality Committee

Information derived from internal sources



PATIENT SAFETY - TREND INDICATORS

Information derived from internal sources

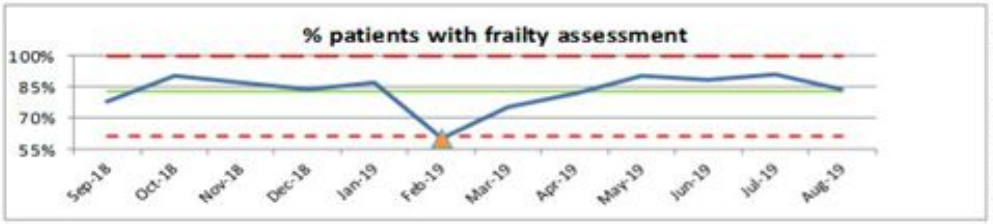
Ambulance handover delays (over 30 minutes)	This period 114 Sep-19		120 60 0
A&E - Median time to triage (minutes)	This period 18 Sep-19		22 18 14
Avoidable cardiac arrests	This period 1 Sep-19		6 3 0
Extended perinatal mortality (per 1000)	This period 3.3 Sep-19		6.0 4.0 2.0
Stillborn babies - at 24 weeks or later (per 1000)	This period 2.9 Sep-19		4.5 3.0 1.5
New mothers visited within 14 days of birth	This period 94% 19/20 Q2		100% 95% 90%
Safeguarding training - children and young people	This period 86% Sep-19		100% 85% 70%
Line infections	This period 2 Aug-19		6 3 0
Crude mortality (rolling 12 month average)	12 month average 1.1% Sep-19		1.4% 1.1% 0.8%
Medical Examiner screens selected for further review	This period 15% Aug-19		20% 10% 0%
Outstanding clinical audits causing concern	This period 7 Sep-19		20 10 0

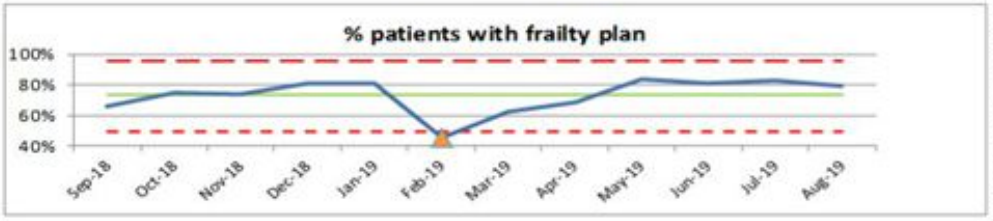
Quality: patient safety

PATIENT SAFETY- LEADING INDICATORS (SPC)

Lead - Quality Committee

Information derived from internal sources



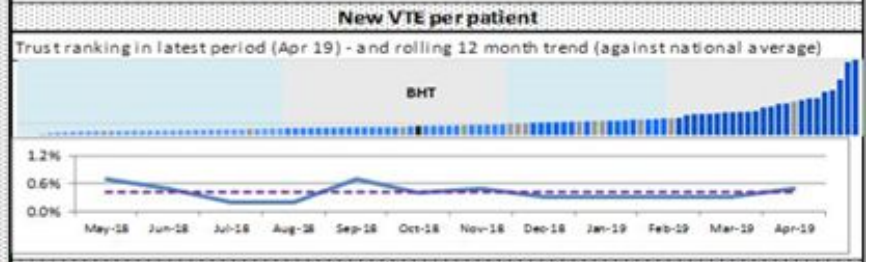


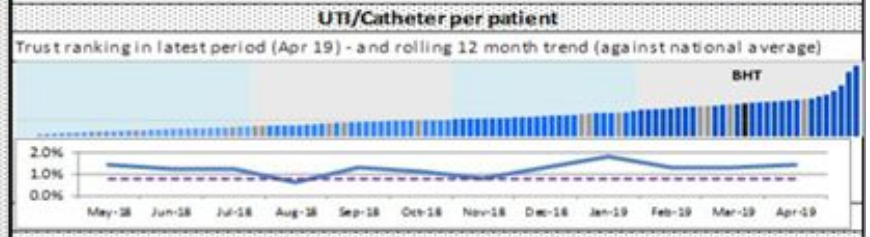
Safety incident reporting

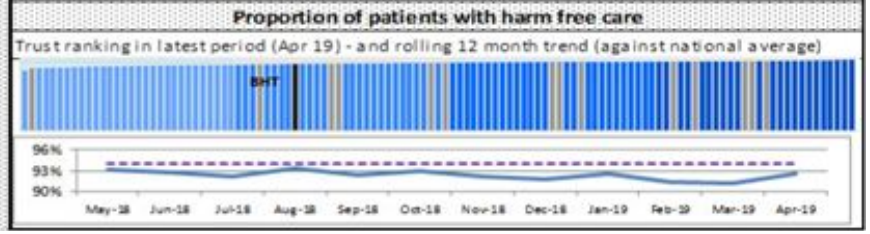
Information source is latest CQC Insight

PATIENT SAFETY - TREND INDICATORS

Information source is NHSI Model Hospital - for benchmarking nationally







Quality: Key Issues and Learning

Mortality review and alerts

Total Adult Deaths 115. Total deaths of people with a learning disability 3

Total serious investigations declared 1

Number of deaths that were reviewed and considered more likely than not to be due to problems in care 0

Total compliance with ME screens 94% at month end

86% no care problems identified

14% (n15) selected for SJR of total screened- 5 following relative concern

16% of all compliments led to excellence reporting

92% patients had DNACPR

85% patient had TEP

5% of all deaths of total screened following re-admissions within 72 hours

89% of applicable calls achieved by medical examiner to bereaved relatives

95% compliance with Medical Examiner conversation with the certifying doctor achieved

BHT publication in RCP 2nd National Mortality Report Oct 2019

Milton Keynes visit to BHT ME service Oct 19

Service Improvements

Recent Key Achievements and key priorities:

- Building capability across BHT continues with a further cohort of staff undertaking the Quality Service Improvement Redesign (QSIR) practitioners course
- World Quality Day planning continues; video developed from visit to Walsall Hospital
- Each Division will have a nominated link from the Quality Improvement team Quality I team
- supporting a number of projects, some of these include:

  - NIV project; agreement obtained for the purchase of new equipment
  - Coding project; following the implementation of the Standard Operating Procedure data shows there is a reduced time for notes to travel between the wards and medical records
  - Early arthritis pathway; process mapped including the biologics process, work streams being developed
  - Gastroenterology pathway, demand and capacity work undertaken and scoping of existing pathways

Key lessons learned/Actions from SI report this month.

The CCG closed 4 Serious Incident investigations during October. Themes emerging were as follows:-

Communication – clinical decisions discussed with patients and families must be clearly documented.

Clarity on roles and responsibilities:-

it is the responsibility of the lead clinician to document in the medical notes, if attending an arrest or peri arrest call

X-rays must be reviewed by the requesting team in a timely manner and documented findings in the medical notes, escalating as necessary.

Documentation of assessments is critical for clinical baselines including wound charts for Pressure Ulcers, manual handling assessments, and VTE assessments.

CQC insight (latest published 13.10.19)

Two indicators showing as Much Better than national average

Proportion of patient shaving perioperative medical assessment (Hip fracture data base)	**88.6%**	97.5%
Case mix adjusted one year survival rate (%)- Lung cancer	37%	40.3%

Two indicators showing as Much Worse than national average

Flu vaccination Uptake- worse than national average, although upwards trajectory	**72.6%**	68.8%
The Dementia environment ,based on PLACE results.	78.2%	62.8%

Workforce

STATUTORY TRAINING			Latest statistical analysis	
Oct-19		Compared to last period		96% 92% 88% 84%
90%		Deterioration 91%		May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct

SICKNESS RATE (Trust overall)			Latest statistical analysis	
Sep-19		Compared to last period		4.8% 4.1% 3.4% 2.7%
3.8%		Improvement 4.0%		Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep

STAFF TURNOVER (Trust overall)			Latest statistical analysis	
Oct-19		Compared to last period		16% 15% 14% 13%
13.1%		No change 13.1%		May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct

	Jul18 to Sep18	Oct18 to Dec18	Jan19 to Mar19	Apr19 to Jun19	Jul19 to Sep19
STAFF FFT (recommend as place to work)	56%	60%	65%	63%	59%
GO ENGAGE	3.88	-	3.91	3.93	3.87

Summary:

Flu campaign

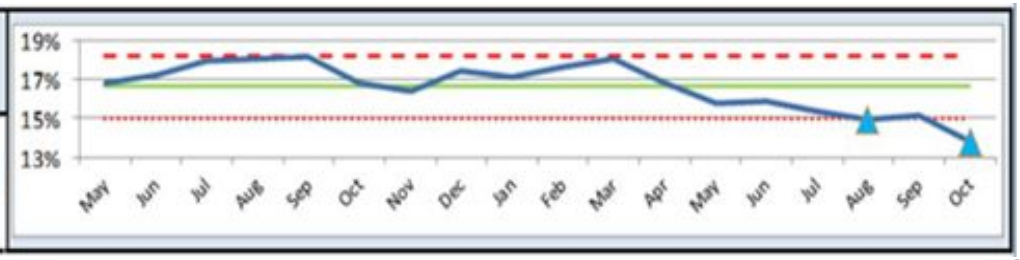
The CQUIN is for 80% of front line staff to be vaccinated. We had a very positive response from staff this year and we reported a vaccination rate of 46% as of 31 October 2019. We are using data analysis to target areas of low uptake and drive peer vaccinator activity. Our aim is to offer the vaccine to 100% of staff during the flu campaign. A successful flu campaign will in turn support the reduction of short term sickness absence.

Staff Turnover

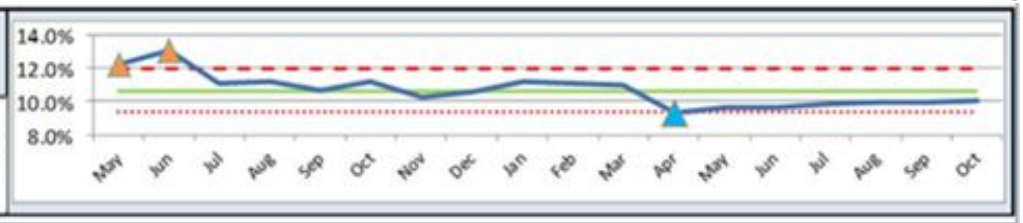
Our staff turnover remains stable after a period of consistent reduction in response to our targeted retention initiatives.

Workforce

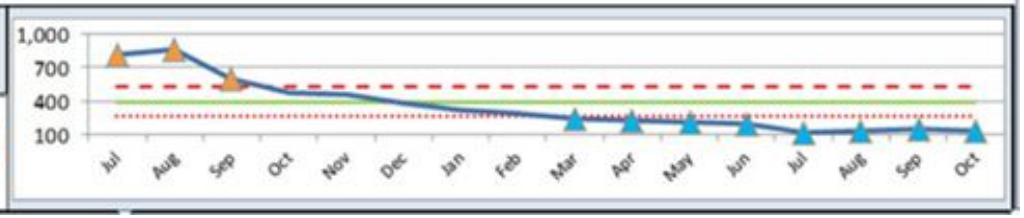
NURSING VACANCY RATE			Latest statistical analysis
Oct-19		Compared to last period	
13.8%		Improvement 15.2%	



% staff temporary spend			Latest statistical analysis
Oct-19		Compared to last period	
10.0%		Deterioration 9.9%	



SHIFTS BREACHING AGENCY CAP			Latest statistical analysis
Oct-19		Compared to last period	
131		Improvement 143	



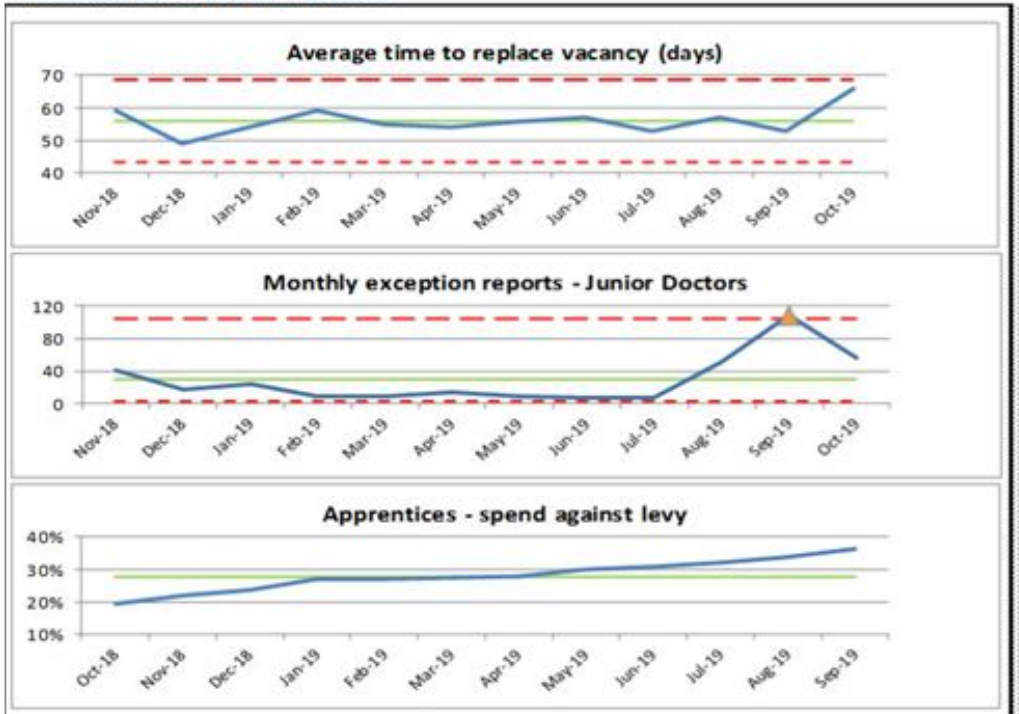
Summary:
We have seen a 1.4% improvement in our nursing vacancy rate. At 13.8%, this is the lowest we have seen since March 2016, after which there was a rate rise coinciding with the NMC introduction of English language test requirements . This is due to the positive impact of recruitment, particularly from Portugal and the improved success rate of our overseas nurses passing their Occupation English Test (OET) due to training and support we have put in place, means this is now a sustainable pipeline. International recruitment is also successfully supported by our successful Erasmus programme.

Workforce indicators

WORKFORCE - LEADING INDICATORS (SPC)

Lead - Workforce Committee

Information derived from internal sources



Exception Reporting

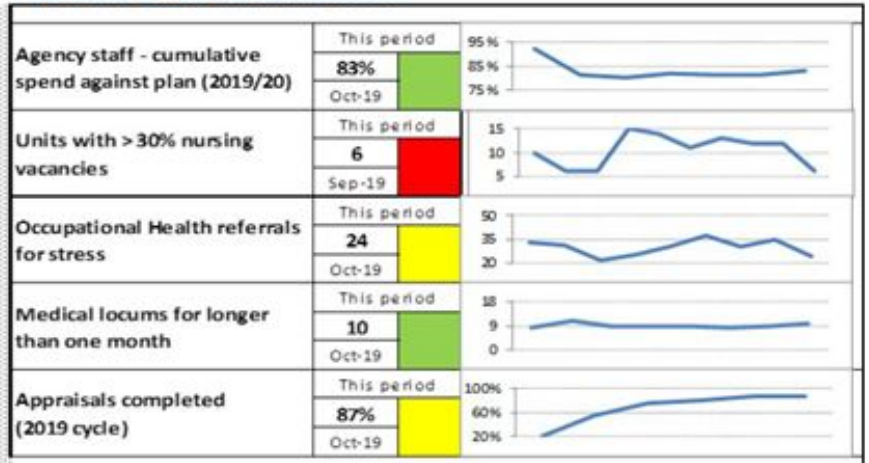
Following the rise in August and September 2019, particularly in reporting by Foundation year 1 doctors, this is now reducing, due in part to the new doctors becoming more settled and quicker in their work. Our Guardian of Safe Working hours reviews and responds to all exception report.

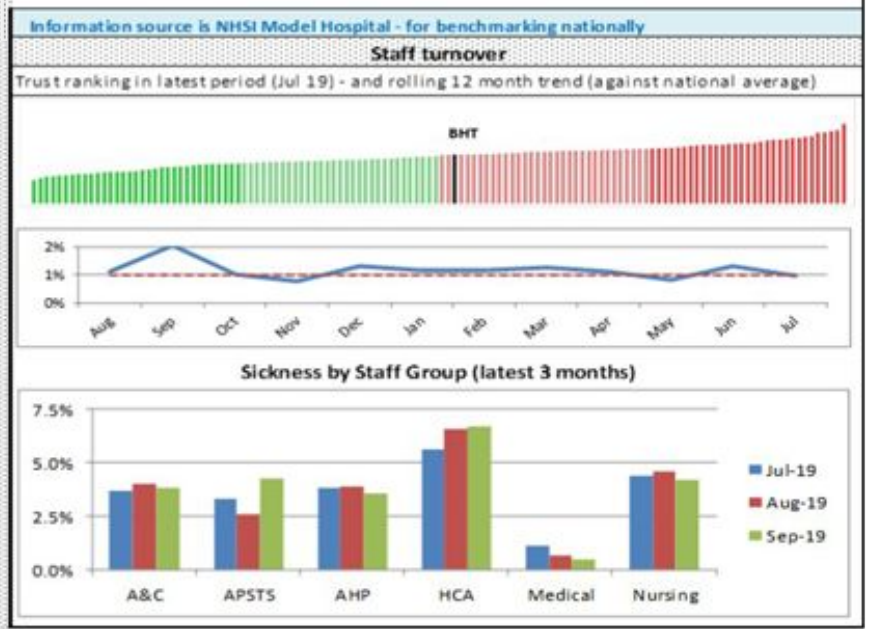
Wards with greater than 30% vacancies

Alongside the stabilising of turnover, due to our retention initiatives, the improved nurse vacancy rate is also positively impacting the number of wards with 30% or higher vacancies. Targeted initiatives are in place to support this reducing further, including holistic workshop planning meetings.

WORKFORCE - TREND INDICATORS

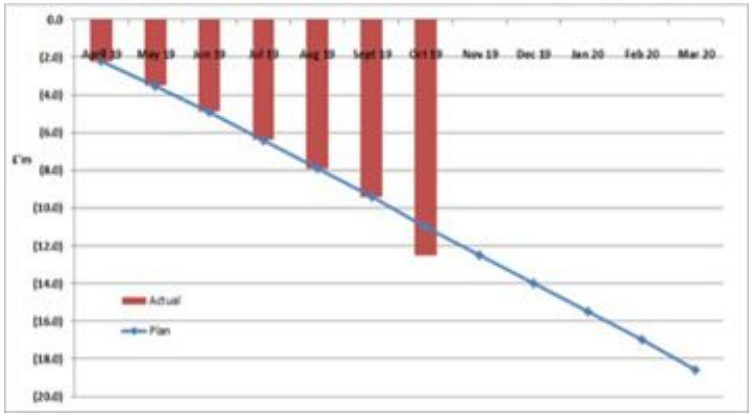
Information derived from internal sources





Finance: income and expenditure

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



Key Highlights

- • The Trust reports a £12.5m normalised deficit YTD, £1.6m adverse to plan YTD. The in month position for October is a £3.1m deficit, £1.6m adverse to plan.
- • The YTD position includes the receipt of quarter 1 and quarter 2 Performance Sustainability Fund (PSF), Financial Recovery Fund (FRF) and Marginal Rate of Emergency Threshold (MRET) monies totalling £7.1m. The YTD position assumes PSF and FRF monies will not be received for month 7 totalling £1.5m.
- • The Trust received additional Performance Sustainability Funds relating to 2018-19 totalling £0.5m in month 4. These additional monies can not be included towards the Trust's 2019-20 financial plan and therefore are excluded from the Income and expenditure summary.
- • The YTD position includes pro rata element of £5m improved contract value agreed with Bucks CCG, and £3.0m non-recurrent ICS income phasing support from Bucks CCG. The level of ICS income phasing support has reduced by £1.5m in month 7 compared to the total £4.5m ICS phasing support reported at month 6. The YTD position also assumes full receipt of the maternity CNST rebate totalling £0.4m.
- • Delivery of Efficiency Plans are £0.8m favourable to plan YTD.
- • Both pay and non-pay spend are above plan in-month and YTD. Further details are provided later in this report.
- • The Trust's current Forecast outturn is in line with the breakeven plan. Excluding STF/ FRF the plan is a £14.4m deficit and with the exclusion of MRET, an £18.6m deficit. A detailed assessment of divisional forecasts and financial risks are considered later in this report. The divisional forecasts will be stress-tested through performance review meetings in November 2019. The current risk assessment shows a forecast range from breakeven in the best case scenario to a £39.6m deficit in the worst case scenario. The most likely and worst case forecasts have deteriorated significantly during month 7.

Trust I&E Performance (£M)

(£m)	In Mth Plan	In Mth Actuals	In Mth Variance	YTD Plan	YTD Actuals	YTD Variance	Annual Plan	Forecast
Contract Income	33.5	33.1	(0.4)	234.4	236.2	1.8	401.2	401.2
Other income	2.7	2.9	0.2	18.7	20.2	1.5	32.5	32.5
Total income	**36.2**	**36.0**	**(0.2)**	**253.1**	**256.4**	**3.3**	**433.7**	**433.7**
Pay	(22.2)	(22.7)	(0.5)	(157.1)	(158.3)	(1.2)	(268.4)	(268.4)
Non-pay	(13.2)	(14.2)	(1.0)	(91.1)	(95.0)	(3.9)	(156.7)	(156.7)
Total operating expenditure	**(35.4)**	**(36.9)**	**(1.5)**	**(248.2)**	**(253.3)**	**(5.1)**	**(425.1)**	**(425.1)**
EBITDA	**0.8**	**(0.9)**	**(1.7)**	**4.9**	**3.1**	**(1.8)**	**8.6**	**8.6**
Non Operating Expenditure	(2.3)	(2.2)	0.1	(15.8)	(15.6)	0.2	(27.2)	(27.2)
Retained Surplus/(Deficit) before PSF, FRF and MRET	**(1.5)**	**(3.1)**	**(1.6)**	**(10.9)**	**(12.5)**	**(1.6)**	**(18.6)**	**(18.6)**
Performance Sustainability Fund (PSF)	0.6	0.0	(0.6)	2.6	2.0	(0.6)	5.8	5.8
Financial Recovery Fund (FRF)	0.9	0.0	(0.9)	3.9	3.0	(0.9)	8.6	8.6
Marginal Rate of Emergency Threshold (MRET)	0.3	0.3	0.0	2.4	2.4	0.0	4.2	4.2
Retained Surplus/(Deficit) including PSF, FRF and MRET	**0.3**	**(2.8)**	**(3.1)**	**(2.0)**	**(5.1)**	**(3.1)**	**0.0**	**0.0**
Non Recurrent I&E	1.8	0.3	(1.5)	8.9	7.4	(1.5)	18.6	18.6
Normalised I&E Surplus / (Deficit)	**(1.5)**	**(3.1)**	**(1.6)**	**(10.9)**	**(12.5)**	**(1.6)**	**(18.6)**	**(18.6)**

Divisional I&E Performance (£M)

Division / (£m)	YTD Variance	Annual Plan	Forecast	Forecast variance	Finance YTD Sector Rating	Forecast Sector Rating	Signed off by division	Last 3 Month Run Rate M05	M06	M07
Integrated Medicine	(1.6)	(77.5)	(83.4)	(5.8)	4	4	Yes	(6.8)	(6.9)	(6.9)
Integrated Elderly Care	0.9	(35.0)	(34.3)	0.7	2	1	No	(2.8)	(2.7)	(2.8)
Surgery And Critical Care	(2.9)	(87.6)	(93.6)	(6.1)	4	4	Yes	(7.7)	(8.1)	(8.0)
Women and Children	0.5	(46.0)	(46.2)	(0.2)	1	1	Yes	(3.7)	(3.8)	(3.9)
Specialist Services	(2.4)	(69.8)	(74.4)	(4.6)	4	4	Yes	(5.9)	(6.2)	(6.6)
Total Clinical Divisions	**(6.6)**	**(315.9)**	**(332.0)**	**(16.1)**				**(26.9)**	**(27.7)**	**(28.2)**
Chief Executive	0.4	(4.3)	(4.3)	0.0	1	1	Yes	(0.2)	(0.3)	(0.3)
Chief Operating Off-Management	(0.0)	(1.4)	(1.5)	(0.1)	1	1	No	(0.1)	(0.1)	(0.1)
Corporate Services	0.2	1.0	1.5	0.5	1	1	Yes	0.2	0.5	0.1
Commercial Director Mgmt	0.2	0.0	0.1	0.1	1	1	No	0.0	0.0	0.0
Finance Dept	0.4	(4.8)	(4.7)	0.1	1	1	Yes	(0.2)	(0.4)	(0.4)
Information Technology	1.1	(7.6)	(7.6)	0.0	1	1	Yes	(0.5)	(0.5)	(0.5)
Performance and Delivery	0.1	(3.6)	(3.6)	(0.0)	1	1	Yes	(0.3)	(0.3)	(0.3)
Property Services	(1.5)	(46.6)	(51.5)	(4.9)	4	4	No	(4.1)	(4.2)	(4.0)
Human Resources	0.1	1.5	1.5	0.0	1	1	Yes	0.1	0.1	0.2
Medical Director	0.1	(0.3)	(0.2)	0.1	1	1	Yes	0.0	(0.0)	0.0
Nursing Director	0.5	(15.8)	(15.6)	0.1	1	1	No	(0.9)	(1.3)	(1.3)
Pdc And Depreciation	(0.4)	(18.4)	(19.2)	(0.7)	3	1	Yes	(1.7)	(1.6)	(1.6)
Bht-Bhpl Sla	0.1	0.0	0.2	0.1	1	1	No	0.0	0.0	0.1
Strategy And Business Dev.	0.0	(0.6)	(0.6)	0.0	1	1	Yes	0.0	(0.0)	0.0
Total Corporate	**1.2**	**(100.6)**	**(105.3)**	**(4.6)**				**(7.7)**	**(8.2)**	**(8.1)**
Contract Income	(1.2)	416.0	398.1	(17.9)				32.6	33.4	34.6
ICS Risk Allocation Contract Income	3.0	0.0	0.0	0.0				0.5	1.0	(1.5)
MRET	0.0	4.2	4.2	(0.0)				0.3	0.3	0.3
Provisions	0.5	(3.6)	0.0	3.6				0.0	0.0	0.0
Donated Asset Reporting Adj	0.5	0.0	0.8	0.8				0.1	0.1	0.1
Mitigation Plans to be allocated	0.0	0.0	19.8	19.8						
Retained Surplus / (Deficit) before PSF and FRF	**(1.6)**	**(0.0)**	**(14.4)**	**(14.4)**				**(1.1)**	**(1.1)**	**(2.8)**

Finance: cash & Accounts Payable / Receivable

Cash Position

	Oct '19	Nov '19	Dec '19	Jan '20	Feb '20	Mar '20	Apr '20	May '20	Jun '20	Jul '20	Aug '20	Sept '20
OPENING BALANCE	2.6	2.3	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0
INFLOW												
Receipts	35.4	38.4	36.3	35.5	35.7	37.0	36.7	36.7	36.7	36.7	36.7	36.7
PSF/MRET/FRF		2.0	(4.5)									
	35.4	40.4	31.8	35.5	35.7	37.0	36.7	36.7	36.7	36.7	36.7	36.7
OUTFLOW												
Pay	(22.5)	(22.2)	(22.2)	(22.2)	(22.2)	(22.2)	(22.2)	(22.2)	(22.2)	(22.2)	(22.2)	(22.2)
Non Pay	(14.2)	(17.6)	(10.4)	(15.5)	(15.5)	(15.5)	(15.5)	(15.5)	(15.5)	(15.5)	(15.5)	(15.5)
Capital Expenditure		(2.0)	(2.0)	(1.8)	(2.0)	(1.0)	(1.0)	(1.0)	(1.2)	(1.2)	(1.2)	(1.2)
Loans						(1.0)						
Interest and PDC						(3.0)						
	(36.7)	(41.8)	(34.6)	(39.5)	(39.7)	(42.7)	(38.7)	(38.7)	(38.9)	(38.9)	(38.9)	(38.9)
NET INFLOW / (OUTFLOW)	(1.3)	(1.4)	(2.8)	(4.0)	(4.0)	(7.7)	(2.0)	(2.0)	(2.2)	(2.2)	(2.2)	(2.2)
Cash Support - Working Capital Management	1.0	1.1	2.8	4.0	4.0	7.7	2.0	2.0	2.2	2.2	2.2	2.2
CLOSING BALANCE	2.3	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 continues to draw down cash to support the in-year deficit. The drawdown currently occurs two months in arrears, hence the requested December support is based on the month 7 position.
- In year cash borrowing includes advances for incentive payments (PSF,FRF) up to the end of Q2. These amounts will either be offset against actual payment or future loans.
- £1.1m has been drawn down for November.
- The expected increase in November cash inflow is driven by payments from Bucks CCG of £2m for system wide working and £2.6m from Health Education England.
- System wide working will be repaid in December, consequently creditors payments will need to be flexed cross periods to accommodate this.
- The cash support - working capital management line illustrates where pressure occurs in managing working balances, or where additional draw down will be required. The forecast as presented assumes no change to current rates of spend and that the organisation will continue to overspend against plan.
- The committee is requested to approve future cash drawdowns of £2.8m for December and £4m for January and February respectively.

Accounts Payable & Accounts Receivable

Accounts Receivable

(£m)	Current	30-60 days	60-90 days	90-120 days	>120 days	Total
NHS	6.8	1.6	1.6	0.6	4.4	15.0
Non-NHS	1.7	1.0	0.4	0.1	2.8	6.1
% of total	41%	12%	9%	4%	34%	100%

Accounts Payable

(£m)	Current	30-60 days	60-90 days	90-120 days	>120 days	Total
NHS	0.9	0.0	0.0	0.0	-0.1	0.8
Non-NHS	1.8	0.0	0.0	0.0	0.0	1.8
% of total	104%	0%	0%	0%	-4%	100%

Better Payment Practice Code

	Count Total	Count Pass	% Pass	Total (£m)	Pass (£m)	% Pass
NHS	3,357	1,086	32%	23	17	73%
Non-NHS	54,855	42,425	77%	148	131	89%
Total	58,212	43,511	75%	171	148	86%

Accounts Payable & Accounts Receivable – Key Highlights

- **Accounts Receivable** -Debtors has increased from £16.2m to £21.1m in month 7. Most of this increase is evidenced in NHS current ly due to Health Education being billed quarterly in advance £2.6m and an invoice raised to Bucks CCG for system wide working £2m. Overdue debt has decreased by £0.7m in month from £13.5m to £12.7m.

- **Accounts Payable** -Invoice payables have increased from £1m to £2.6m in month 7. The increase is not unexpected as the team had been paying creditors before due date in recent months. The shift in aging to current reflects that old invoices are not being processed on to the system with the regularity of prior months. We will continue to monitor this but it suggests that the backlog has to a large extent caught up. The team will focus attention in the coming month to the clear down of old credit notes, applying these to future payments or getting reimbursement from the relevant suppliers.

- **Better Payment Practice Code** -BPPC performance has remained relatively unchanged from prior months. As the metric is calculated cumulatively, and high volumes of old invoices have been processed earlier in the year, the achievement of the 95% national target for the year is unlikely..

Finance: business performance

USE OF RESOURCES - TREND INDICATORS

Lead - Finance and Business Performance Committee

Information source is NHSI Model Hospital - for benchmarking nationally

CAPITAL SERVICE CAPACITY

12 months from September 18

LIQUIDITY (days)

12 months from September 18

I&E MARGIN

12 months from September 17

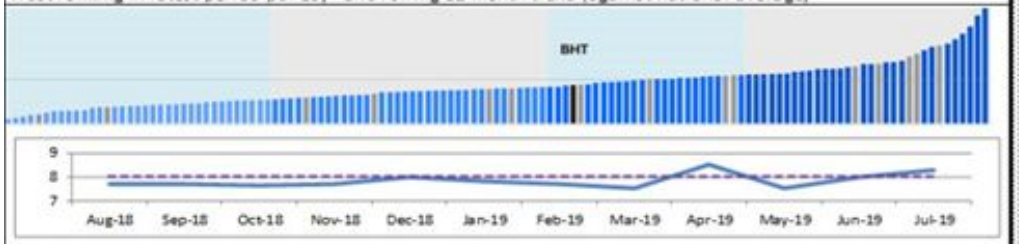
DISTANCE FROM FINANCIAL PLAN

12 months from September 18

Information source is NHSI Model Hospital - for benchmarking nationally

NURSING CARE HOURS PER PATIENT DAY

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



USE OF RESOURCES - TREND INDICATORS

Information derived from internal sources

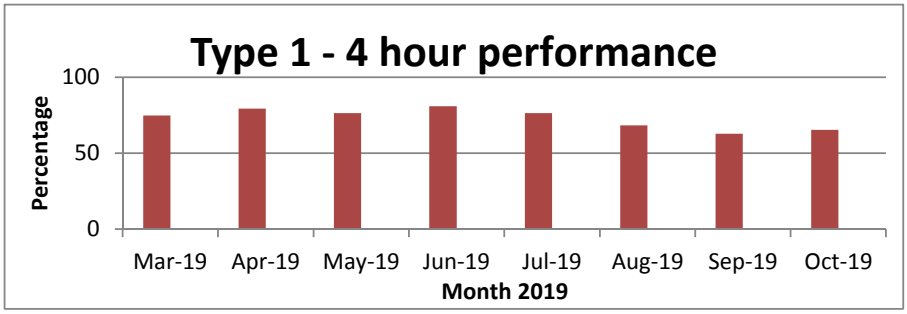
Outpatient appointments - cashing up within target	This period 98.8% Oct-19	
Outpatient appointments - DNA's	This period 6.1% Oct-19	
Job Plans completed (current cycle started Oct 19)	Cycle has restarted this month	
Impact of non compliance with Best Practice Tariff (potential lost income)	This period £18K Sep-19	
LoS > 21 days - patients in acute hospitals	This period 91 Oct-19	
LoS > 21 days - patients in community hospitals	This period 16 Oct-19	
Temporary shifts requested	This period 6,368 Oct-19	
Receipts without a purchase order	This period 322 Oct-19	
GP referrals	This period 10,007 Oct-19	

<table>
<tr><td colspan="3">Performance Exception Report – supporting Integrated Performance Report November 2019</td></tr>
<tr><td>Month reported:</td><td>Executive Director:</td><td>Dan Gibbs</td></tr>
<tr><td>September 2019</td><td>Completed by:</td><td>Lorraine Pitblado</td></tr>
<tr><td>Indicator/Performance standard</td><td colspan="2">Trusts Accident & Emergency 4hr Standard - 95% of patients to be seen, admitted or discharged within four hours</td></tr>
<tr><td>Variation from plan/performance standard</td><td colspan="2">
<table>
<tr><td>October Plan</td><td>90.9% Total patients expected 13,527</td></tr>
<tr><td>October Actual</td><td>81.48% Total patients attended 13,949</td></tr>
</table>

Attendances were 422 more than planned and the 4 hour standard was 9.42% less than trajectory.
• The daily average of patients for the month was 450 which was a decrease from 454 in August.
• The best days performance 29/10/2019 was of 89.39%.
The daily average seen through GP steaming was 40 patients which was an increase from 38 in September.
</td></tr>
<tr><td>Brief Reason for variation</td><td colspan="2">
Highlights for the month of October 2019:
Attendances across Urgent & Emergency Care at BHT were higher this year 13,949 compared to October last year 12,883 and also higher than plan. Performance has continued to be more varied and challenged dropping to 72.99% on 6/10/19

Performance of the Emergency Department (ED) constitutional standard of patients seen or discharged within 4 hours has continued to see more variation throughout October and in particular weekend performance has been continued to be challenged. In October the ED attendances were in excess of 500 on 5 occasions which and Monday continues to be the busiest days. The highest recorded day was 542 patients on 14th October 2019.

Type 1 A&E performance continues to be a challenge and there was an even further reduction in performance in September,

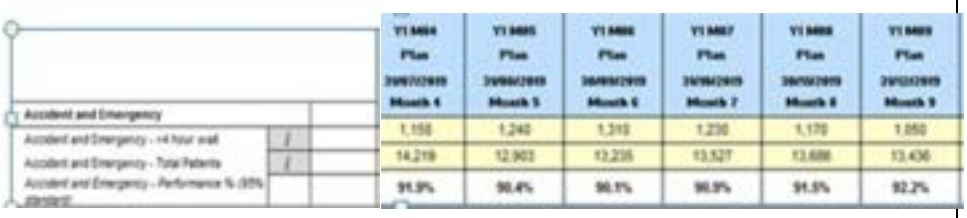


Minors breaches continue to pose a significant problem especially out of hours when all patients are managed through one single queue. Minors breaches continue to contribute to 18-22% of the overall breaches. However there was a significant reduction to 9%in the 1st week of November. A revamped streaming process has been introduced and the minor stream between 08:00-23:00 will now be processed out with ED and so the flow should be improved. There is however the issue of overnight and this is being reviewed as part of the mitigation for winter.
</td></tr>
</table>

<table>
<tr><td></td><td colspan="2">The Trust implemented its ‘Full Capacity Protocol’ and reported OPEL 4 externally predominately due to lower discharges than admissions which correlated to acuity of those being admitted on a number of occasions in October and escalation capacity was utilised throughout the month

Escalation beds on St Joseph’s continue to be utilised which impacts the effectiveness of delivering a medical day unit although there has been some success in the provision of a discharge lounge and this needs to continue to be embedded within practice. There was also escalation beds opened in day surgery throughout the month of October</td></tr>
<tr><td rowspan="5">Key Actions to be taken to address variation</td><td>Date:</td><td></td></tr>
<tr><td>7th November</td><td>Movement of minors service into GP streaming area to support the crowding element of PDU.</td></tr>
<tr><td>11th November</td><td>NHSi site visit for support. Agreed to focus on:

ED huddles
Nurse in charge/EPIC roles
RAG rated operational sheets
Band 7s – development
Triumvirate development
Streaming – options

NHSi will be onsite for 3 weeks initially with negotiated time afterwards.</td></tr>
<tr><td>November 19</td><td>Introduction of new streaming model to include using targeted observations to identify unwell patients as well as increase the volume of patients to the GP streaming service.</td></tr>
<tr><td>November 19</td><td>PDSA of an additional GP for 3 weeks to support performance – reviewing the following metrics
LoS in the department
Performance
Number seen in GP streaming</td></tr>
<tr><td>Impact and forecast timeline</td><td colspan="2">  </td></tr>
</table>

7

Buckinghamshire Healthcare NHS Trust - Emergency Pathway Improvement Plan 2019

Emergency Department Improvements

No.	Overarching Theme	Site	Actions Required	Progress Update	Divisional Lead	Operational Lead	Timescales
1	Establish weekly Breach Analysis and learning group, identifying and shared with the teams. Established Weekly Task & Finish Group to review breach analysis and implement changes based on learnings, themes with action plan to follow up on progress	SMH	1. Review breach reasons on Medway 2. Set up a working group to identify definitions for breach reasons 3. Develop a reporting template that will be sent weekly		Helen Byrne	Lorraine Pitblado	
2	Improve Escalation	SMH	1. Work with NHSi to develop roles & responsibilities for escalation 2. Embed escalation triggers 3. Set up daily huddle with ED/Site/Paeds to identify actions of the day		Helen Byrne	Lorraine Pitblado	
3	Reduction of non admitted breaches	SMH	1. ED Senior team to manage the non admitted flow throughout the ED. 2. Initiate the pathways from minors/GP streaming and triage as appropriate with support from NHSi. 3. Updates on the non admitted breaches required at the Performance review. 4. Review non admitted breaches on a daily basis		Abs Banerji	Lorraine Pitblado	
4	Improve the management of EOU	SMH	1. ED team to review and update EOU SOP 2. Management to ensure EOU is ring fenced for ED only, out of hours Silver/Gold to be informed of speciality patients on the unit. 3.Keep medway up to date in real time, improve utilisation of EOU beds and chairs		Abs Banerji	Claire Lazaruk	
5	Management Support to ED	SMH	1. Band 7 development- support from NHSi 2. Triumpherite support from NHSi		Sarah Lafbery	Claire Lazaruk	
6	Flow Support	SMH	1. Tracker role to be protected 2. Review streaming options with a view to increase pathways 2. Consider admin support for ED team	Support from NHSi	Helen Byrne	Claire LazarukSaba Hussain	

Bed & Site Management

No.	Overarching Theme	Site	Actions Required	Progress Update	Divisional Lead	Operational Lead	Timescales
1	Establish action focused site meetings	SMH	A review of site meetings		Helen Byrne	Chris Smith	
2	Develop and implement use of SITreps x5 times a day	SMH	1. Embed use of daily brief on a page		Helen Byrne	Chris Smith	
3	Embed confirm and challenge (Red to Green)	SMH	Ward 6 commenced pilot for further rollout		Sarah Lafbery	Louise Hultquist/Tammy Nossiter	
4	Responsive flow	SMH	Site Manager to base themselves in ED to assist with flow and coordination		Helen Byrne	Tammy Nossiter/Chris Smith	
5	Long stay patients	SMH	Weekly long stayers meeting DPTL		Helen Byrne	Tammy Nossiter	

Women's, Children's & Sexual Health

No.	Overarching Theme	Site	Actions Required	Progress Update	Divisional Lead	Operational Lead	Timescales
1	Paediatric breach analysis tool implemented, reviewed daily by Clinical and Operational leads to identify themes and lessons learnt shared with the teams,	SMH	1. Review breach reasons on Medway 2. Set up a working group to identify definitions for breach reasons 3. Develop a reporting template that will be sent weekly		Isobel Day	Gayle Porter	
2	Regular board rounds where the paediatric Matron and ward manager join the ED team to coordinate the flow through the wards and PDU.	SMH	1.Participate in daily huddle with ED/Site/Paeds to identify actions of the day		Attanu	Sally Harrison	
3	WCS weekly meeting with Clinical leads specifically monitoring performance, regular meetings with the speciality teams to ensure compliance with the agreed professional standards	SMH	1. Agree IPS		Isobel Day		
5	ED & Paediatric interface meetings	SMH	Regular interface meetings to identify improvements			Maria Fernades	

Performance Exception Report – supporting the Integrated Performance Report		
Month reported:	**Executive Director:**	Chief Nurse
October 2019	**Completed by:**	Helene Anderson, Deputy Chief Nurse
Indicator/Performance standard	Zero hospital acquired ulcers with deep tissue damage	
Variation from plan/performance standard	An increase of five pressure ulcers with deep tissue damage from the previous month. 	
Brief Reason for variation	**Celebrating success:** Surgery, Specialist and Women's, Children and Sexual Health reported no ulcers with deep tissue damage in October 2019. Reduction of Grade two pressure ulcers this month – from 20 down to 14. Reporting will be in SPC charts by December 2019. The six deep tissue damage ulcers causing severe harm were attributed to Integrated Medicine and three to Integrated Elderly and Community. Five of the six pressure ulcers were unstageable and one was a category three pressure ulcer. Although all six were acquired at BHT only one has met the criteria for a Serious Incident (SI) investigation. When an SI is declared this is usually an indication that care has been suboptimal. A Root Cause Analysis (RCA) is completed for all pressure ulcers to ensure there is an understanding of any areas for further learning. Current status of the six incidents: • Three are currently having RCA's completed, • One has been completed and the care was exemplary – not an SI • One was a patient in the community whose family refused all care and this was clearly documented- the pressure ulcer was felt to be unavoidable. • One is subject to a current SI investigation as above.	
Key Actions to be taken to address variation	**Date:**	**Action**
	November 2019	Heads of Nursing to triangulate nursing metrics to understand if there are other variances that might indicate the wards are under increasing pressure eg staffing levels, multiple ward moves
	November 2019	Face to face training in Amersham & Wycombe on pressure ulcers - by the Tissue Viability team
	January 2020	Review of the RCA process to understand if there are improved ways to understand and share learning. This will include learning from areas that have done this well.
	November 2019	Additional support to the integrated medical wards and the Integrated Elderly and Community wards from the Tissue Viability team.
	January 2019	Carry out joint investigations with residential homes & care agencies to share the learning as a system and improve the care for patients across their entire Buckinghamshire pathway.
Impact and forecast timeline	Severe harm caused by pressure related damage is on a three year downwards trajectory. Change made to the categorisation on pressure ulcers last June 2018 has the	

	potential to increase reporting. This is currently being monitored closely to understand further and enable appropriate action to be taken.

Performance Exception Report – supporting Integrated Performance Report November 2019

Month reported:	**Executive Director:**	Dan Gibbs, COO
September 2019	**Completed by:**	Wendy Pocknell, Titus Burwell

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/performance standard

2019	July	August	September
Monthly waiting list plan	29,725	29,942	29,845
Monthly waiting list **actual**	29,947	29,902	30,642
Waiting list growth/shortfall **actual** (March 19 - 29,225)	+722	+677	+1417
Actual incompletes >18 weeks	3,989	4,391	4,791
Monthly RTT plan	88.6%	88.3%	88.6%
Monthly RTT **actual**	86.7%	85.3%	84.4%
52 week breaches	0	0	0

Brief Reason for variation

Deterioration in compliance by key specialities below:

	August	September	Reason
Diabetic Medicine	97.7%	90.2%	Endocrine and diabetes appointment cancellations due to staff vacancies causing breaches
Endocrine	90.5%	88.1%	
General Surgery	91.5%	89.7%	Reduced capacity due to annual leave over summer, position largely corrected in Oct 19.
Pain	82.7%	76.4%	Increase in referrals in May-Jul extending polling range to 20-weeks. Planned short term reduction in RTT performance experienced.

Key Actions to be taken to address variation

Date:	
October 2019	'Operation Arthroplasty' – targeting long waits for hip and knee surgery commenced.
November 2019	Plan to improve performance of Pain service going forward, following full service reconfiguration in July 2019. Trajectory expected to be 82% at end of 19/20 with continuous improvement going forward.
October 2019	Ophthalmology plan for 12 additional weekend theatre lists
November 2019	Endocrinology capacity planning: expected improvement in November and recovery December.
October 2019	Extra diabetes capacity: expected recovery October
November 2019	Plans to recover or improve performance by speciality to be discussed within Divisions and escalated to Chief Operating Officer.

Impact and forecast timeline

More patients are waiting longer for treatment. Expected improvement in waiting list size in October. Surgery continues to manage long waiting patients to avoid 52 week breaches.

Referral to Treatment	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11
Incomplete pathways <=18 wks	26,285	26,225	26,258	26,350	26,439	26,432	26,578	26,599	26,598	26,644	26,714
incomplete RTT pathways Total	29,624	29,672	29,639	29,725	29,942	29,845	29,998	30,286	30,484	30,523	30,632
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%**
incomplete RTT pathways >52 weeks	0	0	0	0	0	0	0	0	0	0	0

7

Performance Exception Report – supporting Integrated Performance Report November 2019

Month reported:	**Executive Director:**	Dan Gibbs
August 2019	**Completed by:**	Catherine Richards

Indicator/Performance standard

- 31 day to first treatment - **96%** or more of patients to be treated within 31 days of cancer diagnosis
- 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
- 31 day Rare cancer standard – 85% or more of patients

Variation from plan/performance standard

Cancer 62 day recovery	Aug 19 M05
Breaches > 62 days - predicted	11
Total treated - predicted	84
Predicted Performance	85.7%
Breaches > 62 days - actual	15.5
Total treated – actual	93.5
Monthly Performance - actual	83.4%
104 day breaches*	1.5

* This is number of accountable breaches rather than number of patients

Brief Reason for variation

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

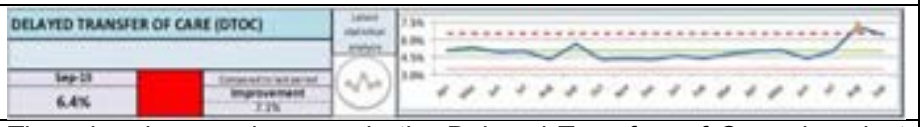
Gynae	80%	2.5 patients treated – 0.5 breached (1 shared tertiary patient) Reason: Two week wait for CT then one month wait for surgery
Haematology	71.4%	7 patients treated – 2 patients breached Reason: Both were difficult diagnosis and originally referred on ENT pathway
Lower GI	0%	3 patients were treated, all of which breached. Reasons: multiple/additional diagnostics and long wait for treatment in Oxford.
Lung	66.7%	1.5 patients treated – 0.5 breached (1 shared tertiary patient) Reason: patient delay for diagnostics then change of treatment plan
Urology	78.8%	16.5 patients were treated of which 3.5 breached (3 BHT patients and one shared tertiary) Reasons: Sequential diagnostics, patient choice, capacity for surgery, tertiary capacity.

Key Actions to be taken to address variation

Date:	
Dec 19	Pilot of using coloured bags for 2ww skin samples is running for two months to reduce the number being sent to backlogs for reporting.
Nov 19	From the beginning of November, a separate PTL will be piloted for skin patients who have been given a preliminary non cancer diagnosis. This will ensure patients are tracked until their pathology results are received but will reduce the number of long waiting patients on the main PTL and weekly NHSE submission.
Nov 19	An analysis of reasons for 62 day breaches has been carried out for Q1. The most frequent breach reason was for patients needing repeat or additional diagnostics.

7

		A more detailed analysis has been requested for the type of repeat diagnostic tests to see if there is a particular area of focus or specific improvement. The ongoing analysis of breach reasons will continue on a month by month basis. Action plan to be developed once results are known.
	Nov19	Continue daily review of 2ww capacity to reduce impact of increased breast referrals on achievement of 2ww target.
Impact and forecast timeline	Impact will be: • Reduce delays to Pathology reporting by reducing number of samples being sent to back logs • Reduce size of PTL by monitoring patients with preliminary non cancer diagnosis separately • Understand which specific diagnostics are causing the most breaches • Mitigate the impact of breast breaches on achieving the 2ww target in November	

Performance Exception Report – supporting Integrated Performance Report November 2019		
Month reported:	**Executive Director:**	Dan Gibbs
October 2019	**Completed by:**	Tammy Nossiter
Indicator/Performance standard	Delayed Transfer of Care (DTOC)	
Variation from plan/performance standard		
Brief Reason for variation	There has been a decrease in the Delayed Transfers of Care since last report however it remains above the upper control limit The number of Non-Weight Bearing (NWB) patients continues to put extra pressure on community hospital beds referrals which then causes them to be a delayed transfer of care Access to the Bucks County Council (BCC) Reablement Service has been restricted due to availability of double handed care provision Procurement for Continuing Health Care (CHC) funded care packages and care homes moved to bucks County Council (BCC) this has had an impact in length of time it takes to identify and discharge the patient resulting in health delayed transfers of care New pathways due to come on line to support flow out of hospital, however confirmation of start dates is still required	
Key Actions to be taken to address variation	**Date:**	
	Nov 2019	10 care home beds to be funded to support NWB pathway for patients – date to be operationalised TBC
	Nov 2019	Pilot of Single Joint Assessment form for review and plan for roll out across BHT
	Nov 2019	Continue the work with ICP on moving CHC assessments out of the acute Trust – pilot to commence once care homes identified
	Nov 2019	Daily Medically Fit meeting with Health, Social care and Community to support flow
	Nov 2019	Continuous feedback to CCG with examples of prolonged delays
	Nov 2019	6 intermediate Care reablement beds funded by BCC to support reablement discharges
Impact and forecast timeline	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. Delayed transfers of Care will be monitored monthly	

Safe & compassionate care, every time

NHS
Buckinghamshire Healthcare
NHS Trust

Meeting: Trust Board Meeting in Public

27 November 2019

Agenda item	Infection Prevention & Control Report October 2019
Board Lead	Tina Kenny
Type name of Author	Niamh Whittome
Attachments	IPC Monthly Report October 2019
Purpose	Information
Previously considered	Type in Board / Committee or Group and date considered, minute number

Executive Summary

The report outlines Healthcare Associated Infection data for October. It is a mandatory requirement that the following HCAI are reported:

- *Clostridium difficile*
- MRSA bacteraemia
- MSSA bacteraemia
- Gram negative Blood stream infections (GNBSIs)

The report also highlights line infections, pleased to report zero line infections in September

8

Decision	The Board / Committee is requested to endorse the report

Relevant Strategic Priority

Quality ☒	**People ☒**	**Money☒**

Implications / Impact

Patient Safety	HCAI's contribute significantly to patient safety and experience. They can impact on prolonged hospital stay, increase resistance of microorganisms to antimicrobials & disrupt patients and their families lives
Risk: link to Board Assurance Framework (BAF)/Risk Register	Type in box
Financial	HCAI can have additional financial burden
Compliance Select an item. **Safety**	Type in box
Partnership: consultation / communication	Type in box
Equality	Type in box
Quality Impact Assessment [QIA] completion required?	Type in box

1 Introduction/Position

1.1 October HCAI position outlined in the report

1.2

2 Problem
This may include a brief overview of the background to provided context

2.1

2.2

3 Possibilities
[ENTER SECTION HEADING]

3.1

3.2

Key risks and mitigations in place for your proposal should mentioned

Are there any resource implications for your proposal

4 Proposal, conclusions recommendations and next steps.

5 Action required from the Board/Committee

5.1 The Committee / Board is requested to:

a)

b)

APPENDICES
Appendix 1:
Appendix 2:

Infection Prevention & Control Report – October 2019

NHS Buckinghamshire Healthcare NHS Trust

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	23	4	0	1	0	1
Clostridium difficile *– COHA (Community onset healthcare associated)* (Note – RCA is only completed when requested by CCG)		9	1	0	0	0	0
MRSA Bacteraemia	0	1	0	0	0	0	0
MSSA Bacteraemia (BHT associated (post 48 hours)	n/a	12	0	0	0	0	0
Hand Hygiene Observational Audit Compliance %	n/a	n/a	99%	98%	100%	99%	98%

Clostridium difficile

Total of **6** Cases were identified in October 2019
HOHA = 5 cases, COHA = 1 case

BHT / CCG Investigation Meeting has been undertaken for all cases:

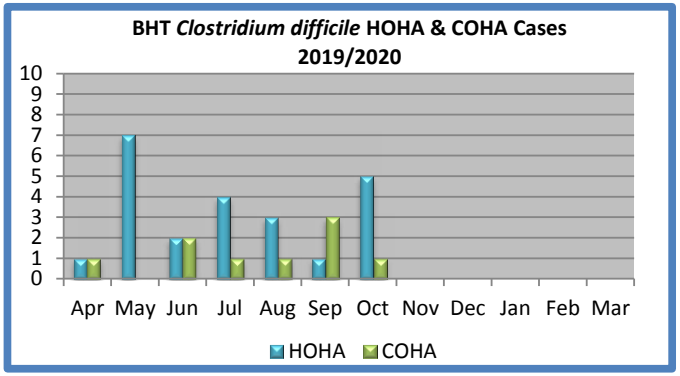
October cases – 3 Avoidable
- 3 Unavoidable

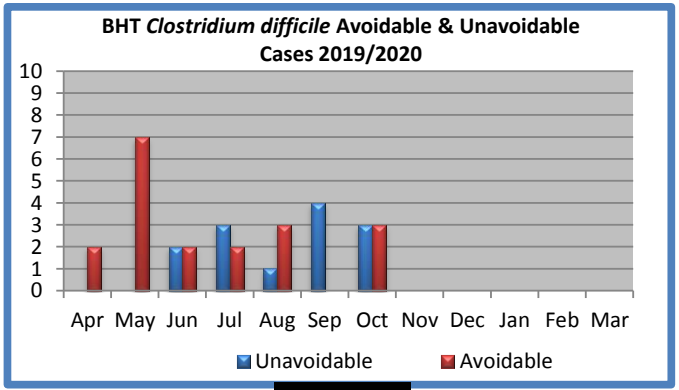
We would like to highlight some great practice and improvements

- Prompt stool collection & isolation
- Excellent antibiotic stewardship (prescribing and consultant reviews). Nursing teams encouraged to challenge doctors on antibiotic reviews
- Weekend equipment and cleaning checks implemented & led by nurse in charge
- Improvement on equipment cleaning and sign off noted on spot check to ward by IPCN

The Trust total of 32 to date incorporates 4 positive results from patients, who experienced a relapse/reinfection. All positive cases are required to be mandatory reported if over 28 days from a previous positive result and are counted against our annual limit.

Totals for 2019/20 = 19 Avoidable, 13 Unavoidable,





Meticillin Resistant Staphylococcus aureus (MRSA) Bacteraemia

0 Cases identified in October 2019

Meticillin Sensitive Staphylococcus aureus (MSSA) Bacteraemia

0 Cases identified in October 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.

Infection Prevention & Control Report – October 2019

Buckinghamshire Healthcare NHS Trust

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**	2	0
	Unavoidable	3	0
Peripheral Line Infections		0	0
Totals		5 (1 yet to be determined)	**0**

Yearly Comparison Table

		17-18	18-19	19-20
Central Line	**Avoidable**	5	3	2
	Unavoidable	24	24	4
Peripheral Line Infections		3	4	0
Totals		32	31	**6**

Great to report ZERO cases in October

Outstanding August cases

August cases:
Case 1 - RCA being completed to be discussed at next line infections meeting, update to be provided in next report.

Infection Prevention & Control Report – October 2019

Buckinghamshire Healthcare NHS Trust

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

Aim – NHS England/Improvement have set an ambition to reduce healthcare associated GNBSI's.

Ambition - The NHSE/I ambition is to have a 25% reduction by March 2021 and a 50% reduction by March 2024.

Definitions of different categories are: Hospital onset, Community onset healthcare associated, Community onset non-healthcare associated. The top three GNBSI causative organisms are E.coli, Klebsiella, Pseudomonas.

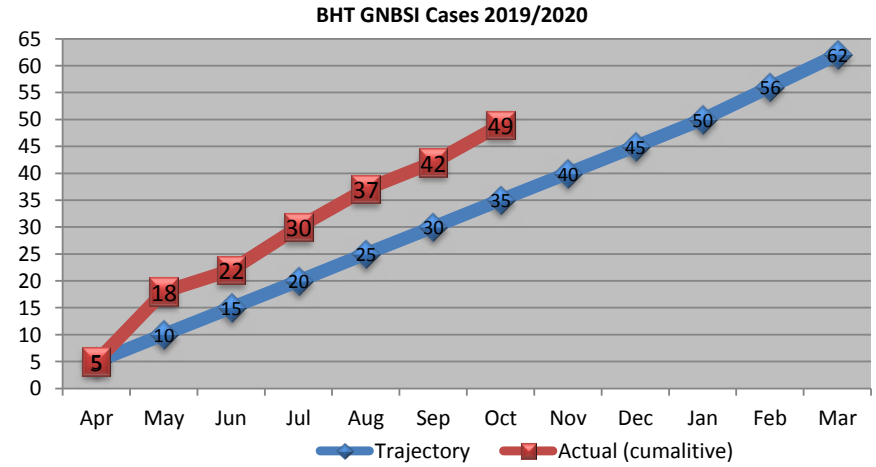
Hospital onset cases	Year to Date	Current Month
E.coli	29	3
Klebsiella	14	4
Pseudomonas	6	0
Totals	**49**	**7**

Yearly Comparison Table		
	18-19	19-20
E.coli	44	29
Klebsiella	13	14
Pseudomonas	11	6
Totals	**68**	**49**

Update

NHSE/I are creating Senior Responsible Officers (SRO) across the integrated care systems. For the BOB system our interim SRO is the Consultant Pharmacist at Oxford University Hospitals.

The purpose of this role within the system is to create, implement and deliver a system wide strategy to drive improvement related to healthcare associated GNBSI's. Activities and projects will be shared across the system.



Safe & compassionate care, every time

NHS
Buckinghamshire Healthcare
NHS Trust

Meeting: Trust Board Meeting in Public

27 November 2019

Agenda item	Trust Care Quality Commission Quality Improvement Plan
Board Lead	Chief Nurse
Type name of Author	Helene Anderson, Deputy Chief Nurse
Attachments	Quality Improvement Action Plan
Purpose	Assurance
Previously considered	Quality and Clinical Governance Committee, 05.11.19 and EMC, 01.11.19

Executive Summary

This paper provides an update of progress against the Trusts Care Quality Commission (CQC), quality improvement plan. The improvement plan has been developed based upon feedback provided by the CQC following their inspection of Buckinghamshire Healthcare NHS Trust in February and March 2019 and the subsequent report published in June 2019.

The feedback from the CQC consists of two lists of actions; those that the Trust MUST do (regulatory actions) and those the Trust SHOULD do. The actions are numbered for reference within the attachment and will be proceeded with an MD (Must Do) or SD (Should Do) accordingly.

The report describes the overarching governance framework for the quality improvement plan and describes areas of risk identified in achieving this relating to three individual actions. The RAG rating on the improvement plan relates to progress against the action not the level of risk associated with achieving it.

The plan has been divided into milestones so that progress can be mapped and monitored over a period of time if the issue cannot be resolved quickly. There are no CQC issued deadlines for individual actions other than to have submitted a Trust action plan to them by the end of July 2019, which was achieved. The action plan will be reviewed as part of the monthly CQC call with the Chief Nurse and Medical Director from January 2020.

Progress has been made against both the “Must Do” and “Should Do” actions and fortnightly meetings are in place with action leads and other key stakeholders to maintain timely progress, provide support to the team and gain assurance around completed actions.

Decision	The Board / Committee is requested to note the report.

Relevant Strategic Priority

Quality ☒	**People ☒**	**Money☒**

Implications / Impact

Patient Safety	To provide a consistently high quality patient focused service, which minimises avoidable harm. Compliance with regulatory standards

9

Risk: link to Board Assurance Framework (BAF)/Risk Register	We will offer high quality, safe and compassionate care in patients' homes, the community otr one of our hospitals
Financial	Financial implications of poor quality care
Compliance CQC Standards	Applicable to all CQC standards
Partnership: consultation / communication	Communication of key changes required to support compliance
Equality	Relevant but not required for this report.
Quality Impact Assessment [QIA] completion required?	NA

Safe & compassionate care, every time

Buckinghamshire Healthcare NHS Trust

REPORT DETAILING PROGRESS AGAINST THE CQC IMPROVEMENT PLAN
BUCKINGHAMSHIRE HEALTHCARE NHS TRUST
OCTOBER 2019

Introduction

1.1 This paper intends to inform the Trust Board of progress against the Care Quality Commission (CQC) improvement plan. The improvement plan has been developed based upon feedback provided by the CQC following their inspection of Buckinghamshire Healthcare NHS Trust in February and March 2019 and the subsequent report published in June 2019.

Process

2.1 The feedback from CQC consists of two lists of actions; those that the Trust MUST do (regulatory actions) and those the Trust SHOULD do. The actions are numbered for reference and will be proceeded with an MD (Must do) or SD (Should do) accordingly.

2.2 The plan has been divided into milestones so that progress can be mapped and monitored over a period of time if the issue cannot be resolved quickly. Each milestone should be ideally completed two weeks ahead of the quarterly CQC visits which are scheduled for 26th November 2019, February 2020, May 2020 and August 2020.

Governance Framework

3.1 Each milestone should inform the actions that are to be completed by the deadline. Once the action has been completed, details will be sent to the Operational lead who should in turn send for sign off to the Executive lead, along with the relevant evidence and details as to how this will be monitored to ensure compliance is maintained.

3.2 Operational leads currently attend a fortnightly meeting chaired by the Deputy Chief Nurse (DCN) and Project lead. These are intended to be supportive but equally ensure there is a corporate overview of the work, build momentum around the actions and support timely completion and submission of evidence. Meeting frequency will decrease as assurance is provided around ongoing work.

3.3 Any risks identified to quality and safety of patient care and experience as a result of a delay to compliance with any of the actions will be escalated by the DCN to the Chief Nurse and Medical Director.

3.4 RAG ratings have been applied to each action. These denote the progress of the action rather than the level of risk associated with the action. A blue rating indicates the action is complete with all evidence submitted and assurance received that the action has been embedded. Green

indicates completed actions and awaiting evidence. Amber and Red actions require further work and monitoring.

3.5 Going forward there will be two sets of RAG rating contained within the plan. The first relating to completion of the regulatory action and the second relating to the ongoing and wider work across the organisation.

Progress to date- key messages

3.6 Work on actions completed prior to the improvement plan being finalised in August are being captured for completeness (actions completed to date). Further evidence is required to finalise this section of the plan. Meetings are taking place with individual owners of actions to gain full assurance.

3.7 Work which is ongoing and awaiting finalisation within Q3 or submission of evidence in order to close the action is described under "Q3 milestones" and "Q3 actions completed" sections of the plan.

3.8 A number of the" Should" do actions are progressing well (currently green) and at the submission of evidence stage, these will be closed in the next two weeks.

3.9 The "Must" do element of the plan has progressed where actions relate to a specific area visited at the time of the inspection. However, broader pieces of work are being carried out provide assurance more globally in relation to the particular aspect of practice across all relevant clinical areas. Systems and process are being developed to provide assurance around on-going compliance, which will become part of business as usual for all aspects of the plan.

Summary of current compliance against "must" do regulatory actions

The table below summarises compliance against the regulatory actions.

Regulatory Action	MD1	MD2	MD3	MD4	MD5	MD6	MD7	MD8	MD9	MD10	MD11	M12
Compliance Y/N	Y	Y	Y	N	N	N	N	N	Y	Y	N	Y

Risks

4.2 WHO assurance- audits are proving labour intensive and time consuming to complete across all theatre specialities. Concerns relate to the length of time before full assurance received for all specialities and a regular audit cycle is embedded. By way of mitigation the audit process has been reviewed and support identified. A baseline audit across all specialities will be complete by December'19.

4.2 Patients presenting in ED and across the organisation with a mental health need should be cared for in a risk assessed environment. Risk assessment templates are currently being developed in line with this action, but also a recent CAS alert. A risk assessment tool is being developed. The issue is currently on the corporate risk register.

4.3 Medical equipment maintenance. Some excellent work proposed as part of the improvement plan but with a 12 month deadline. Operational leads asked to review this timeline and prioritise aspects of the work, but await feedback.

4. Reporting

4.1 The improvement plan will be presented to the following committees for review and assurance:-

- Monthly at the Quality and Patient Safety Group
- Quarterly reports to EMC
- Quarterly reports to Quality and Clinical Governance
- Bi-annually to the Trust Board

5. Recommendation

5.1 That the Committee:-

- Note the content of the paper
- Are cited on key areas of risk
- Approve the milestones reported.

Author
Miss Helene Anderson, Deputy Chief Nurse for Quality and safety.

Reporting Executive
Chief Nurse

Date
28th October 2019

KLOE		CQC Report June 2019 MUST/ SHOULD DOs	Service	Location	Division	Executive Lead	Lead	Date for Completion	Response From	Actions Completed To Date	Q3 Milestone	Q3 Actions Completed	Q3 RAG	Q3 Evidence	Evidence Location
	MUST Dos														
Safe	MD1	The service must ensure medicines including controlled drugs are managed safely and in line with regulations to protect patients.	Surgery Core Service	WGH & SMH		Medical Director	J Ricketts	July	J Ballinger/ J Ricketts	*Master tracker system in place to enable recording of all take home medication and contemporaneous records of all TTO's provided to all patients. *Nurses trained and competent to administers ward packs. * All Wycombe staff trained in line with SOP. *Questions included in Perfect Ward for Pharmacy	*Accountability Framework to be considered using Perfect Ward- HA to D/W JA by 11/10/19. *To complete baseline compliance audit by 28/11/19- LO	* Baseline compliance re-audit carried out across the organisation against registers and compliance with process- await final report. JB	A		L:\Governance Team\CQC Inspection 2018-2019\Draft Improvement Plan 2019\Evidence\MD1
Safe	MD2	The service must ensure medicines including controlled drugs are managed safely and in line with regulations to protect patients.	Trust-wide			Medical Director	J Ricketts	July	Rachel Cox	*New process in place to manage expired CD stock- need to explore if this works for clinical teams and supporting to manage CD stock. Pharmacy seeking feedback by 28/10/19	*HA to meet with JB and Divisional reps regarding frequency, quality and areas for further forcused work around CD checks by 18/10/19. * Current cascade of data to be extended to divisions- JB by 18/10/19. * Assurance required re double checking of CDs by ODPs and Aneasthetists JB by 18/10/19. Copy of anaesthetic SDU lead letter letter to trainees and consultant staff required- by 18/10/19 as evidence.		A		
Safe	MD3	The service must ensure emergency medicines (Glucagon) are stored safely in line with manufacturer's guidance to ensure they are fit for use.	Surgery Core Service	WGH & SMH		Medical Director	J Ricketts	July	J Ricketts	*Trust wide comms to highlight importance of checking the expiry date of drugs and consumables. *Glucagon removed from Resus Trollies - now stored in fridges.	*Medical Audits of Resus Trollies to confirm ongoing compliance with glucagon storage across BHT- twice annually. *confirm that question re the Glucagon is included in the resus trolley audit. HA by 18/10/19	*Posters in place re location of Glucagon for new starters *Now included on quarterly resus trolly audit	G		L:\Governance Team\CQC Inspection 2018-2019\Draft Improvement Plan 2019\Evidence\MD3
Safe	MD4	The service must ensure care is provided in a safe way to include all necessary checks such as the five steps (WHO Checklist) to surgery safety checks must be completed in line with practice guidelines.	Surgery Core Service	WGH & SMH		Medical Director	J Ricketts	July	J Ricketts	* Weekly compliance report now available from blue spier to monitor adherence to WHO (doesn't monitor quality only comletion). * WHO checklists board in place in each theatre to support process.	Audits complete by Dec '19. *Monthly spot check audits to take place from Jan'20. * introduction of Perfect ward theatre specific quality rounds by Nov '19 CY/JA	* process agreed and in place to facilitate completion of WHO audit of all specialties by December '19.	A		L:\Governance Team\CQC Inspection 2018-2019\Draft Improvement Plan 2019\Evidence\MD4 and AC1

Safe	MD5	The service must ensure risk assessments are completed and actions developed to mitigate those risks for patients undergoing surgical procedures. (VTE)	Surgery Core Service	WGH & SMH		Medical Director	J Ricketts	July	J Ricketts	* Quarterly VTE snapshot audit in place. * Monthly compliance data from Medway capturing patients assessed for VTE. * SOP to support staff compliance with VTE process in place. *Ward receptionist and medical support workers have clear instructions on how to input VTE data onto Medway * VTE assessment in place on surgical checklist and WHO	*Working Party reviewing VTE across SMH and WGC to develop standard pathway. Update CY by 15/11/19 *VTE Guideline to be reviewed and ratified. (Input from Maternity and Paeds awaited). MC By 15/11/19. * SOP about to go live for medical support workers MC to provide as evidence- 18/10/19. April audit data showed 97% compliance with pts assessed on admission. *100 patient trial of new assessment form currently under way		A		L:\Governance Team\CQC Inspection 2018-2019\Draft Improvement Plan 2019\Evidence\MD5 and AC2
Safe	MD6	The service must ensure equipment used at the service for providing care and treatment must be properly maintained and safe for use.	Surgery Core Service	SMH		Commercial Director	J Ricketts	July	J Ricketts / Stephen Squires		*Medical Equipment Audit underway - expected to take up to 1 year *Improve route for Medical Equipment coming into the Trust *Removal of all labels on equipment to be replaced by highly visible licence plates - expected to take up to 1 year *Medical Equipment Policy review * Trust wide equipment purchases to be overseen via Medical Devices Committee- Action for SM to attend medical devices committee and discuss these actions/timelines with the Chair and SS. *SM to seek clarification from CQC regarding specific detail to prioritise equipment identified as a concern		R		
Safe	MD7	The service must ensure vulnerable patients and those who present with acute mental health needs are treated in a suitable, safe, risk assessed environment.	Emergency care core service	SMH		Chief Nurse	Sarah Lafbery	July		*Self harm policy drafted and currently awaiting comments and then final ratification. * Timeline in place for ED work by end Dec '19 * Risk assessment document being finalised -by 28/10/19. *Missing patient policy drafted and awaiting final ratification.	*Estates/Nursing team developing an environmental risk assessment for all ares to use. AP/HA/HD by 14/10/19 * Inclusion of mental health room in A&E - advice to be sought from Mental Health Trust regarding the set up of this room . SL to advise on any mitigation there is in place in the interim by 18/10/19		A		

Safe	MD8	The service must ensure patient's records are fully completed in a timely manner	Emergency care core service	SMH		Chief Nurse	Helen Byrne	July			*Await assurance/update from service on actions to date on communications with ED team; progress of quarterly notes audit; staff confirmation of compliance with standard. AF to email Helen Byrne and Jane Dickinson (cc. HA) to request an update by 14/10/19. * to clarify frequency of trust wide documentation audits and to understand any associated risks. HA/LW and group by 18/10/19		A		
Safe	MD9	The service must ensure safer staffing levels are appropriately assessed against patient need.	Community health inpatients core service	Comm		Chief Nurse	K Kennedy	Monthly reporting		*Lead for Physio has daily safer staffing monitoring systems in place	*Actions completed around daily safer staffing systems for nursing - recruitment is ongoing. KK provides monthly update report to CQC - evidence to SK: Safe Care element on Allocate report and monthly report	*Safe Care element on Allocate commenced. *monitoring and regular reporting systems in place to CQC.	G		
Safe	MD10	The service must ensure suitable numbers of staff are deployed to match identified safer staffing levels.	Community health inpatients core service	Comm		Chief Nurse	K Kennedy	Monthly reporting			*KK/CM to provide evidence to SK: Safe Care element on Allocate report and monthly report for therapists by 14/10/19.	*Safe Care element on Allocate commenced.	G		
Safe	MD11	The service must ensure processes are in place and effective in identifying, and responding to, the impact of safer staffing levels on patient's rehabilitation journeys.	Community health inpatients core service	Comm		Chief Nurse	K Kennedy	Monthly reporting			*CM to have conversation with team regarding Datix use for dropped therapy sessions. Currently maintain a local data base but not on datix. *CM to have conversation with team about recording all nurse interactions with patients by 14/10/19		A		
Responsive	MD12	The service must ensure waiting times are reduced for paediatrician and therapy services.	Community health services for children young people and families	Trust wide		COO	Isobel Day	July			*Consultant led service- documented challenges around achieving 18 wks- monitored quarterly by the Trust Board against action plan and via joint commissioning meetings. * Therapies- evidence of current performance and actions- reported on monthly. Not currently demonstrating an improvement but robust actions and monitoring in place. Risk assesmsent completed.	*Evidence provided	B	MD12 Combined YTD stats MD12 community paeds performance updated sept 19	L:\Governance Team\CQC Inspection 2018-2019\Draft Improvement Plan 2019\Evidence\MD12
	SHOULD DOs														

Safe	SD1	The service should review non-compliance with mandatory training including safeguarding training and implement action plans to improve compliance.	Trust			Director of Org Devt and Workforce Trans	Karon Hart	Oct		Training data monitored monthly via core divisional meetings; EMC and Staffing Workforce Committee.	*Currently on coporate risk register. SK to get evidence from HR - assurance that the data is going to the correct people and reported into relevant committees * Intercollegiate Safeguarding document will impact on denominator for L3 training. Await feedback from divisions on absolute numbers. By 28/10/19	* intercollegiate document reviewed and training matrix provided for divisional teams to calculate impact on divisional staff training numbers.	A		
Safe	SD3	The endoscopy unit should consider alternative arrangements for the decontamination of their scopes.	Medicine Core Service	WGH		COO	Helen Byrne	Oct			Corporate strategy - including JAG accreditation especially at Wycombe. This is risk assessed and under control with clear plan & time lines in place *SM to provide evidence by 14/10/19. *SL to obtain evidence from Janet Hercules re the mitigations currently in place		A		
Safe	SD4	The staff should complete all medical and nursing records to ensure a full and contemporaneous record.	Trust wide			Chief Nurse/ Medical Director	Please advise Lead?	Oct		* Await most recent audit report to understand gaps and areas for further focused work. HA	*HA to speak to Lynda Oswald to understand audit cycle and overall performance/ areas for further focus/risk by 28/10/19		A		
Safe	SD5	The service should consider how to store patient's paper records more securely to protect data protection breaches and to protect patient confidentiality.	Trust wide			Chief Nurse/ Medical Director	Divisional Directors	Oct			*SM & HA to look at CQC report to identify what this action applies to specifically. By 28/10/19		A		
Safe	SD6	The hospital should continue to improve its antibiotic prescribing to reach the trust target of 90%.	Medicine Core Service	WGH & SMH		Medical Director	Claire Brandish	Oct		*Review of practice in other organisations with a view to identfying transferable practice. * work with leaderhsip team in ED around AMR and cultural shift in working practice. * Biochemistry reviewing urniary dipstix from somehting which could improve practice around automatic testing.	*HA to discuss existing CQUIN with Claire Brandish to understand detail CQUIN Q2 data imminent and recovery plan being developed by HA. * To understand detail & scope of any other antimicrobial audits being carried out in order to determine further organisational wide actions. By 31/10/19	* Regular meetings set up to support team leading AMR CQUIN. * Recovery plan being drafted	A		
Safe	SD7	The hospital should provide appraisals for all of its staff. The service should work with staff to complete appraisals in line with the trust policy	Trust wide			Director of Org Devt and Workforce Trans	Divisional Directors/ Karon Hart	Oct		*Monitoring by SWC & Div performance meetings.	Monitored via EMC and SWFC. Current challenges around data validation. KH to advise on this by 28/10/19		A		
Safe	SD8	The hospital should monitor the safe management of disinfectant.	Medicine Core Service	WGH & SMH		Medical Director	A Adkins	Oct		* Practice changes agreed and rolled out from 1/10/19	Moving to Clinelle wipes from 1st October *HA to contact Niamh Whittome to get evidence of changes.	* evidence received.	B		L:\Governance Team\CQC Inspection 2018-2019\Draft Improvement Plan 2019\Evidence\SD8 and AC6

Safe	SD10	All intravenous fluids should be stored safely.	Medicine Core Service	SMH		Medical Director	S Lafbery/ J Neal	Oct			*Potential requirement for audit and costings to install didgi locks as required. *HA to get hold of copy of basleine audit from Matt Lee, Head of Security to understand where the Trust have any gaps. If not available then audit of each area will be undertaken to determine requirements. 31/10		A		
Safe	SD11	The hospital should monitor the ambient room temperature in treatment rooms where medicines and intra-venous fluids are stored.	Medicine Core Service	SMH		Medical Director	S Lafbery	Oct	Rachel cox	*Busness case completed for Trust wide solution for fridge and ambient temperature monitoring. Currently no funding although agreed in prinicple.	*Temperature monitoring is inconsistent. HA to discuss with JB. No upper guidence in place currently		A		L:\Governance Team\CQC Inspection 2018-2019\Draft Improvement Plan 2019\Evidence\SD11 and Gold3
Safe	SD12	The hospital should check hard copies of standard operating procedures and policies are in date and the latest version. Policies and procedures should be reviewed and reflect current guidelines to support staff's practices.	Trust Wide	SMH		Chief Nurse	Heads of Nursing	Oct			Robust procedure in place for policy review and ratification. All policies currently up to date on the intranet. *HA to check if there are any questions on PW regarding hard copies of policies being held by staff. By 18/10/19 * SM reviewing intranet.	* assurance received that currently all Trust policies up to date and clear governance process in place.	A		
Safe	SD13	The process for assessing and recording food and fluids intakes should be reviewed and action plans put in place to protect patients from the risk of malnutrition.	Surgery Core Service	SMH		Chief Nurse	Liz Anderson	Oct			*KK to contact Liz Anderson re frequency of Audit and clarification of process *not currently on perfect ward.		A		
Safe	SD14	Staff should follow the standard operating procedures for transfer of patients to the wards, and patients are not nursed in corridors for a prolonged period whilst waiting for beds to become vacant.	Surgery Core Service	SMH		Chief Nurse	Helen Byrne	Oct			*AF to email Helen Byrne to find out about policy and transfer of patients, and plus one by 14/10/19 *Policy to go to DOC, TPSG, EMC *HB planning Pre-emptive Discharge Policy	* HB has completed Transfer policy & received comments await final ratification	A		
Caring	SD15	The trust should consider some form of annual, end of life mandatory training to capture staff who may have been working for the trust for many years and missed the induction session on end of life. The service should consider including responding to the deteriorating patient as part of their mandatory training programme	End of Life Care core service	SMH		Chief Nurse	H Pegrum	Oct			*KK to pick up with Helen Byrne and Liz Monaghan by 21/10/19		A		
Safe	SD16	The service should consider how to provide consultant presence 16 hours a day in line with the Royal College of Emergency Medicine's recommendations.	Emergency care core service	SMH		Medical Director	Stephen Gardener	Oct			*AF to pick up with Jane Dickinson and Helen Byrne around current plans. By 14/10/19		A		
Safe/ Car	SD17	The service should consider better line of sight by staff for waiting area	Emergency care core service	SMH		COO	Helen Byrne	Oct			*AF to pick up with Jane Dickinson and Helen Byrne by 14/10/19 Should change with ED build		A		
Caring	SD19	The service should consider how to protect patient's privacy when carrying out assessments in the GP streaming area waiting area.	Emergency care core service	SMH		COO	Helen Byrne	Oct			*AF to pick up with Jane Dickinson and Helen Byrne by 14/10/19 Should change with ED build	* Time line for ED build in place	A		

Caring	SD20	The service should consider making the 'fit to sit' area in the major's area a more patient friendly space	Emergency care core service	SMH		COO	Helen Byrne	Oct			*AF to pick up with Jane Dickinson and Helen Byrne by 14/10/19 Should change with ED build		A		
Safe	SD24	The service should document and evidence action is taken in response to an identified deteriorating patient.	Community health inpatients core service	Comm		Chief Nurse	K Kennedy	Oct			*KK to provide evidence of training dates and number of staff trained to SK. All staff trained to date although further dates planned in a rolling cycle.By 14/10/19		G		
Caring	SD25	The service should update the trust website to ensure ward visiting times reflected the actual, flexible visiting hours	Community health inpatients core service	Comm		COO	L Clifford	Oct			*KK to chase with Lesly Clifford		A		
Safe	SD26	The service should review out of hours transfers to the service to identify ways to minimise wherever possible.	Community health inpatients core service	Comm		COO	K Kennedy	Oct			*AF to find out if Helen Byrne policy supports this practice. By 14/10/19	*HB has drafted the policy and circulated for comment.	A		
Safe	SD27	The service should continue to monitor and identify the reasons for delays in looked after children health assessments and take appropriate action to bring about improvements.	Community health services for children, young people and families	W&C		Chief Nurse	Vicky Perkins	Oct			*ID to email Vicky Perkins re evidence that this info is being provided on a fortnightly basis by 14/10/19	*Evidence Provided	B	SD27 2019 09 24 BHT Youth Offending Service Activity report SD27 2019-09-24 LAC Assurance Report_BHT	L:\Governance Team\CQC Inspection 2018-2019\Draft Improvement Plan 2019\Evidence\SD27
Safe	SD28	The service should develop a formalised process to record risks associated with staffing levels and monitor the impact of the risk to children and families.	Community health services for children, young people and families	W&C		Chief Nurse	Vicky Perkins	Oct			*ID to email VP re evidence of monthly vacancy report; on risk register; meeting with joint commissioners monthly by 14/10/19	*Evidence Provided	B	SD28 Risk Register August 2019 SD28 Risk Register for SLT Autumn term delivery 2019 SD28 Therapy Monthly report August 2019	L:\Governance Team\CQC Inspection 2018-2019\Draft Improvement Plan 2019\Evidence\SD28
Safe	SD30	The service should continue to work towards health visiting performance meeting national targets.	Community health services for children, young people and families	W&C		Chief Nurse	Vicky Perkins	Oct			*ID to email VP re evidence but process as above.by 14/10/19	*Evidence Provided	B	SD30 Q1 - HCP 0-19 data submission template 2019-20	L:\Governance Team\CQC Inspection 2018-2019\Draft Improvement Plan 2019\Evidence\SD30
Safe	SD32	The service should carry out risk assessments for all environments that services are provided from, including those not owned by the trust.	Community health services for children, young people and families	W&C		Commercial Director	I Day/ E MacFarlane	Oct			*ID: can provide evidence of people being risk assessed when going back into homes; lone worker devices in place. *ID to pick up - Has not seen risk assessments for Health visitor joint sessions in village halls.		A		
Safe	SD34	The service should ensure staff working with children, young people and families in the community have the knowledge and skills to identify the specific signs and symptoms for a child or baby suffering from sepsis and take appropriate action.	Community health services for children, young people and families	W&C		Chief Nurse	S Harrison	Oct			*ID to clarify if missing acute paeds SI – nothing to do with community by 14/10/19		A		
Safe	SD35	The service should monitor the temperature of the chilled room.	Hospice	IECC		Chief Nurse	K Kennedy	Oct			Thermometers are in place. A quote has gone in for the Aircon unit for one location in the hospice. *KK to find out which room it is by 18/10/19		A		
Safe	SD36	The service should undertake local audits to monitor the effectiveness of care and treatment and use the findings to improve them.	Hospice	IECC		Chief Nurse	K Kennedy	Oct			*KK to contact Liz Monaghan for local leads and audit timetable by 18/10/19		A		

Safe	SD37	The service should monitor when patients were not able to access the service when they needed.	Hospice	IECC		Chief Nurse	K Kennedy	Oct			There is a daily bed meeting and trust wide report into sitrep every day to prioritise who is coming in and where and provide oversight to trust. Matron manages e roster. *KK to provide evidence to SK	G	

Safe & compassionate care, every time

NHS
Buckinghamshire Healthcare
NHS Trust

Meeting: Trust Board Meeting in Public

27 November 2019

Agenda item	Patient Experience Strategy-Annual Report 2018-19
Board Lead	Chief Nurse
Type name of Author	Amarjit Kaur, Head of Patient Experience and Involvement
Attachments	Patient Experience Strategy Annual Report 2018-19
Purpose	Assurance
Previously considered	Executive Management Committee and Quality Committee

Executive Summary

The Trust aims to be in the top 25% of trusts for patient experience by 2021

- In 2018 Buckinghamshire Healthcare Trust (BHT) was the 11th most improved Trust for inpatient experience out of 77 Trust surveyed by the Picker Institute for Experience.
- The Trust rose from the third quartile of Trusts into the second quartile (36th out of 77) for overall positive score ranking in the inpatient survey.

The Patient Experience Strategy aims to improve patients experience of the Emergency Department (ED) , discharge from hospital, to listen and respond to the voice of the child and Outpatients

- BHT's Children and Young People (CYP) inpatient and day-case services ranked 8th out of 66 surveyed by Picker with 7 of the eight above being specialist children's services
- During 18/19 there was a significant improvement in BHT's discharge processes with reflected in the 2018 Picker inpatient survey where three out of the five of top scores in survey and four out of the five most improved scores related to discharge
- The introduction of SMS text messaging for appointments and Bulk Mail has improved our communication with patients and the 3 percentage reduction in Did Not Attend (DNA) rates are amongst the lowest in the country. However, appointment delays and cancellations continue to be an area for improvement
- The Emergency Department (ED) have made improvements in a range of areas such as reducing waits to see a doctor or nurse and involving patients in decisions about care, but could do more to manage patient's pain

Decision	The Board / Committee is requested to review and challenge the report

Relevant Strategic Priority

Quality ☒	**People** ☒	**Money** ☐

Implications / Impact

Patient Safety	Improved care, patient experience and outcomes
Risk: link to Board Assurance Framework (BAF)/Risk Register	BAF 1.1 : To listen to our patient's voice
Financial	Relevant but not applicable
Compliance Select an item. Select CQC standard from list.	Patient centred care

10

Partnership: consultation / communication	Working in partnership with patients
Equality	Equal access
Quality Impact Assessment [QIA] completion required?	N/A

1 Introduction/Position

1.1 The Patient Experience Strategy 2017-20 aims to bring BHT into the top 25% of trusts for patient experience by 2021

1.2 The strategy contains eight commitments to patients and identifies the ED, Outpatients, discharge and listening to the voice of the child as priority areas for improvements in patient experience

2 Problem

2.1 In 18/19 the Trust was in the top 50% of Trusts for patient experience as measured by the Picker in-patient survey. By 2021 we need to have moved into the top 25%

2.2 Issues such as Outpatient appointments, delays, cancellations, the ED environment, waiting times and food quality are all areas that have been identified for improvement. These areas will be the focus for improvement in 19/20

3 Possibilities

The Patient Experience Strategy provides the opportunity to deliver a focussed approach to improving patient's experience of care at BHT

4 Proposal, conclusions recommendations and next steps.

- In 18/19 BHT made good progress in improving patient experience in key areas, reflected by the fact that it rose from the third quartile of Trusts into the second quartile (36th out of 77) for overall positive score ranking in the Picker inpatient survey.
- Discharge processes and our services to children and young people did particularly well in demonstrating good performance.
- Improvements to communication methods for outpatients significantly improved patient experience
- Patients feel involved in decisions about their care
- Areas for improvement include:
  - Outpatient appointment delays and cancellations
  - Food quality
  - Pain management
  - Patient's experience of A&E environment

5 Action required from the Board

The Board is requested to:

a) Note the contents of the report and challenge any concerns
b) Be assured upon the delivery of the Patient Experience Strategy

6 Appendices

Appendix 1: Patient Experience Strategy Annual Report18/19

Buckinghamshire Healthcare NHS Trust

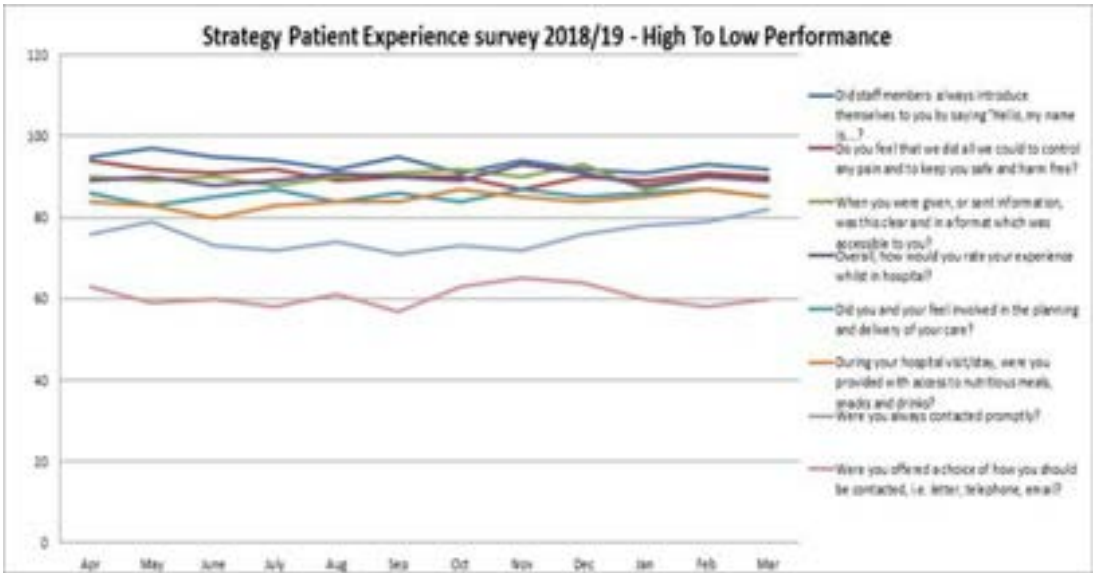
Patient Experience Strategy: Annual report

1. Introduction:

The Patient Experience Strategy 2017-20 aims is to take Buckinghamshire Healthcare NHS Trust (BHT) into the top 25% of trusts for patient experience. In 2018 the Trust made good progress towards this goal. BHT was the 11th most improved Trust out of the 77 who commissioned Picker to conduct their annual inpatient survey, and the Trust was assessed by the CQC as 'Good' and 'Outstanding for Care'. This report demonstrates how BHT has performed against the goals of the Patient Experience Strategy in 18/19.

2. Our commitments to patients:

Performance 2018-19



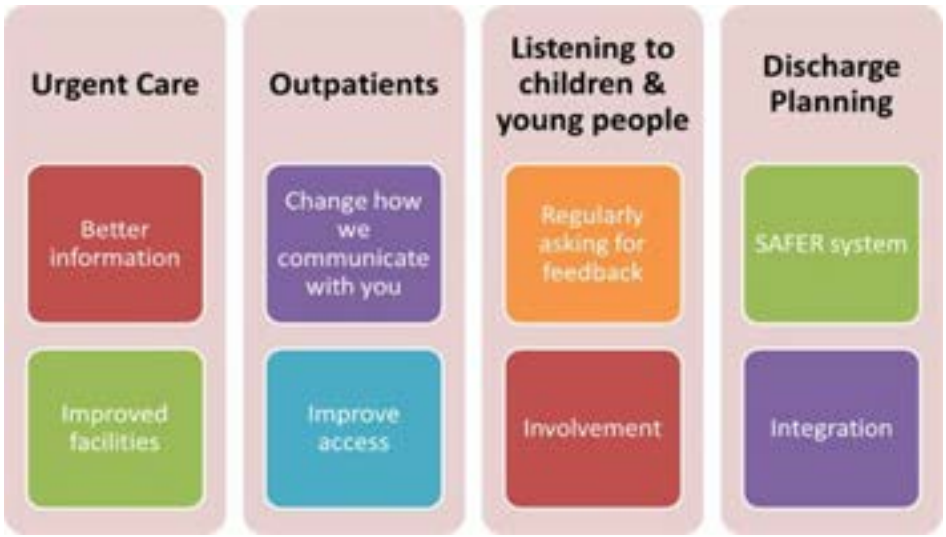
Each month all patients discharged during the period receive a text link to our patient experience survey to assess performance against our commitments:

- There has been an upward trend over the year in the view our patients have expressed about how involved they feel in the planning of their treatment and care. This is reflected in the 2018 Picker inpatient survey where 91% said they were involved as much as they wanted in decisions up from 88% in 2017 and above the national average of 90%
- Over the period an average of 93% of surveyed patients said staff introduced themselves by name. This continues to be a popular and effective initiative
- Over the year we improved our performance in the promptness with which people were contacted, as a result of the introduction of Bulk Mail and SMS for appointments.
- On average 90% of our patients across the reporting period said that they were given clear information in a format they could understand,
- Only an average of 61% were given a choice in how they were contacted (phone, email or letter)
- Across the period there has been a slight downward trend in how patient's feel we have controlled their pain, though we did score above average in this area in the Picker in-patient survey
- The quality of food continues to be one of our lower scoring areas, though encouragingly there has been a slight upward trend in patient views over the year. The 2018 inpatient survey rated the Trust as below average for food quality for the 5th year in a row so this continues to be an area for improvement

Areas for improvement 2019-20

- Food quality
- Pain management
- Choice in how to be contacted

3. Strategic areas of focus



3.1 Urgent Care:

Examples of actions taken to improve in 2018-19:

- Introduction of patient information screens, providing patients with up to date waiting times
- Launch of the Friends and Family Test (FFT) Envoy platform to automatically collect FFT responses by SMS allowing for real time feedback to inform improvement
- Reintroduction of the wearing of uniforms for the Emergency Department (ED) receptionists to support a positive first impression
- Plans for refurbishment of the ED agreed which will address many of patients concerns with the ED environment, including improved waiting area
- Expansion of the ED buddy programme, volunteers whose role it is to support patients through the ED for example by providing refreshments

Performance 2018-19

2018 Picker Urgent and Emergency Care survey results

- 13th most improved Trust out of 69 who commissioned Picker
- BHT 48th out of 69 organisations surveyed by Picker for overall positive score

Improved performance:	Performance over time				Compared to average	
Question	2014	2016	2018		Average	BHT
Waited under two hours to be seen by doctor/nurse		80%	86%		86%	86%
Involved in decisions about care and treatment	88%	91%	95%		92%	95%
Understood explanation of condition or treatment	93%	88%	94%		94%	94%
Doctors/nurses didn't talk in front of patients as if weren't there	82%	85%	87%		85%	87%
Enough attention from medical or nursing staff	89%	92%	94%		93%	94%

Areas for improvement in 2019-20:

	Performance over time				Compared to average	
Question	2014	2016	2018		Average	BHT
Able to get help whilst waiting			66%		73%	66%
Told how would receive the results of tests			47%		61%	47%
Staff helped control pain	82%	84%	79%		84%	79%
Able to get suitable food or drink	64%	67%	62%		67%	62%
Understood results of tests	98%	98%	93%		94%	93%

3.2 Outpatients

Examples of action taken to improve patient experience in 2018-19

- Introduction of Envoy SMS messaging for appointment reminders
- Introduction of Bulk Mail system
- Appointment letters Accessible Information Compliant
- Patient focus pathways developed eg. Virtual Fracture clinic
- Improved Patient information in department

Performance 2018-19

- DNA rates are down by 3%, amongst the lowest in the country**.**

- Around 12000 more appointments per annum
- Average of 45% of letters via the system were picked up digitally (no letter posted)
- 23,794 letters sent via Bulk Mail, 59% of all outpatient letters
- Patient and user feedback rated the out patients service as 88.5% positive**.**

Areas for improvement 2019-20

The following continue to be issues for patients featuring in complaints and FFT feedback

- Patients appointment delays
- Patients cancelled multiple times
- Transport delays
- Communication
- Wayfinding

3.3: Listening to the Voice of the Child

Examples of actions taken to improve patient experience in 2018-19:

- Redecoration of rooms in the Paediatric Department Unit (PDU) with animal theme to make it more child friendly
- Improvements to service to children with complex needs , following listening event with parents including, more advice on feeding, prioritising children with complex needs for access to side rooms, review of the Hospital at Night policy and introduction of soft close bins in clinical areas.

Performance 2018-19

2018 Picker Children and Young People's survey results

- Overall positive score 8th out of the 66 organisations Picker surveyed
- Seven of the eight who scored better are specialist children's hospitals

Improved performance:	Over time			Compared to average	
Question	2016	2018		Average	BHT
Parent felt they were treated with respect and dignity by staff	100%	100%		98%	100%
Child was involved in decisions about their care and treatment	84%	95%		86%	95%
Staff provided clear information to parent about child's care and treatment	98%	100%		98%	99%
Parent felt that there was enough things for child to do in hospital	93%	96%		93%	96%
Child felt staff spoke to them in a way that they could understand	99%	100%		99%	100%

Areas for improvement in 2019-20:

	Over time			Compared to average	
Question	2016	2018		Average	BHT
Child able to talk to doctor or nurse without parent/ carer being there if wanted to	50%	46%		52%	46%
Child liked the hospital food	85%	84%		83%	&4%

3.4: Discharge

Examples of actions taken to improve patient experience in 2018-19

- Work begun on the welcome and discharge pack.
- Implemented weekly long stay reviews
- Pharmacy discharge co-ordinator role piloted in Acute Medical Unit (AMU) and Ward 10 to support a more efficient and effective discharge process with a particular focus on TTOs and a reduction in waiting times.
- Establishment of additional discharge lounge facility at Stoke Mandeville Hospital

Performance 2018-19

- Telephone discharge survey launched Feb 2019, 82% of respondents satisfied or extremely satisfied with their discharge experience
- 2018 Picker in-patient survey results: three out of the five of top scores in survey and four out of the five most improved scores relate to discharge, demonstrating impact of BHT's focus on improving patient experience in this area

Inpatient survey results: Improved performance:	Performance over time				Compared to average	
Question	2016	2017	2018		Average	BHT
Discharge: told purpose of medications	91%	89%	94%		91%	94%
Discharge: family or home situation considered	85%	79%	85%		82%	85%
Discharge: family given enough information to help care	76%	76%	81%		76%	81%
Discharge: expected care and support were available when needed			85%		83%	85%

Areas for improvement in 2019-20:

	Performance over time				Compared to average	
Question	2016	2017	2018		Average	BHT
Discharge: was not delayed	51%	59%	52%		60%	52%

Conclusions

- The Trust has made good progress in improving patient experience in key areas, reflected by the fact that it rose from the third quartile of Trusts into the second quartile (36th out of 77) for overall positive score ranking in the inpatient survey in the Picker inpatient survey.
- Discharge processes and our services to children and young people did particularly well in demonstrating good performance.
- Improvements to communication methods for outpatients significantly improved patient experience
- Patient feel involved in decisions about their care
- Areas for improvement include:
  - Outpatient appointment delays and cancellations
  - Food quality
  - Pain management
  - Patient's experience of the ED environment

Safe & compassionate care, every time

Buckinghamshire Healthcare NHS Trust

Meeting: Trust Board Meeting in Public

27 November 2019

Agenda item	Seven day services Autumn/Winter Survey.
Board Lead	Tina Kenny, Medical Director
Type name of Author	Mandy Chetland/Andrew McLaren
Attachments	Type attachment name / reference or None
Purpose	Assurance
Previously considered	EMC 1/11/19, Quality & Clinical Governance Committee 5/11/19

Executive Summary

Note the findings of the Autumn/Winter survey.

BHT continues to meet the 4 priority clinical standards

BHT continues to show evidence regarding the 6 standards for continuous improvement

Decision	The Board is requested to approve prior to submission to NHSE/I on 29th November 2019.

Relevant Strategic Priority

Quality ☒	**People** ☐	**Money**☐

Implications / Impact

Patient Safety	Reducing inequalities
Risk: link to Board Assurance Framework (BAF)/Risk Register	Type in box
Financial	Type in box
Compliance Select an item. **Safety**	Seven Day Services – Board Assurance Framework – NHSE/I
Partnership: consultation / communication	Type in box
Equality	Type in box
Quality Impact Assessment [QIA] completion required?	Type in box

11

BUCKINGHAMSHIRE HEALTHCARE NHS TRUST: 7 Day Hospital Services Self-Assessment - Autumn/Winter 2019/20

Priority 7DS Clinical Standards

Clinical Standard	Self-Assessment of Performance	Weekday	Weekend	Overall score
Clinical Standard 2 All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission.	Following the recommendations from the previous assessment, a larger audit was undertaken. A sample size of 184 patients were reviewed by the Clinical Effectiveness Team. The patients were selected using the suggested methodology recommended in the Seven Day Service Assessment guidance. The largest proportion of patients were from acute internal medicine 43.5%, paediatrics 12.5% and general surgery 10.3%. The Standard was met for "clinical assessment within 14 hours on a weekday and weekend". Consultant cover at weekends - There is provision in job plans to provide weekend Consultant cover for emergency medicine, general medicine, surgery, paediatrics, obstetrics and gynaecology, spinal and anaesthetics, with Consultants on call when not on site. Full post take ward rounds are done in all admitting specialities and are job planned. Mortality - HSMR is 90.4 and lower than expected. Emergency weekend/weekday HSMR is within the expected/lower than expected range. No individual day is considered statistically higher than expected. Discharges - Discharges for inpatients in Stoke Mandeville Hospital are between 15-16% Monday to Friday and 11-12% at weekends. A recent GIRFT visit for Acute and General Medicine highlighted that there was no significant difference in discharges across the seven days and reported that our level of discharge at weekends was higher than most Trusts.	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Standard Met

BUCKINGHAMSHIRE HEALTHCARE NHS TRUST: 7 Day Hospital Services Self-Assessment - Autumn/Winter 2019/20

Clinical Standard	Self-Assessment of Performance		Weekday	Weekend	Overall score
Clinical Standard 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: • Within 1 hour for critical patients. • Within 12 hours for urgent patients. • Within 24 hours for non-urgent patients	Q: Are the following diagnostic tests and reporting always or usually available on site or off site by formal network arrangements for patients admitted as an emergency with critical and urgent clinical needs, in the appropriate timescales?	Microbiology	Yes Available on site	Yes Available on site	Standard Met
		Computerised Tomography (CT)	Yes Available on site	Yes Available on site	
		Ultrasound	Yes Available on site	Yes Available on site	
	All the diagnostic tests listed are available on site during the week and at weekends. This standard has been met consistently for at least the last three assessments.	Echocardiography	Yes Available on site	Yes Available on site	
		Magnetic Resonance Imaging (MRI)	Yes Available on site	Yes Available on site	
		Upper GI Endoscopy	Yes Available on site	Yes Available on site	

BUCKINGHAMSHIRE HEALTHCARE NHS TRUST: 7 Day Hospital Services Self-Assessment - Autumn/Winter 2019/20

Clinical Standard	Self-Assessment of Performance		Weekday	Weekend	Overall score
Clinical Standard 6 Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant directed interventions that meet the relevant speciality guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.	Q: Do inpatients have 24-hour access to the following consultant directed interventions 7 days a week, either on site or via formal network arrangements?	Critical Care	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	Standard Met
		Interventional Radiology	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	
		Interventional Endoscopy	Yes Available on site	Yes Available on site	
		Emergency Surgery	Yes Available on site	Yes Available on site	
	Inpatients have access to consultant directed interventions seven days a week either on site or via formal network arrangements as indicated. This standard has been met consistently for at least the last three assessments.	Emergency Renal Replacement Therapy	Yes Available on site	Yes Available on site	
		Urgent Radiotherapy	Yes available off site via formal arrangement	Yes available off site via formal arrangement	
		Stroke thrombolysis	Yes Available on site	Yes Available on site	
		Percutaneous Coronary Intervention	Yes Available on site	Yes available off site via formal arrangement	
		Cardiac Pacing	Yes mix of on site and off site by formal arrangement	Yes available off site via formal arrangement	

BUCKINGHAMSHIRE HEALTHCARE NHS TRUST: 7 Day Hospital Services Self-Assessment - Autumn/Winter 2019/20

Clinical Standard	Self-Assessment of Performance	Weekday	Weekend	Overall score
Clinical Standard 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). 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.	The audit consisted of a random sample of 183cases over a seven day period from emergency admissions. For those cases at the weekend where no consultant (or delegated) review was recorded it was not documented whether this review was required. Standard met for twice daily reviews and once daily reviews on a weekday and weekend. <u>Systems to support ongoing review</u> Board Round systems – As part of the implementation of SAFER, Board Rounds are carried out twice daily and involve the MDT where all patients are discussed. This is currently being reviewed as part of "Operation Freshstart" to ensure the appropriate attendance and level of check and challenge occurs. System of Escalation – There is ongoing monitoring of sick patients via the electronic Obs system, and processes are being refined in conjunction with the critical care outreach team to ensure ward nursing staff are adequately supported in this regard.	Once daily: Yes the standard is met for over 90% of patients admitted in an emergency	Once daily: Yes the standard is met for over 90% of patients admitted in an emergency	Standard Met
		Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	

BUCKINGHAMSHIRE HEALTHCARE NHS TRUST: 7 Day Hospital Services Self-Assessment - Autumn/Winter 2019/20

7DS Standards for Continuous Improvement

Self-Assessment of Performance against Clinical Standards	
Clinical Standard 1 - Patient Experience Patients, and where appropriate families and carers, must be actively involved in shared decision making and supported by clear information from health and social care professionals to make fully informed choices about investigations, treatment and on-going care that reflect what is important to them. This should happen consistently, seven days a week.	An analysis was completed on complaints received regarding ED between April and August 2019. Thirty five formal complaints .were received that were categorised as "patient experience" and there was no increase in complaints received regarding a patient's experience at the weekend compared to a weekday There was no increase in incidents over the weekend compared to weekdays suggesting there is no variation in patient experience and care at the weekends.
Clinical Standard 3 - MDT Review All emergency inpatients must be assessed for complex or on-going needs within 14 hours by a multi-professional team, overseen by a competent decision-maker, unless deemed unnecessary by the responsible consultant. An integrated management plan with estimated discharge date and physiological and functional criteria for discharge must be in place along with completed medicines reconciliation within 24 hours.	Nursing and medical staff undertake daily board reviews of patients on all wards. Daily Facilitated Meetings are carried out to enable safe, effective and timely discharge through a daily multidisciplinary team review highlighting and documenting issues/and or actions that need to be taken to facilitate the discharge. Safety Huddles are undertaken in A&E and other wards to give healthcare staff (clinical and non-clinical) an opportunity to understand what is doing on with each patient and anticipate future risks to improve patient safety and care.
Clinical Standard 4 – Shift Handovers Handovers must be led by a competent senior decision maker and take place at a designated time and place, with multi-professional participation from the relevant in-coming and out-going shifts. Handover processes, including communication and documentation, must	Weekday and weekend routine morning ward round, afternoon board round and hospital at night handover are undertaken. E-Obs across the Trust supports handovers by enabling clinical staff to: • View the Ward bed board • Access the patients' observations and other clinical information • View the overall status of patients • Deteriorating patients can be detected early and care prioritized accordingly

BUCKINGHAMSHIRE HEALTHCARE NHS TRUST: 7 Day Hospital Services Self-Assessment - Autumn/Winter 2019/20

be reflected in hospital policy and standardised across seven days of the week.	• View detailed charts, historical and current data in real time on any Trust PC without being on the ward
Clinical Standard 7 – Mental Health Liaison mental health services should be available to respond to referrals and provide urgent and emergency mental health care in acute hospitals with 24/7 Emergency Departments 24 hours a day, 7 days a week.	Buckinghamshire Healthcare Trust in collaboration with Oxford Health provides a psychiatric in-reach liaison service (PIRLS). PIRLS provides assessment and support to people who present with mental health needs in the acute hospital setting and operates 24 hours a day, 7 days a week. Once a patient has been referred the response times are: A&E 1 hour; Ward 10; ITU and AMU 4 hours; Wards 24 hours. Mental health services are also available from CAMHS for children presenting at A&E. There are specific pathways for self-harm and eating disorders.
Clinical Standard 9 - Transfer to community, primary and social care Support services, both in the hospital and in primary, community and mental health settings must be available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken.	In patient pharmacy services are open 7 days a week and on call out of hours. Therapy services cover 7 days a week. Social care are on SMH site 7 days a week. Health community Services cover 7 days a week. Transport is available 7 days a week via our Patient Transport Provider, this is also supplemented with a private crew.
Clinical Standard 10 – Quality Improvement All those involved in the delivery of acute care must participate in the review of patient outcomes to drive care quality improvement. The duties, working hours and supervision of trainees in all healthcare professions must be consistent with the delivery of high-quality, safe patient care, seven days a week.	The Trust has a formalised Quality Improvement Dosing Strategy for spreading quality improvement skills. Monthly integrated Performance Report received by the Board contains a comprehensive section on patient outcomes. The Trust is signed up to the tripartite agreement which means that all educational supervisors are job planned to provide protected education to junior doctors. All services have morbidity and mortality meetings. All deaths are reviewed by the medical examiner team with feedback to the clinical teams.

BUCKINGHAMSHIRE HEALTHCARE NHS TRUST: 7 Day Hospital Services Self-Assessment - Autumn/Winter 2019/20

7DS and Urgent Network Clinical Services

	Hyperacute Stroke	Paediatric Intensive Care	STEMI Heart Attack	Major Trauma Centres	Emergency Vascular Services
Clinical Standard 1	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A- service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A- service not provided by this trust	N/A- service not provided by this trust
Clinical Standard 5	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A- service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A- service not provided by this trust	N/A- service not provided by this trust
Clinical Standard 6	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A- service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A- service not provided by this trust	N/A- service not provided by this trust
Clinical Standard 8	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A- service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A- service not provided by this trust	N/A- service not provided by this trust

Assessment of Urgent Network Clinical Services 7DS performance (Optional)	We are able to perform emergency STEMI operations on weekdays only between 09:00-17:00. Outside of these hours, patients requiring emergency STEMI surgery are transferred to one of the nearest urgent network centres for STEMI.

Safe & compassionate care, every time

NHS
Buckinghamshire Healthcare
NHS Trust

Agenda item	Corporate Objectives 2019-2021: April – September 2019 Progress Report

Meeting: Trust Board Meeting in Public

27 November 2019

Board Lead	David Williams, Director of Strategy
Type name of Author	Daniel Leveson, Deputy Director of Strategy
Attachments	None
Purpose	Assurance
Previously considered	Executive Management Committee (15 November)

Executive Summary

- The Board approved the Trust's two year Corporate Objectives in March 2019. The objectives focus on the three key areas of delivery to transform our culture, implement new workforce models and tackle inequalities and variation. EMC and Board Committee agendas have been structured to align with the objectives and they have been routinely scrutinised by the relevant committees.
- This paper provides a summary of highlights from April-September 2019, full details of achievements, benefits, concerns and next steps are available in quarterly reports submitted to Board Committees.
- Progress against priority KPIs has been included where available in the report. Some of the priority KPIs are measured annually and will be included in the final report in May 2020.

Decision	The Committee is requested to note the report

Relevant Strategic Priority

Quality ☒	**People** ☒	**Money**☒

Implications / Impact

Patient Safety	There is a risk that if we fail to deliver the corporate objectives we will not deliver outstanding services for our patients and community.
Risk: link to Board Assurance Framework (BAF)/Risk Register	The BAF is aligned to the corporate objectives.
Financial	There is a risk that if we do not improve staff engagement, reduce waste, improve efficiency and reduce variation we will not be financially sustainable in the future.
Compliance Select an item. Select CQC standard from list.	Well-led
Partnership: consultation / communication	N/A
Equality	Equality Impact Assessments are conducted for individual change projects where required
Quality Impact Assessment [QIA] completion required?	No

12

Safe & compassionate care, every time

NHS
Buckinghamshire Healthcare
NHS Trust

Corporate Objectives 2019–2021: April-September 2019

1. Introduction

The Board approved the Trust's corporate objectives at the start of the financial year. These are the goals that relate to the organisation as a whole and have the most influence on delivering our vision to be the safest healthcare system in the country and deliver safe and compassionate care every time for every patient.

While we monitor the Trust's performance as part of the Integrated Performance Report we monitor the impact of our corporate objectives on our strategic objectives of quality, people and money at the relevant Board Committee.

Below is the list of our three corporate objectives, the related programmes and Executive Lead along with the relevant Committee that scrutinises the progress on a quarterly basis:

Corporate objective	Programmes	Executive lead	Committee
Continue to improve our culture	BHT Way – always improving: - Listening to the patient voice - An organisation that learns - Culture of quality improvement - Making it easier to get things done	Chief Nurse Chief Nurse Director of Strategy Chief Operating Officer	Quality Quality Quality Finance
	Small Change, Big Difference	Medical Director	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	Finance
	Get It Right First Time and reduce clinical variation	Medical Director	Quality
	Modernise outpatient services	Chief Operating Officer	Quality
	Embed use of accurate data across the Trust	Director of Strategy	Finance
Enablers To deliver: • Digital strategy • Estates strategy • Clinical strategy • Commercial transformation • Corporate service transformation		Director of Strategy Commercial Director Director of Strategy Commercial Director Director of Finance	Finance Finance Quality Finance Finance

This paper provides a summary of highlights from April-September 2019, full details of achievements, benefits, concerns and next steps are available in quality reports submitted to Board Committees.

Safe & compassionate care, every time

NHS Buckinghamshire Healthcare NHS Trust

2. April-September 2019 Progress

This is a high level summary of the highlights from the year so far; more detail is available in individual reports and has been reviewed by the relevant committees.

Corporate objective	Programmes	Measure	Baseline	Target
Continue to improve our culture	**Listening to the Patient Voice** • BHT Children and Young Peoples services rated 8th out of 66 Trusts surveyed by Picker. • Progress against patient recommendations in National Spinal Injuries Centre (NSIC) including reduction in bed days for non-spinal cord injury patients, bed occupancy on target (96%), responding to requests for accessible bins and additional commodes. • Trained nine patient assessors in Perfect Ward and assessing close to 25% of wards. • Achieved FFT approval rating of 87.5 (target 95%) and response rate of 22% (target 30%). Reviewing what actions needed to improve in both areas.	**National inpatient survey** (Reported at the end of the financial year)	Top 50%	Top 25%
	An organisation that learns • The number of incidents reported onto the National Reporting and Learning System (NRLS) in Q2 was 2,901 compared to 2,755 in Q1 (increase of 5%). • Perfect Ward compliance scores across the divisions have increased by 20% and the majority of divisions now reach above the 90% target. This supports more efficient and effective ways to inspect wards / services. • An average of 944 incidents per month was reported between M1 and M6 this year (above the monthly target of 925). See table in appendix.	**National reporting and learning system**	877 per month	925 per month
	Culture of Quality Improvement (QI) • 69 QSIR practitioners have been trained across the Buckinghamshire ICP. 125 BHT staff have completed the 1 day fundamentals training and 143 staff have completed QSIR sessions as part of leadership pathway, Go Engage, Preceptorship and team training. • Completed Board development programme in Q2 (3 sessions).	**Staff Survey: Q '…able to make improvements in my area of work'** (Reported at the end of the financial year)	57%	61%
	Small Change, Big Difference • Process in place to monitor the cost and quality impact of identified savings via the CIP tracker. YTD savings in CIP is 74.5k. • Continued improvement in compliance with timely Purchase Order (PO) submission, reduction to 4.23% of total Purchase Orders late at month 5. • Full year saving of £25k identified for change of printing paper and £6k saving per month by reducing colour printing. • Proportion of late POs in 18/19 was av. of 4.97% and 19/20 YTD it is 4.34%.	**Reduction in proportion of late orders**	4.97%	3.6%

Corporate objective	Programmes	Measure	Baseline	Target
Implement new workforce models	**Innovate with new models of care and/or staffing to tackle gaps in workforce** • Reduced nurse turnover rate to from **14.3%** in March 2019 to **11.7%** in August 2019. • Recruiting into training of apprenticeships in Senior Healthcare Support x 60 (22 YTD), Assistant Practitioner x 15 (planned for February), Nursing Associate x 40 (9 YTD, 31 planned for February), Register Nurse (degree) x 10 (YTD 9), Advanced Clinical Practitioner (degree) x 12 (6 YTD, 6 planned for February). • All staff moved from Rosterpro to HealthRoster and able to stop contract for multiple roster systems. • Roll out of SafeCare across all inpatient wards and training which helps to inform decision making and aims to reduce temporary staff use (25 wards completed at 13.9.19. On target to complete by December 2019).	**Nurse Turnover Rate**	14.3%	13.3%
	Make BHT a great place to work • Implementing nurse retention plan and in June saw the lowest level of leavers on record. • Implementing a revised format for induction making it engaging, informative and completing mandatory training where possible. • Continuing to implement Go Engage – effective team training to support team improve their engagement and staff satisfaction. • Published Workforce Race Equality Standard (WRES), Public Sector Equality Duty (PSED). Workforce Disability Equality Standard (WDES) to support us to become a more inclusive organisation. • WRES data shows improvements in indicator 2 and 3 (recruitment and disciplinary) and slight worsening in 4 (non-mandatory training). Also learnt BME staff reported experiencing discrimination at work in greater proportions that white staff (10% v 5%). Actions in place to improve recruitment and disciplinary processes and also improve representation in senior pay bands.	**Staff Survey: Engagement Score** (Reported at the end of the financial year)	7.0	7.1
	Develop teams, talent and an inclusive workforce • Established and supporting staff networks (race, LGBT, ability and spirituality) to deliver action plans to improve inclusion for marginalised groups. Hosted an Inclusion Conference with guest speakers from different groups and Yvonne Coghill from NHS E WRES Team. • Established and running an Executive Talent Pool supporting staff with potential to work at Executive level in the future. • Launched Buckinghamshire Health and Care Academy.	**Staff Survey: KF21 '% staff believing the organisation provides equal opportunities'** (Reported at the end of the financial year)	White staff 90% BME staff 81%	90%

Corporate objective	Programmes	Measure	Baseline	Target
Tackle inequalities and variation	**Build new community partnerships** • Draft BOB ICS response to the NHS Long Term Plan submitted in September. • Integrated 2020/21 business planning between CCG and BHT launched. A series of engagement events with system leaders and PCNs have taken place to build relationships. • Draft Joint Prevention plan with BCC complete to support reducing health inequalities and delivering CQUIN. • System providing additional resource for new service models for paediatric and respiratory care targeting areas of greatest need (linked to deprivation and inequality). • North Buckinghamshire Health and Care Centre outline business case complete for review and submission in November. • NEL admissions growth is above target at the end of Q2. Target = 20,921 and Actual = 22,654.	Slow the growth in NEL admissions	40,011	41,504
	Get It Right First Time and reduce clinical variation • Ophthalmology: Band 6 nurse injectors saves medical time – saving £47k • Oral Maxillo-facial surgery (OMFS): Coding review to put outpatients as OMFS – income gain (off block) £85k / year • Pain: Theatre productivity 4 cases per list increased to 7 cases per list. Will increase to 8 per list in next 6 months • Urology: Introduction of Urolift – move to daycase procedure • Breast: Aiming to increase daycase rate for mastectomy to national average (15% from 6.4%)	Top 2 recommendations in GIRFT specialties (Detailed reporting and monitoring at GIRFT Board)	Benchmark per specialty	Benchmark per specialty
	Modernise outpatient services • BHT Outpatient Transformation programme established and incorporated recommendations from Trainee Leadership Board, ICS Outpatient Programme and adopting the QSIR methodology in its approach. • There are 10 specialty areas and 1 cross-cutting (partial booking) in the programme and a total of 14 improvement projects have begun. • The aim is to reduce face-to-face outpatient appointments (30% over 5 years) using new models of care, improving efficiency and adopting new technologies. • During the first half of the year the average clinic utilisation is 82%.	Improve clinic slot utilisation	80%	90%
	Embed use of accurate data across the Trust • A full review of the BHT Business Intelligence (BI) function (Informatics Team) is underway. The process will establish an ICP wide BI function providing support to inform the decision making in the delivery and planning of services. Review will be complete with recommendations in December 2019.	Clinical Coding: Average number of co-morbidities per episode of care	4.4	5.5

Corporate objective	Programmes	Measure	Baseline	Target
Enablers	**Digital Strategy** • Information, Communication and Technology Strategy approved by the Trust Board. Included a review of ICP strategy to enable and maximise the benefits of integrated working. • Electronic Recording of Observations (eOBS) in all adult wards is in-place. • CareFlow Connect – secure messaging and clinical handover solution technically live and being piloted. • Single Sign On – access to multiple systems using one password is live in ED and will be rolled-out fully by December 2019. • Information Dashboards for capacity and demand in ED is complete and being used.			
	Estates Strategy • One Public Estate projects being implemented. North Buckinghamshire Health and Care Centre Outline Business Case drafted and ready for EMC in November and Board in January. Stoke Mandeville feasibility study, linked with clinical strategy development. Initial options will be reviewed in December. • Outpatient services have been transferred to Amersham. • A number of capital projects are underway at SMH including Central Sterile Service Department (CSSD), A&E refurbishment, university of Bedford centre and the Local Enterprise Partnership funded Innovation Centre (to open in March/April 2020). • 'Staples' site agreement signed creating an additional 94 parking spaces at Wycombe. • Temporary MRI scanner in-place at Wycombe and works underway for permanent new scanner to be in-place at the beginning of 2020.			
	Clinical Strategy • A number of key areas of work continue to progress in outpatient transformation, MSK, ophthalmology and pathology network. • Clinical strategy and case for change under development for completion by end of March 2020. Clinical strategy is focussed on emergency and acute services, rehabilitation, outpatient transformation, diagnostics and integrated community care. • Clinical strategy development is closely linked with the digital strategy and estates strategy – particularly the Stoke Mandeville feasibility study and developing Health and Care Centres. • Integrated business planning launched to work with divisions and SDUs and corporate services and commissioners to develop business plans (aligned to clinical strategies) for 2020/21.			
	Commercial and Corporate Services • Introduced new overseas patient policy and patient registration at A&E/GP streaming. Also developed additional private patient services in radiology, pathology, ophthalmology and urology. YTD CIP delivery of £498k (£210k private patients, £71k overseas patients, £51k amenity beds, £166k BMI).			

Safe & compassionate care,
every time

NHS
Buckinghamshire Healthcare
NHS Trust

Safe & compassionate care, every time

NHS Buckinghamshire Healthcare NHS Trust

3. Corporate Objectives Governance

Corporate objectives and plans traverse our three strategic priorities – Quality, People and Money and will be in place for two years. Our digital, estates, clinical and commercial strategies are supporting the delivery of our objectives. All Board committees, together with EMC, are overseeing the delivery of the associated projects. In doing this we aim that our plans have an impact on all three of our strategic priorities to deliver sustainable care in Buckinghamshire.

Each lead executive is accountable for the delivery of these plans. Where there are additional financial benefits or impacts on the Trust's cost improvement these projects are linked to the PMO and the transformation programme.

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

4. Routine Reporting and Monitoring of Corporate Objectives

The delivery of these plans is reported at the relevant sub-committee of the Board and will be used to drive the work programmes for these sub-committees during the year. The sub-committees provide assurance to the Trust Board about the governance as well as progress or risks to delivery. This report is a summary of some of the highlights halfway through the year and we will provide a final highlight report at the end of the year.

Routine Committee reports are in a short and simple template to report the progress status of projects, known as **ABCD** reporting. **ABCD** reports have four aspects presented in a quadrant as follows:

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

5. Recommendation

The Board is asked to note some of the highlights from the year so far. Each Committee has reviewed the detailed quarterly ABCD reports during the first half of the year and these reports are available in agendas and minutes of Committees.

The Board is also asked to note that some measures are annual and unavailable at this stage of the year but will be reported at the end of the financial year. Some of the metrics are being refined as we learn how best to measure the impact of the corporate objectives.

Safe & compassionate care, every time

NHS
Buckinghamshire Healthcare
NHS Trust

Meeting: Trust Board Meeting in Public

27 November 2019

Agenda item	Fit and Proper person
Board Lead	Bridget O Kelly
Type name of Author	Karon Hart
Attachments	
Purpose	Assurance
Previously considered	Type in Board / Committee or Group and date considered, minute number

Executive Summary

1. The Care Quality Commission (CQC) holds NHS trusts to account in relation to Fit and Proper Person as part of the key lines of enquiry under their regulatory assessment framework (under their well-led domain).

2. In order to meet compliance with these requirements, all NHS trusts must ensure they have robust processes in place to assess the suitability of directors at the point of recruitment and throughout their ongoing employment.

3. The purpose of these requirements is not only to hold board members to account in relation to their conduct and performance but also to instill public and patient confidence in those who have lead responsibility for NHS organisations and the services they provide.

4. This paper demonstrates our annual compliance process and satisfactory results.

Decision	The Board / Committee is requested to note actions taken for assurance

Relevant Strategic Priority

Quality ☐	**People** ☒	**Money** ☐

Implications / Impact

Patient Safety	N/A
Risk: link to Board Assurance Framework (BAF)/Risk Register	N/A
Financial	N/A
Compliance Select an item. Select CQC standard from list.	Well Led The CQC requires that the fitness of directors is regularly reviewed by the provider to ensure that they remain fit for the role they are in
Partnership: consultation / communication	N/A
Equality	N/A
Quality Impact Assessment [QIA] completion required?	N/A

13

Fit and proper persons test

1.0 Introduction

The fit and proper person regulation (FPPR) requirements came into force for all NHS trusts and foundation trusts in November 2014. The regulations require NHS trusts to seek the necessary assurance that all executive and non-executive directors (or those in equivalent roles) are suitable and fit to undertake the responsibilities of their role.

2.0 Overview

2.1 The CQC requires that the fitness of directors is regularly reviewed by the provider to ensure that they remain fit for the role they are in; the provider should determine how often fitness must be reviewed based on the assessed risk to business delivery and/or the service users posed by the individual and/or role.

2.2 In order to meet compliance with these requirements, all NHS trusts must ensure they have robust processes in place to assess the suitability of directors at the point of recruitment and throughout their ongoing employment. They are also required to have effective arrangements in place to tackle issues should any concerns be raised about a directors' ongoing fitness and suitability to carry out any such role. The purpose of these requirements is not only to hold all board members to account in relation to their conduct and performance but also to instill public and patient confidence in those who have lead responsibility for NHS organisations and the services they provide.

2.3 The Care Quality Commission (CQC) holds NHS trusts to account in relation to FPPR as part of the key lines of enquiry under their regulatory assessment framework (under their well-led domain). Its role is to assess that NHS trusts have appropriate and effective processes in place to assess a directors' suitability and to take action if they are failing to meet these requirements. While the CQC cannot investigate or prosecute for a breach of the requirements, it can take regulatory action against an individual's breach of a regulation, condition of its registration, or other relevant requirement. It can also assess the quality of any evidence presented and whether the NHS trust has appropriately taken this into account. Where the CQC has its own concerns about a director (Executive and Non-Eexecutive) , it has the power to take enforcement action against the employing organisation.

3.0 Meeting compliance

3.1 To ensure compliance with regulatory requirements, NHS trusts must be able to demonstrate to the CQC that they have robust and effective:

- Recruitment processes in place to assess the suitability of all newly appointed director as outlined within the NHS Employment Check Standards
- Assessment processes in place to regularly monitor and review the ongoing fitness of directors in their employ. This may form part of pre-existing appraisal and revalidation processes, as appropriate
- Arrangements in place to handle concerns about a directors' fitness and suitability in a timely manner, ensuring these are widely communicated and understood by all staff, including processes of appeal for directors
- Arrangements in place to share relevant information to health and social care regulators and other bodies (as appropriate), if a director no longer meets the FPPR requirements

3.2 Guidance from NHS Employers, NHS Confederation and NHS Providers is that on an annual basis:

- An assessment of continued fitness to be undertaken each year as part of appraisal process.
- Checks of insolvency and bankruptcy register and register of disqualified directors to be undertaken each year as part of the appraisal process.
- Board/Council of Governors reviews checks and agrees the outcome.

4.0 Conclusion

The table below demonstrates full compliance

4.1 Directors' in post compliance: 14 November 2019

Assessment/check	**Non-executive directors**	**Executive directors**
Annual appraisal	Carried out by the Trust chair in Q1	Carried out by the Trust CEO in Q1
Insolvency and bankruptcy register	On-line check carried about by a member of the recruitment team in November 2019	
Signed FPPT declaration	All have signed FPPT declarations within the last 12 months	
DBS checks	All have DBS checks in place in line with Trust requirements	

4.2 All Directors appointed in year 2019 have all been through correct recruitment process.

5.0 Action required from the Board/Committee

The Committee / Board is requested to take assurance that tests have been undertaken in accordance with guidance

Safe & compassionate care, every time

NHS Buckinghamshire Healthcare NHS Trust

Meeting: Trust Board Meeting in Public

27 November 2019

Agenda item	Appointment of a Non-Executive Director (NED) to the Trust Charity Committee
Board Lead	Sue Manthorpe
Type name of author	Sue Manthorpe
Attachments	None
Purpose	Approval
Previously considered	None

Executive Summary

Ms Nicola Gilham, Non-Executive Director has expressed an interest in becoming a NED on the Trust Charity Committee.

The Chair is seeking approval from the Board for this appointment.

Decision	Approval of appointment to the Charity Committee

Relevant strategic priority

Quality ☒	**People** ☒	**Money** ☒

Implications / Impact

Patient Safety	N/A
Risk: link to Board Assurance Framework (BAF)/Risk Register	N/A
Financial	N/A
Compliance Select an item. **Good Governance**	N/A
Partnership: consultation / communication	N/A
Equality	N/A
Quality Impact Assessment [QIA] completion required?	N/A

14

Safe & compassionate care, every time

NHS
Buckinghamshire Healthcare
NHS Trust

Meeting: Trust Board Meeting in Public

27 November 2019

Agenda item	Board Assurance Framework (BAF)
Board Lead	Sue Manthorpe
Type name of author	Sue Manthorpe
Attachments	Board Assurance Framework
Purpose	Assurance
Previously considered	None

Executive Summary

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.

Decision	The Board is requested to Note the BAF

Relevant strategic priority

Quality ☒	**People** ☒	**Money** ☒

Implications / Impact

Patient Safety	Identifies any potential patient safety concerns
Risk: link to Board Assurance Framework (BAF)/Risk Register	Risks articulated in the BAF
Financial	Risks articulated in the BAF
Compliance Select an item. **Good Governance**	Risks articulated in the BAF
Partnership: consultation / communication	Consultation and Communication identified in the BAF where required
Equality	Identified in the BAF
Quality Impact Assessment [QIA] completion required?	Not Applicable

15

Reference	Description of risk to achieving objective	Risk score unmitigated by controls	Key controls	Assurance on controls	Assurance RAG	Gaps in controls or assurance	Current Risk Rating (mitigated by controls)	Action to address gap	Lead
Includes Reference to Corporate Risk Register where relevant	*Focused on strategic risk.*	*The score if there were no controls in place*	*IC = internal control* *EC = external control* *Controls recorded on separate lines*	*IA = internal assurance* *EA = external assurance* *Assurances map to individual controls.*	*No assurance = red* *No external assurance = amber* *Internal and external and timely assurance = Green*	*Areas which will require action if risk score or assurance RAG are to improve.*	*This indicates the level of concern i.e. are the assurances giving us negative or positive indications.*	*This will include timescales for tracking and show where timescales have not been met.*	*Executive director lead*
Quality **We will offer high quality, safe and compassionate care in patients' homes, the community or one of our hospitals**									
1. Continue to improve our culture **Key Focus:** **1.1 Listening to the patient voice** **1.2 An organisation that learns** **1 .3Culture of quality improvement** **1.4 Making it 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**									
BAF 1.1	There is a risk that if we do not listen to our patients and take appropriate action that this will negatively impact on patient experience and care outcome. *Board Committee with oversight: Quality and Clinical Governance*	16	Systematic collection of Friends and Family Test (FFT) information. All our services within a hospital setting are asked to provide this feedback.(EC) National surveys for Inpatient, cancer, ED, Maternity and Children's and Young People to monitor patient experience (EC) Systematic Quality Rounds on a monthly basis in all clinical areas and in the community. There is real time patient feedback through this mechanism. (EC) Non-Executive director review of a sample of complaints each month. (IC) Chief Executive Officer and Chief Nurse see every complaint that comes to the organisation. (IC) Themes from FFT and compliments fed back at local level. (IC) Patient story at each public board meeting. (IC) Patient representative on the Quality and Clinical Governance Committee. (IC) Patient Experience Strategy and Implementation Plan. (IC) Patient Experience Group chaired by Associate Chief Nurse for Quality standards and Patient experience, provide patient oversight of implementation of PE strategy (IC)	FFT data is reported in the Integrated Performance Report to the Board. Information including the narrative is sent to wards on a monthly basis. (IA) Patient Safety and Quality Group receives progress reports on a bi-monthly basis on the implementation plan. (IA) Summary report from Quality Rounds reported to Patient Safety and Quality Group, Executive Management Committee and Quality and Clinical Governance Committee. (IA) External peer reviews seek patient views as part of the process e.g. CARF, cancer. (EA) Healthwatch oversight of quality including focused reviews. (EA)	**Green**	Listening to the patient voice is inconsistently prioritised within the Quality Service Improvement R design (QSIR) methodology There is a time lag with current FFT data collection and reporting, which impacts on ability of frontline staff to take action to improve the patient experience	**6 (3x2)**	Work with the Quality Improvement team to incorporate listening to the patient voice into QSIR methodology; Development to a patient engagement activity database which incorporates the activity, the feedback and the changes subsequently made to the service. implementation timeline July 2020 Patient story presented at every Quality Committee and Public Board. Patient representatives participate in quality rounds	Chief Nurse

Reference	Description of risk to achieving objective	Risk score unmitigated by controls	Key controls	Assurance on controls	Assurance RAG	Gaps in controls or assurance	Current Risk Rating (mitigated by controls)	Action to address gap	Lead
1.2 Develop as a learning organisation (Chief Nurse) **Key Focus: The key performance indicators that will used to monitor the progress of this project is the following:** **One defined purpose that will result in one KPI with the following objectives** **1. Clinical Accreditation Programme established across all inpatient wards and ten wards accredited by the end of March 2020** **2. Create a learning panel with system wide partners as an ICS that focuses on improvement by the end of September 2020** **3. Develop a system wide quality strategy for learning (including QISR methodology) by December 2020** **4. Support the organisation to move to a predictive state rather than a reactive state to improve quality and patient safety by the end of June 2020 (measure against baseline audit taken 2019)** **5. Ensure all patient facing teams have team level safety huddles on a daily basis by the end of June 2019 (annual audit against SOP)** **6. Incorporate the Safety I safety II principles across the trust with a focus on looking at what goes right and learning from it by the end of March 2021**								
BAF 1.2	There is risk that without a strategy in place setting out how we will develop as a learning organisation that the quality of care and staff engagement will be impacted negatively. *Board Committee with oversight: Strategic Workforce Committee*	16	Additional field added to the datix reporting system about feeding back the investigation findings to the reporter	Internal Patient Safety audit report completed an reporting to Audit Committee November 2019	**Amber**	There needs to be dedicated time and support to review and re-balance quality control, assurance and improvement to reduce variation across the Trust	**9 (3x3)**	Compete a gap analysis of existing mechanisms for sharing learning in order to support understanding where we need to focus- January 2020 Look both internally and externally to identify good practice that could adopted and scaled up and out- e.g. maternity services – January 2020 Consider ways to triangulate existing data to optimise thematic review and understanding of key areas for further work- February 2020 Embed Trust behaviours into the organisation to improve patient safety and support the development of a positive culture of kindness and civility Develop a business case in 19/20 to ensure the sustainability of the Clinical Accreditation programme via the Perfect Ward tool into 20/21 Implement the Knowledge Management Strategy to support cross site leaning and sharing Develop a Standard Operating Procedure for daily ward safety huddles and audit compliance Embed the NHS Patient Safety strategy into the organisation to improve the way safety is managed within the system Focused work on completion of incidents through investigation and closure . Utilise the staff survey heat map to target variation in incident reporting and closure. Encourage the use of social media to celebrate success and learn best practice form other organisations.	Chief Nurse
			Go Engage programme introduced across the Trust (IC)	Reporting of results to Executive Management Committee and Strategic Workforce Committee. (IA)					
			Excellence Reporting embedded within the organisation	Reports presented monthly to the Patient Safety and Quality Group					
			BHT way programme in place for the year (IC)	Records of content and numbers of staff attending BHT Way (IA)					
1.3 Culture of quality improvement (Director of Strategy) **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:** **Practitioners course** **Fundamentals** **Essentials** **• 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')**									

Reference	Description of risk to achieving objective	Risk score unmitigated by controls	Key controls	Assurance on controls	Assurance RAG	Gaps in controls or assurance	Current Risk Rating (mitigated by controls)	Action to address gap	Lead
BAF 1.3	There is risk that without a culture of quality improvement for staff there will not be the capacity to undertake the transformation required to improve the Trusts services *Board Committee with oversight: Quality and Clinical Governance??*	16	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 (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)**	69 QSIR Practitioners trained across the organisation: 13 QI projects have been completed 107 completed the QSIR fundamentals day training Widen the QI faculty and get a standard training programme across the Bucks ICP. Use business planning process for 20/21 to combine PMO QI resources to spread improvement methodology through Divisions - Jan 2020. Share improvement ideas across Divisions at Marketplace events - December 2019.	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					
BAF 1.3a	There is a risk that the Quality Peer Review process does not reduce variation in quality. *Board Committee with oversight: Quality and Clinical Governance*	16	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)	**Amber**	There is an assurance gap in that we are not yet confident that all the self reviews are done in a consistent way. Variability in the way trends are reviewed at Divisional Quality Boards.	**8 (4x2)**	Development of a governance framework that facilitates ward to board reporting, oversight and accountability for all quality, safety and patient experience data - January 2020. Internal audit action plan in place including working to embed the process within Divisions. Commence Clinical Accreditation programme by March 2020 based on the outputs from Quality rounds.	Chief Nurse
			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)					
			Programme of peer review within the organisation using an independent peer review team including external reviewers. (IC)	Peer review reports. (IA)					
			Learning and real time feedback on excellence and areas for improvement. (IC)	Outputs from the Perfect Ward App (IA) Monthly reports to the Quality and Patient Safety Group and minutes from that meeting. (IA) Quarterly reports to the Quality and Clinical Governance Committee and minutes from that meeting. (IA) Excellent reporting in place and increasing over the past 6 months. (IA)					

Reference	Description of risk to achieving objective	Risk score unmitigated by controls	Key controls	Assurance on controls	Assurance RAG	Gaps in controls or assurance	Current Risk Rating (mitigated by controls)	Action to address gap	Lead
BAF 1.4a	There is a risk that we will not deliver the NHS Constitution Standards if we do not make it easier to get things done. This will directly impact on patient experience. Specifically: 4 hour A&E performance, Referral to Treatment Times, Access to Diagnostics & Cancer 62 day waits. Risks: Quality - impact on patient experience Financial - link to STF Regulatory (Monitored through Finance and Business Performance Committee, F&BP)	20	IPR and Exception reports of escalated performance issues at weekly performance group meetings, chaired by the Chief Operating Officer. Weekly demand and capacity group managing access for RTT, Cancer and diagnostics. (IC) Demand Management Programme to commence with the Buckinghamshire Clinical Commissioning Group Plan for reducing non-elective and elective admissions. (EC) Escalation of all patients within 10 days of a breach to Divisional Directors and Divisional Chairs for cancer pathways. (IC)	Demand and Capacity Group minutes (IA) Operational performance dashboard reported at Divisional, Board and Committee level (IA) Internal audit of performance reporting Service Strategies (IA) Deep dives and performance reviews (IA) Deep dive presentations to Finance and Business Performance Committee (IA)	**Green**	The Trust is currently not meeting the 4 hour A&E, the RTT and 62 day cancer standards on a consistent basis. RTT specific: £300K additional CCG funding secured for Ophthalmology. - waiting lists will continue to grow - further discussions with CCG. Dermatology - long waits for routine appointments.	**16 (4x4)**	he Trust has implemented the following processes to improve delivery of the constitutional standards. Theatre utilisation group to improve flow through theatres and ensure maximisation of available operating time. Outpatient transformation Group to improve clinic utilisation, reduce DNA's and improve new to follow up ratios through the implementation of revised clinical pathways and non face to face outpatient appointment providing capacity to deliver services within 18 weeks. Development of revised PTL's to enhance waiting list management and reduce the number of patents on hold to improve RTT compliance. Demand capacity modelling in place at speciality and sub speciality level to ensure appropriate resources are allocated. Urgent Care Improvement Group established to deliver improvements in ED performance Patient flow group focusing on clinical pathways to reduce length of stay and DTOC patient to provide effective utilisation of available bed capacity therefore delivering access to beds in a timely manner for patients on a non elective pathway. Further development of same day emergency care services overseen by the patient flow group and implementation of revised pathways for minor injury and minor illness patients. System wide A&E delivery board providing assurance of actions taken by system partners to improve delivery of the 4 hour standard including the delivery of the non weight bearing pathway etc. Local performance trajectories for each of the constitutional standards agreed with regulators for 2019/20. End date 31 March 2020	Chief Operating Officer
			oversight and performance meetings	Meeting minutes (EA)					
			Urgent Care working Group and Accident and Emergency Delivery Board (IA)	Programme Board actions and minutes. (IA)					
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: *Finance and Business Performance 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. in place from 01/08/19 IT project bids process to be submitted 01/12/19 Identified the source problem as the processing speed of the hardware device; preparing business case to be submitted 01/12/19 New escalation framework implemented from 01/07/19 Develop a training plan - access to new ledger will be dependant on training compliance. all training to be completed by 31/03/20 Social Movement process to be developed by 30/03/20	Medical Director/Director of Finance

Reference	Description of risk to achieving objective	Risk score unmitigated by controls	Key controls	Assurance on controls	Assurance RAG	Gaps in controls or assurance	Current Risk Rating (mitigated by controls)	Action to address gap	Lead
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)**									
BAF 2.1	Innovate with new models of care There is a risk if our leaders do not have the right skills to develop strong teams the teams will not innovate and develop their services. This may negatively impacting on patient care and staff engagement *Board Committee with oversight: Strategic Workforce Committee*	12	6 teams engaged in the Go Engage programme in both June and 8 in December (IC) Survey results as part of Go Engage programme (IC)	Outputs from Go Engage programme reported to Strategic Workforce Committee on a quarterly basis - cohort of 6 pioneer teams (IA)	Amber	No Gaps	9 (3x3)	Recruitment plan in place to address each area. Actions that will be completed by March 2020 include: *Students final placements to areas that they have expressed an interest in working in *Offer letters sent in year 2 *Close support for students and line managers by recruitment and education teams through preceptorship programme. *Robust overseas recruitment plan in place.	Chief Nurse
			75 Leaders (in 3 cohorts) enrolled in Trust leadership programme during the year (IC)	Cohort numbers reported to SWC (IA) Feedback from cohorts reported to SWC (IA)					
			Trust-wide programme to transform the clinical workforce: - Recruitment including career pathways and skills mix (IC) - Education and training, including language training (IC) - Promoting excellence (including health & wellbeing) (IC) - Smart working (IC) - Temporary staffing (IC) - Participating in Cohort 4 of NHSI's retention programme (EC)	Outcomes of actions from the programme, reported to Executive Management Committee and Strategic Workforce Committee (IA) Nurse turnover rate (IA) Nurse vacancy rate (IA) Sickness absence rate (IA)	Amber	Nurse vacancy rate			
2.2 Make BHT a great place to work (Pioneering new ways of working) **Previous Key Focus:** **Use apprentices to provide skilled workers for the future** **60 Level 3 by March 2019** **60 Level 5 by March 2019** **20 Level 6 by March 2019**									

Reference	Description of risk to achieving objective	Risk score unmitigated by controls	Key controls	Assurance on controls	Assurance RAG	Gaps in controls or assurance	Current Risk Rating (mitigated by controls)	Action to address gap	Lead
BAF 2.2	Make BHT a great place to work There is a risk that without us pioneering new ways of working, the numbers and calibre of staff would be impacted and therefore the quality of patient care would be impacted. *Board Committee with oversight: Strategic Workforce Committee*	12	Have the right people at the right place with the right skills (IC)	% completion rate for safe guarding training (IC) % of utilisation of apprenticeship levy (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 % number of areas with nurse vacancy rate >30% % number of undergraduate nurse starters dropping Areas with key medical vacancies	**9 (3x3)**	Actions during September and October are Director of Workforce and OD and Chief Nurse wrote to staff in September; further training and notices placed in AMU.	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 place to work (EA)					
			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 for Health Care Assistants. Increased incidents of violence against staff in AMU			

Reference	Description of risk to achieving objective	Risk score unmitigated by controls	Key controls	Assurance on controls	Assurance RAG	Gaps in controls or assurance	Current Risk Rating (mitigated by controls)	Action to address gap	Lead
2.3 Develop teams, talent and an inclusive workforce (Attracting and retaining high calibre and engaged people) **Previous Key Focus:** **Transform our nursing workforce for the future** **Recruitment of 70% of University of Bedfordshire students in September 2018** **Recruit 25 individuals from Portugal by March 2019** **Increase internal appointments from 179 to 230 by March 2019**									
BAF 2.3	There is a risk to the developing teams, talent and an inclusive workforce and delivering all corporate objectives if we don't attract and retain high calibre and engaged people *Board Committee with oversight: Strategic Workforce Committee*	20	All teams and individuals have access to education provision(IC)	% of staff receiving non-mandatory training, learning or development in the last 12 months as reported in annual staff survey (EA) Achieve 100% utilisation of apprenticeship levy funding by end of Year 2 (IA)	**Amber**	Current staff survey scores from 2018. WRES Data % difference in BAME and white staff involved in the final disciplinary process Safeguarding training levels not meeting target % Apprenticeship levey utilised	**16 (4x4)**	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. To be completed by March 2020.	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)					
			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)				Review of recruitment outcomes for BAME applicants 30/12/19	
Tackling inequalities and variation **Key Focus:** **3.1 Build Community Partnerships (Chief Operating Officer/Director of Strategy)** **3.2 Get It Right First Time and reduce clinical variation** **3.3 Modernise outpatient services** **3.4 Embed use of accurate data across the Trust**									

Reference	Description of risk to achieving objective	Risk score unmitigated by controls	Key controls	Assurance on controls	Assurance RAG	Gaps in controls or assurance	Current Risk Rating (mitigated by controls)	Action to address gap	Lead
BAF 3.1a	There is a risk if we do not build partnerships with our stakeholders and the community, we will not make an impact on improving health outcomes and reducing health inequalities	**12**	BHT health Inequalities Taskforce (IC) Bucks Health and Well being 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) Achievement 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)**	Focussed support for respiratory and paediatric patients in areas of highest need approved; to be implemented - December 2019. Monthly monitoring of CQUIN target. Health inequalities Taskforce to review actions - Jan 2020. Population health management developed as part of case for change March 2020.	Director of Stratagem
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)**	engagement process for temporary closure of Chartridge ward in Amersham - paper to HASC due February 2020. Thame and Marlow sustainability options part of ICP case for change - March 2020 report back to HASC February 2020. Buckingham Community Hub outline business case for consideration - December 2019.	Director for Strategy
BAF 3.1c	There is a risk that if we do not launch a Buckinghamshire Lifesciences Innovation Hub supporting businesses we will not be able to develop their healthcare products and services in conjunction with our patients and clinicians.	16	Buckinghamshire Lifesciences Partnership Board (EC), LEP Capital Investment (EC), 2018/19 Capital Plan (IC), Business case for Innovation Hub (IC), European funding confirmed (EC) Health and Social Care Ventures launched 10 September 2018. (IC)	Minutes Buckinghamshire Lifesciences Partnership Board (EA), Business case for capital changes at SMH (IA), Memorandum of Understanding and Partnership Agreements (IA), LEP Grant Letter (EA), European Funding grant letter (EA)	**Green**	Full Business case yet to be agreed, Robust capital estimate.	**4 (4x1)**	Innovation Centre Business Case approved. Refurbishment to take place by January 2020	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

Reference	Description of risk to achieving objective	Risk score unmitigated by controls	Key controls	Assurance on controls	Assurance RAG	Gaps in controls or assurance	Current Risk Rating (mitigated by controls)	Action to address gap	Lead
3.3 Modernise outpatient services Key Focus to 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**	BIU resource not sufficient to moderate capacity and demand	**9 (3x3)**	Operational transformation being commencing in November 2019 and led by Chief Operating Officer Analyse the impact of change weekly/fortnightly and adjust actions to ensure targets are met.	Chief Operating Officer
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 not 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**	Business information review being conducted across CCG, Trust and Council due to report with recommendations - December 2019. Refreshed Integrated Performance Report - December 2019	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:									
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									

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 4.1a (link to CRR 32)	The failure to deliver the annual financial plan has the potential to jeopardise the future of the organisation. It is also a breach of the statutory duty to break even. Receipt of the Provider Sustainability Funding is dependent on achieving the financial plan trajectory on a quarterly basis. This will have a negative impact on the Trust Segmentation score (Monitored through Finance and Business Performance Committee, F&BP)	20	Compliance with Standing Orders and Standing Financial Instructions. (IC)	Financial report to Board. (IA) Monthly FIMS forms for NHSI. (EA) External audit programme. (EA) Internal audit programme (EA) Minutes of NHS I Integrated Delivery Meeting. (EA) Audit Committee review of compliance with Standing Financial Instructions (waivers, losses etc.)	**Amber**	Cost improvement programme not yet delivering to target. (C)	**20** **(5x4)**	Continued focus on financial control and accountability at all levels of the organisation. - meeting s every two weeks for divisions at level 3 and 4 Cost Improvement Programme Oversight groups established and CEO FRB group continue on a weekly basis. . Grip and Control checklist deployed and monitored at weekly FRB . FGAP in place and monitored at weekly FRB	Director of Finance
			Signed Service Level Agreements (EC)	Performance management process against service / contractual specifications both internal and external with Buckinghamshire Clinical Commissioning Group. (IA & EA)					
			Divisional Performance Management process including monitoring, review and actions to address variances on Key Performance Indicators. (IC)	Deep Dive process each month for Divisions. (IA) Run rate analysis and actions - performance management framework Income and Expenditure deep dive. (IA) Divisional monthly and quarterly performance reviews. (IA) FRB weekly meetings (IA). Two weekly meetings with Divisions in difficulty (IA). Non pay board in place (IA)					
			Nursing and medical agency staffing still running within caps (IC)	Performance against NHS Improvement cap reviewed monthly (IA)					

Reference	Description of risk to achieving objective	Risk score unmitigated by controls	Key controls	Assurance on controls	Assurance RAG	Gaps in controls or assurance	Current Risk Rating (mitigated by controls)	Action to address gap	Lead
BAF 4.1b (Links to CRR 38)	There is a risk that if we do not deliver the financial plan we will not have sufficient cash to make repayments to facilities and loans and fund capital requirements. (Monitored through Finance and Business Performance Committee, F&BP)	20	Compliance with Standing Orders and Standing Financial Instructions. (IC)	Financial report to Board. (IA) Monthly FIMS forms for NHSI. (EA) External audit programme. (EA) Internal audit programme (EA) Minutes of NHSI Integrated Delivery Meeting. (EA)	Amber	Cost improvement programme not delivering to target. (C) Nursing and medical agency staffing still running above internal targets. (C)	20 (5x4)	Debtor review and focus on collection. Cash forecast and ongoing discussions with NHSI Capital and Cash re loan drawdown. FRP to improve financial position and reduce cash requirements by 30/03/2020	Director of Finance
			Signed Service Level Agreements (EC)	Performance management versus contractual specification. (IA)					
			Divisional Performance Management process (IC)	Deep Dive process each month for Divisions. (IA) Internal Audit of Divisional performance in 18/19 (IA) Divisional performance monthly reviews by exception and quarterly reviews. (IA)					
			Prioritisation of cash payments and cash forecast. (IC)	Finance report which includes a section on cash forecast, debt and liquidity to Finance and Business Performance Committee and Board. (IA)					
BAF 4.1c	There is a risk that if we spend more than £10.5m on agency costs that this will impact on financial targets and will impact on NHSI segmentation *Board Committee with oversight: Finance and Business Performance Committee*	20	Escalated sign off by Senior Managers for all agency spend. (IC) Week-end agency signed off by Gold command. (IC) Monthly meetings reviewing agency usage for specific staff groups against agreed targets for the year. Remedial action taken as necessary. (IC)	Weekly reported nurse / doctor agency spend. (IA) Divisional targets monitored through deep dives. (IA) Performance trajectory and monthly targets in place for specific staff groups. (IA) Exception report on agency spend to Improving Performance Group monthly (IA)	Amber	the key drivers of temporary staff are vacancies and sickness absence.	12 (4x3)	Recruitment plan in place to address each area. Actions that will be completed by March 2020 include: *Students final placements to areas that they have expressed an interest in working in *Offer letters sent in year 2 *Close support for students and line managers by recruitment and education teams through preceptorship programme. . *Robust overseas recruitment plan in place. For sickness absence: Health summits focussing on hotspot areas – March 2020 Flu vaccine roll-out from 1 October to end February 2020 Wellbeing team re launching "mental health for managers" training – December 2019 Roll out of "Mental Health First Aid" bite size training to staff – January 2020 Wellbeing manager recruited; starts at the Trust in November 20	Director of Workforce and Organisational Development
			All requests for admin/ clerical agency is signed off by the Director of Finance or the Director of Human Resources as part of the vacancy control panel (IC)	Reconciliation of agency ledger to request process confirmed monthly. (IA) Weekly review by vacancy panel. (IA)					
			Process for booking and managing locum doctors is in-house, with senior sign off. (IC)	Monthly reporting of agency spend provides an indication of how effective this change has been. (IA) Medical agency spend reviewed by Medical Director and Director of workforce & OD on a weekly basis. (IA)					
			National Guidelines on bank and agency usage (EC)	Weekly report on non-compliance to NHS Improvement. (EA)					
			Clear process for booking agency and agency usage policy. (IC)	Weekly reporting internally and to NHS Improvement. (IA)					

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

Reference	Description of risk to achieving objective	Risk score unmitigated by controls	Key controls	Assurance on controls	Assurance RAG	Gaps in controls or assurance	Current Risk Rating (mitigated by controls)	Action to address gap	Lead
4.3 Deliver our capital plan Key Focus: Manage and mitigate risks in capital backlog									
BAF 4.3a (Link to CRR 27, CRR 60, 73 and 79)	There is a risk that we will not deliver the capital programme in the most effective way, or deliver the Capital Resource Limit if the programme is not managed effectively. (Monitored through Finance and Business Performance Committee, F&BP)	**20**	Governance structures: Estates CMG; IT CMG; Medical Equipment CMG; CMG. (IC) Risk assessed prioritisation of schemes. (IC) Prioritised IT and medical equipment replacement strategy developed to inform 5 year capital plan. (IC)	Meeting minutes for CMG (IA) Monthly monitoring of capital programme through Capital Management Group and F&BP (IA) Deferral risk assessment and reported to Capital Management Group, Executive Management Committee and Finance and Business Performance Committee. (IA)	**Amber**	The monitoring of tendering, procurement and contracts needs to be strengthened to provide greater assurance. Assurance around post project reviews to be developed.	**20 (5x4)**	Emergency capital bid and top 4 submitted this week; other capital tasks delivering to programme. 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 19/20 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)**	Emergency capital submission made to NHSIE. Prioritise capital list submitted for year end capital	Director of Finance
HORIZON SCANNING									
BAF 5	There is uncertainty about the potential impact of Brexit on the Trust's ability to deliver objectives in the coming year.	25	Close attention to direction from the Department of Health and Social Care with regard to any actions to minimise risk. (IC)	Supportive advice around the status of employees from the European Union in 2019/20. (EA)Weekly EU Exit group established with expert support from key areas such as procurement, workforce and information.	**Red**	The situation is uncertain.	**10 (5x2)**	Acknowledgement of the risk. Reactivate planning process for no deal Brexit. Implementation of guidance from DH. Ensure all business continuity plans are up to date.	Chief Executive Officer

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

Safe & compassionate care, every time

NHS
Buckinghamshire Healthcare
NHS Trust

Meeting: Trust Board Meeting in Public

27 November 2019

Agenda item	Corporate Risk Register (CRR)
Board Lead	Sue Manthorpe
Type name of author	Sue Manthorpe
Attachments	Corporate Risk Register
Purpose	Assurance
Previously considered	EMC, Audit Committee

Executive Summary

1. Purpose

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

Decision	The Board is requested to note the new risks to the CRR and the updated actions

Relevant strategic priority

Quality ☒	**People** ☒	**Money** ☒

Implications / Impact

Patient Safety	Identifies any potential patient safety concerns
Risk: link to Board Assurance Framework (BAF)/Risk Register	Risks articulated in the CRR
Financial	Risks articulated in the CRR
Compliance Select an item. **Good Governance**	Risks articulated in the CRR
Partnership: consultation / communication	Consultation and Communication identified in updated actions
Equality	Identified in the CRR
Quality Impact Assessment [QIA] completion required?	Not Applicable

Purpose

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

Background

The CRR has been reviewed at Divisional level and Executive Management level. Many of the actions to mitigate the risks are continuing and there has not been any reportable change to their current assessment level. These are therefore not highlighted in the report.

2. Updated Risks

The following risks have changed risk score levels:

CRR79 – Score increased 16-20. Target date revised from 31/10/2019 to 29/02/2020. Residual Score updated to 5

The following risks have been updated with no change to current risk scores:

CRR113; CRR27b; CRR108;

The following risks have additional actions completed to manage the risks; risk score remains the same at present:

CRR100 - The original EU Exit date was 31/10/2019 and is now expected 31/03/2020

CRR102 – the actions have been updated and the target completion date has been changed to 01/09/2020

CRR111 – the actions have been updated and a Business Case has been submitted to CMG 13/11/2019 CRR112 – the actions have been updated and a Business Case has been submitted to CMG 13/11/2019

CRR106 – the actions have been updated and the target completion date amended from 31/10/2019 to 30/11/2019

2. Risks to be removed from the CRR following improved mitigations

CRR53; risk score has been reduced from 16 to 12

CRR81 – Risk Score reduced from 16 to 12.

CRR 87 - Risk Score reduced from 16 to 8

CRR91 – the actions have been updated and the risk Updated actions, score reduced from

16 to 9, target completion date moved forward from 31/10/2020 to 28/02/2020

CRR94 – risk score reduced from 16 to 12

3. New risks to be added to the CRR

CRR115 – New risk added regarding medical gas infrastructure at Stoke Mandeville Hospital & Wycombe Hospital. Existing piped medical gas infrastructure is not compliant with current HTM & HBN resilience requirements. The risk score is 20.

CRR116 – New risk added the current DATIX system as the system can no longer be sustained or supported in the long term by the suppliers this version support is now time limited. The risk score is 16

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)	• Performance management of Recruitment Service - HR & Workforce Group. • Performance management of Divisions and Corporate Services • Performance management of NHSP to ensure quality of temporary staff and high proportion of bank rather than agency staff. • Daily safe staffing huddles. • Weekly safe staffing meeting to identify and review hot spots. • Monthly vacancy heat map by cost centre. • Weekly review by Executive Management Committee. • Detailed recruitment plan. • Active retention strategy (recognised nationally). • Monitored through Strategic Workforce Committee.	5	4	20	• National shortage of registered nurses. • Drop in numbers recruiting to nurse degree programmes. • Delays in conversion of overseas recruits due to the requirements of the IELT and the time it takes to register with the NMC.	• Trust-wide recruitment plans in place - this includes, local, national and international recruitment of nurses • Longer term plans: expansion of partner universities . • 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)	• Electrical installations are checked in accordance with the Electricity at Work regulations. • Regular maintenance checks. • BHT approved extension leads are the only ones in use. • Full infrastructure report completed and used to advise the business case relating to remedial work on electrics. • Monthly safety rounds with Property services and theatre manager. • Daily checks by matrons/Lead ODP to ensure that fire exits are clear. • Divisional Director leading the steering group as SRO for capital works to ensure that the risk to activity is minimised and to ensure clinical involvement.	4	4	16	• £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.	The Estates ten year strategy has been approved by the Board. • The High V voltage works have to he 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	• The requirement to contract increased electricity capacity to safeguard supply. • A requirement to replace the UKPN outdated switchboard with dual Ring Main supply units. • A requirement to replace the outdated Hospital HV intake switchboard from single switch and supply to dual switch board options and supply.	• The risk will be reduced by increasing our contractual arrangement with UKPN to supply increased capacity; a business case is being developed to meet this requirement. • A feasibility study is underway to develop an options appraisal based on the upgrade of contract arrangements for the supply of Electricity from 1500KVA to 3000KVA. • Replacement of UKPN HV intake switch gear and Hospital HV intake switch gear including the provision of dual switching capabilities. • The development of Electricity dual supply options. UKPN and the Trust are engaging the wayleaves to allow the 11KVA cable to be run The 1.25MW generators are being procured from St Georges Hospital to give resilience to the site The transformers and concrete pads are being designed to be built by end financial year The theatre lighting program will start and deliver by end financial year The HV switch in Tower 69B will be stripped of asbestos as will the entire tower to allow normal working access and the HV/LV connectivity to be developed	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)	• 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	• Delay in Cost Improvement Programme delivery. • Detailed financial recovery plan required.	• Continued weekly focus on financial delivery, including CIPs and controls on temporary staff spend. • Focus on key milestones to ensure CIP delivery. • Interim support to finance recovery plan.	31/03/2020	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)	• 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	• Operational pressures and delay in CIP delivery, mean I&E is not delivered. • Contractual and other challenges mean that receivables are delayed. • Receipts for asset sales are not delivered.	• Working capital loan application. • NHSI engagement on liquidity and 2019/20 planning round. • Estates disposal strategy.	31/03/2020	Director of Finance			15
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)	• 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	• 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.	• The monitoring of compliance is with every SDU, going through to the relevant Divisional Board. • Resolution of the outstanding IT issues will be dependent on funding. • Clarification regarding ICE/Winpath locations. Action: ICE project teamare 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.	31/03/2020	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 retinal speciality the most affected. This has resulted in compromised patient outcomes.	20 (5x4)	• Booking standards in place and monitored through key performance indicators. • Provision of One - Stop Acute Macular Degeneration (AMD) clinic in Amersham. • AMD patient tracking system in place which includes a weekly review. • Weekly access meetings with daily reporting in place. • Clear patient guidance for appointment schedule. • Additional Fellows in place. • Mobile answer-machine for the AMD coordinator. • All letters have this telephone number on so that patients/GP's will have a direct point of access. • Daily safety huddles introduced at the beginning and the end of all One Stop clinics. • Medisight Steering group, chaired by the Divisional Director for Surgery, meeting fortnightly to ensure robust project oversight. • Recruitment of a retinal failsafe co-ordinator in 18/19 to ensure that clinics are managed and patients who DNA are followed up. • Two additional retinal consultants appointed in December 2018. • Identified backlog of retinal patients (718) were clinically reviewed in December 2018, and the 200 identified as 'high risk' have been seen in clinic. Completed by 14 February 2019. No serious harm identified.	5	3	15	• 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.	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. Review of Ophthalmology booking processes to reduce appointment cancellations.	31/12/2020	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)	• Ensuring staffing is in place in accordance with agreed levels. • Daily breach meetings with cross divisional input held to understand cause of breaches and actions required. • Escalation protocol in place with support out of hours from on-call managers. • Issues of flow and bed capacity managed internally and with partners. • GP streaming in place. • System wide weekly escalation meeting in Place. • Length of Stay initiatives. • Winter System Winter Director.	5	4	20	• 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.	Implementation of urgent care transformation: ENPs working to full scope of role Delivery of the national 7 pillars of care (urgent care). Escalation areas opened. Including new medical team. EAPMG - supports & monitors. Working group to be set-up to address, manage and monitor minors and type 1 breaches.	31/07/2020	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)	• 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.	3	4	12	Clinical risk to patients whose treatment might be delayed as a result of capacity	*Service manager in post, *D+C modelling to be repeated following successful recruitment to the team (x2 psychologists and x2 paediatricians), *EHCP referral project underway looking at efficiencies and reduction in inappropriate referrals and waiting list interrogation underway to better understand the current pathways	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)	• Defined list of information deliverables for Information Department. • Encourage staff requiring information to use self-service wherever possible through Qlikview.	4	5	20	Comprehensive and complete Data Warehouse and BI Solution.	• Review tools to be used to access information. • Build dashboards etc. required by the Trust internally so as not to exacerbate the situation. • Implemented CareCentric and Population health databases first as part of the overall ICS solution. • 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.	30/3/2020	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)	• 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 (Caldecott 3/CQC requirements moving forward). • Anti-Ransomware software in place (heuristic monitoring of devices).	5	4	20	Cyber Security strategy not yet in place.	NHS digital pilot cyber security programme supporting the Trust with detailed risk assessment.	31/03/2020	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 telephoney due to age of equipment at SMH, Wycombe and Amersham. Risk also includes bleep system and switchboard.	25	• IT and Estates currently running regular Resilience meetings to address risks and look at mitigating strategies. • Disaster recovery plan on contract looks to provide a back up of 50 set lines within 24hrs. • Utilisation of 2-way radio devices and/or mobiles. • Work underway with Sodexo/Unify to carry out repairs to SMH main switch required to reactivate failover equipment. This requires several hours downtime, Sodexo in discussion with senior management to arrange a convenient time to do this. • Ongoing monitoring of the systems. Parts specialist external support via support contracts in place. • Network/Telephony replacement programme will address the replacement of the telephony and bleep systems. Red emergency phones available across wards.	5	4	20	• 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 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.	• 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.	31/12/2020	Director of Strategy and Business Development			15
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 i.e. 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)	BHT recovery and sustainability plan submitted to NHSE. Plan is monitored though: weekly Patient Tracking List (PTL) meetings; weekly Access Performance Management Group (APMG) meetings; weekly performance escalation meetings chaired by the Chief Operating Officer; recruitment of additional consultants/Fellows in ophthalmology/Plastics; training programme established for IFR funding process and adherence to CCG criteria; additional Waiting List Initiatives to manage demand; outsourcing completed of additional 200 cataracts to the private sector; full demand and capacity review of all specialities underway.	4	4	16	• Outpatient Clinic capacity does not currently meet demand. • Inability to recruit to nursing and medical vacancies in theatres and ophthalmology. • Rise in demand for ophthalmology and orthopaedic procedures. • NHSE expectation to reduce elective operating in times of pressure in the system.	• Moving almost all elective in patient activity to WH - except gynae and some orthopaedic spinal and increasing the amount of day case surgery to reduce cancellations due to operational pressures on the SMH site. • Data quality request submitted to NHS Improvement. 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 MDD93/42/EEC. The faults are now occurring on a daily basis, is expensive to keep resolving and needs a system upgrade to resolve on a long term basis. If the current system cannot be rectified prior to an upgrade we would have to outsource sterilisation of theatre equipment with a cost, time and efficiency implication.	20	IT removal of infrastructure completed 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 completed	4	4	16	Temporary reliance on one aging single CSSD site at Wycombe whilst new site is being built - Business continuity plans in place and up to date	Estates team to lead on review of the storage of all records stored in the SMH CSSD building and allocate alternative storage areas March 2020 CSSD staff working 24/6 to ensure adequate provision of service Business Continuity plans in place for the event of the WH site failure. Expected completion date March 2020 Asbestos removal to begin following HSE submission	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)	• 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 purpose	• Bucks IT review includes assessment of infrastructure issues. • Cost estimates provided and to be build in to 19/20 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.	31/03/2020	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 diverted to Care UK resulting in lost income.	20 (4x5)	• Constant review of image quality. • Patients redirected to SMH or outside providers as necessary. • Business continuity plans in place based on individual clinician judgement and how long the scanner is likely to be down. *Mobile Scanner in place	5	4	20	24/10/19- There is limited access to the mobile MRI scanner which means that ITU patients are unable to be scanned. Provisional plans in place to mitigate this.	24/09/2019- Mobile MRI has arrived and applications testing commenced on 23/09/2019. old MRI to be removed and building begins in Oct 2019. Provisional completion Feb 2020	29/02/2020	Chief Operating Officer			5
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 B15/S/a (Cancer: Chemotherapy (Adult) per month (approx. £25000 per month) until full implementation is achieved).	16 (4x4)	• Intrathecal chemotherapy to being retrospectively prescribe on ARIA by a Haematology consultant. Allows compliance with SACT data requirements as an interim measure. • New IT solution in place that includes the ability to transfer Urology prescribing data to Aria helping to meet SACT requirements. System in place from April 2018.	4	3	12	Implementation delayed.	Confirmed by Macmillan Consultant Nurse for Cancer (18/9/2019) that urology service are now using Aria to prescribe and dispense intravesical chemotherapy.	ARCHIVED	Chief Operating Officer			4
CRR 83	Finance	Trust	22/09/2017	Corporate services transformation	There is a risk that payroll processes are not sufficiently robust.	25 (5x5)	• Quality assurance by Payroll department to reduce risk of errors. • Trust process reminders sent out to all staff. • Contractual review to determine legal options.	5	3	15	Additional payroll resource to be recruited.	• Payroll transformation project under development to include process automation. • Serious Incident investigation and lessons learnt implemented. Monitoring of payroll process in place.	31/12/2019	Director of Finance			5
CRR 85		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	• 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	National shortage of doctors from key groups. Internal audit has identified the need for more central oversight of leave management. There are identified gaps in rotas in medicine.	• 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. • Develop policy for leave management including central oversight. • Move to electronic rostering system in medicine. • Continued development of new roles to support medical rotas e.g. associate physicians, extended nurse practitioners. (Divisional Chair and Director, Integrated Medicine.)	30/03/2020	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)	• RiO diaries to show where visits are planned. • Ipads so visits can be monitored during the day. • If RiO is down staff will follow business continuity plan. • Buddy system phone in place. • Risk assessments for patients/ areas with known risks with specific actions, e.g. double handed visits, ringing in back to office. • Mobile phones and contact lists for colleagues. • Safe phrase. • Conflict resolution training. • Processes explained to staff as part of induction. • Staff are empowered to risk assess on each visit and to leave if they feel they should. • Monitoring DATIX incidents and working in collaboration with safeguarding.	4	4	8	Poor assurance that controls are being followed. Not all staff use RIO so the local procedures need to be very clear and managed thoroughly. The staff use "diaries" and move meetings regularly. The Management of visits is sporadic and a central control system needs to be implemented. We do not know where staff are as they are not tracked by GPS or other means. The contact of staff is not centrally managed with check calls.	• Introduction of lone working devices for identified staff ordered. • All staff to have access to GPS function through IT for IPADs. • Reinforce use of buddy system and responsibilities of buddy pairs. • Explore practicalities of using Alert on RiO and Total Mobile and explore how best to communicate between teams. • Reinforce to staff to notify number changes. • Timely divisional sign off required Reinforce to staff to call 999 if required even if no reception it is still possible. • Share safe phrase with teams, share escalation procedures with teams, Use of 999 and 55 if indicated; update escalation chart. • Request more sessions so the Trust can put on more sessions; empower staff to make attendance a priority. • Standardised induction pack. • Reinforce employees responsibilities for their own health and safety. • Continue to support as managers. • Plan for allocate roster system to be enabled to track staff visits effectively. • 1000 Sky Guard devices now purchased • 653 devices issued to lone workers • 810 user accounts set up • 870 staff now trained Risk rating reduced from 16 to 8 and to come off the CRR but remain on PS Divisional RR	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)	IT reviewing process and considering alternatives to enable the repeated movement of patients to be clearly visible so they can be monitored and reviewed. Outpatient review group. Compulsory follow up date to be in Medway. Working through On Hold lists for each SDU. Insufficient capacity in Outpatients for several SDUs. Risk to achieving RTT performance and clinical risk due to delays in seeing follow ups.	5	4	20	• '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.	• Validation of outpatient records in an 'on hold' state. • 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.	31/05/2020	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 failing on a regular basis and this is affecting the dental clinics and patients and resulting in delays. Sourcing parts for these units is difficult due to their age and they are all obsolete.	20 (4x5)	If X-ray down, extra appointment made for patients at another site of another day Business case to replace the three units has been written.	3	3	9	• 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.	Severity reduced to 3 as access of dental x-ray are still available but at Amersham only. Completion date on schedule Jan 2020	28/02/2020	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)	• 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	3	12	Lack of capacity to deliver HCP and reduced delivery of screening services.	New safeguarding referral process in place. Project manager in place to support transformation Monthly project board to oversee and monitor service .Plan for transformed service delivery to be circulated - commence revised service from next academic year.	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	• 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	• 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.	Recognition that new Endoscopy unit required, business case under development, strategy to be revisited for a final solution. Fund strategy being established, exploring various options Working through versions of business case Work being undertaken on waiting room Exploring outsourcing decontamination Independent review undertaken re: JAG requirements 7 day working business case being explored	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. • Paediatrics – rewording / adaption to current paperwork. • A&E – Adaptions being made to current booklet. Stickers to be provided to the department to add to current booklet in the meantime. • Theatres to re-instate posters in recovery area.	31/12/2019	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. • 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.	31/03/2021 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 Weekly EU Exit group established with expert support from key areas such as procurement, workforce and information	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. • All business continuity plans are up to date.	31/02/2020	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 JM 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.	CR Workshops planned to design pathways and ways of working. Recruitment is ongoing. Project board continues to meet monthly. Still in early stages of redesign.	01/09/2020	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-speciality.	• Working with the Thames Valley Cancer Alliance to ensure compliance across the network. • 62 Day Cancer Target being monitored	31/03/2020	Chief Operating Officer			8
CRR106	Path 57,58,59	Specialist Services	10/09/2019		Cervical Screening Service being moved to BSPS as of Nov/Dec. Staff to TUPE out of Trust. Loss of cytology staff means lack of full resource for diagnostic services and cancer services. Cervical screening not meeting TAT target due to increase workload from the impact of increasing demand from PHE awareness campaign	20	staff performing increased overtime . Out sourcing being investigated. Retention of staff options	3	5	15	Budget lost with cervical screening service move. Seek staff retention where possible. Increased resources being used to cover MLA work. Outsourcing being investigated for backlog	Plan to retain qualified staff and services for the Trust approved and staff recruited into posts - Risks PATH57 and PATH 59 achieved PATH58: There is still a backlog however samples no longer to be sent away. Continue to process/screen samples	30/11/2019	Chief Operating Officer			4
CRR107		Integrated Medicine	10/09/2019		Inadequate storage and tracking of medical records	20	Records stored in date order. Notes scanned where possible	4	4	16	Lack of robust process for storage, tracking and archiving of records including A&E records. Storage does not meet GDPR requirements	Appropriate environment now under review. Record scanning to be costed. Review eOBs as a possible paperless option. Currently reviewing A&E service going paperless. ED now using enotes on Medway system	30/03/2020	Chief Operating Officer			4

CRR 108	PS161	Property Services	10/09/2019		Three plant rooms at Stoke Mandeville require Asbestos Removal .	20	The Trust have appointed following a procurement led process a HSE approved asbestos specialist company to manage the safety of asbestos within the Trust and to manage the surveys, access to asbestos areas, control of contractors, management of safety, on call 24/;7/365 specialist teams to enter the plant rooms under controlled conditions in the event of plant failure and the management of the removal of asbestos. Access to all plant rooms containing asbestos is controlled by the asbestos management company and safety is the primary driver for all works, inspections and management of the process. The asbestos company also act as the Trust AE for asbestos.	5	3	15	We have a comprehensive and safe plan in place to manage the situation	The Trust have appointed following a procurement led process a HSE approved asbestos specialist company to manage the safety of asbestos within the Trust and to manage the surveys, access to asbestos areas, control of contractors, management of safety, on call 24/;7/365 specialist teams to enter the plant rooms under controlled conditions in the event of plant failure and the management of the removal of asbestos. Access to all plant rooms containing asbestos is controlled by the asbestos management company and safety is the primary driver for all works, inspections and management of the process. The asbestos company also act as the Trust AE for asbestos. The energy centre has been stripped of asbestos. The Plan for Tower 69A has been procured and works will start in December 2019 taking about 12 weeks to complete. The design for the Tower 69B is well in development and the clearing of the 2nd floor of the tower has been procured. Works will start in November 2019. This tower 69B is critical to clear of asbestos in order for the theatre air supply for lamina flow to be restored to theatre 5 and for the maintenance and PPM to be conducted on the air handling plan, the chillers, the medical gas manifolds and the HV/LV such gear, all of which are critical for patient safety in the hospital.	30/03/2020	Commercial Director			5
CRR 109	IM146		10/09/2019		Dermatology have identified a lack of capacity for surgical, new and cancer patients - since added we have had more doctors leave and have discussed temporarily suspending service to new referrals	20	Daily scrutiny of patient lists. Options to provided different treatment pathways	4	5	20	Not replacing staff who have left. Patient numbers have increased.	Monitoring of patient pathways. Exploring referrals process with GPs review of patients on the waiting lists	31/03/2020	Chief Operating Officer			16
CRR110	(IT044)	Information Technology	17/10/2019	Improving Communication Value for Money Quality/People	Internet Link between Trust Sites - One internet link of 1GB linking all sites. Single point of failure with no backup If link fails key systems (Medway, Order Comms/ICE, Pathology) will be unavailable.	20	Manual monitoring of the links and usage.	5	4	20	Manual monitoring identifies that usage is going up and the current provision of 1GB is insufficient and users experience slowness when accessing and updating systems. If the link were to go down the outage could be extensive and mean access to systems unavailable for a number of days. Business Continuity Plans within Divisions need to address how they would operate if there were no links between the sites	Upgrade the existing links to 100 GB (paired down to 10GB) and put in place secondary line as fallback of 1GB in the event of outage. On-going revenue cost of new services and one off costs for new hardware. Options to look at joint arrangements with Councils and the provisioning of links to reduce costs and increase resilience. Procure a secondary internet line along with associated hardware (2019-20 financial year).	31/03/2020	Director of Strategy and Business Development			20
CRR111	(IT122)	Information Technology	17/10/2019	Improving Communication Value for Money Quality/People	SMH Upper Data Centre Air Con broken - Can damage the server and network hardware in the room.	20	monitoring equipment equipment supported	4	5	20	Replacement cost £35k (Est) equipment functioning well below optimum so may have a detrimental effect of server and network equipment which have heat intolerance if air cons fails it will damage server and network equipment which will shut down if temperature too high	Funding identified in Trust Capital plan. Business case in progress - going to CMG	31/03/2020	Director of Strategy and Business Development			16

CRR112	IT218	Information Technology	17/10/2019	Improving communication. Focus on Estates and Technology Quality/Money/People	Datacentre UPS fault tolerance SMH and WH. There is no resilience within the Trust datacentres so if a UPS fails there is a risk of loss of services. There is a need to provide fail over UPS to mitigate the risk.	25	None	5	5	25	None	Funding bid in progress. Business case to CMG 13/11/2019	31/03/2020	Director of Strategy and Business Development	5	1	5
CRR113	(IT121)	Information Technology	17/10/2019	Focus on Estates and Technology Value for Money	Unsupported Software - Windows SQL Server 2008: Windows SQL Server 2008 goes end of support Jan 2020, from that point no new bug fixes or cybersecurity patches/updates will be available from Microsoft, increasing vulnerability to cyberattack. More than half of trust servers will be unsupported from Jan 2020.	25	Antimalware software acts as a first line of defence to prevent some forms of cyberattack.	5	5	25	Antimalware software can only provide partial protection. Without security patches from Microsoft, our vulnerability to cyberattack will increase.	Purchase new SQL Server licences from Microsoft and re-architect SQL infrastructure based on a smaller number of more powerful, highly available servers. This would consolidate existing systems to provide greater reliability and licence cost savings. Requires financing, business case being prepared. The discover and design phase is almost complete to establish the licenses requirement and most effective way to replace them	31/03/2020	Director of Strategy and Business Development			25
CRR114	S230	Surgery	12/11/2019	Focus on Estates and Technology Value for Money	There is a risk to the ability to provide an emergency orthopaedic trauma service at Stoke Mandeville Hospital due to the loss of one (out of two) laminar flow theatres.	25	Established daily cross site safety huddles with key stakeholders Monthly electrical safety walkarounds in place with theatre leads and estates	5	4	20	Temporary reliance on only one laminar flow theatre on the Stoke Mandeville Site	Forward planning the theatre scheduling meeting to ensure minimal loss of activity Working closely with the Estate team - pending delivery of new engines that drive the laminar flow canopy(expected date of delivery c February 2020) Business Continuity Plans in place to mitigate current risk and potential loss of the second laminar flow theatre Application to NHSE/I for emergency capital funding to support the repair works required	28/02/2020	Chief Operating Officer			8
CRR115	PS118	Property Services	12/11/2019	Focus on Estates and Technology Value for Money	Stoke Mandeville Hospital & Wycombe Hospital. Existing piped medical gas infrastructure is not compliant with current HTM & HBN resilience requirements. Identified that the medical gas infrastructure is severely compromised due to there being no available backup systems for compressed air and oxygen.		• Affected areas identified • Staff awareness • EBME equipment servicing • Quarterly PPM on MGPS • Portable gas available • Portable suction available	5	4	20	Not compliant with current standards	Immediate works being commissioned to mitigate the highest risk areas with a programme to address all other areas of failure simultaneously. The detailed survey by BOC has raised 1736 items of concern that need addressing. The Trust technical team and the BOC team have managed this into categories of risk and the cost of repairing significant risk is £700,000. these are being prioritised and a plan is being developed with the Capital Management Group to address these urgent issues. Further funding has been allocated to install a backfill loop and to conduct immediate repairs to the system and these works will commence in the FY 2019/20. The works to improve flow in the ICU have been completed and the flow of medical gasses has improved and the new ventilators are now being installed with the correct flow rate. A detailed plan of actions is being developed through the medical gas committee with joint ownership from Pharmacy and Property Services working in partnership with our specialist providers and the AE/AP structure to manage the safety of this very old and complex system. A presentation to the EMC will be prepared for December to allow EMC to decide the actions to be completed and in which order.	30/11/2020	Commercial Director			5

CRR116		Trust	12/11/2019	continue to improve our culture	There is a risk that Business Continuity will be impacted unexpectedly as the current version of Datix cannot be sustained or supported in the long term by the suppliers so the version is time limited. There are multiple scenarios for possible failures with this version. There is a risk that Patient Safety will be compromised through modules in Datix not optimised in interfaces, codes incompatible with national systems, inability to comprehensively benchmark, and an inability to identify risks at the earliest possible stage. There is a risk the Trust will not be able to report incidents in a timely manner due to the poor performance and incapability of the system against national requirements. There is a risk staff will disengage with the reporting and management of incidents processes	20	Monitoring and vigilance and Workarounds Regular meetings and checks within the Patient Safety Team	4	4	16	Financial constraints affect the Trusts ability to purchase a new system. System performance discourages staff from reporting and managing incidents in a timely manner. The Trust ability to learn from incidents is affected due to the difficulty in obtaining information in a clear and timely manner. Datix cannot provide standard technical back room support, and workarounds on the system to support functions may introduce some unintended or unknown risk into the system.	The patient safety team monitor the system on a regular basis. Reminders sent to staff and managers to respond and manage the incident process.	30/05/2020	Director for Governance	2	1	3

Safe & compassionate care, every time

NHS
Buckinghamshire Healthcare
NHS Trust

Meeting: Trust Board Meeting in Public

27 November 2019

Agenda item	Risk Management Policy
Board Lead	Sue Manthorpe
Type name of author	Sue Manthorpe
Attachments	Risk Management Policy
Purpose	Assurance
Previously considered	TPSG; EMC; Audit Committee

Executive Summary

The Board is asked to note the changes to the Risk management Policy.

An annual review was carried out to bring the Policy up-to-date with organisational changes and the outcome actions from an internal Audit assessment. Areas changed are the presentation of the divisional risk registers annually at the committee and updated appendices.

Decision	The Board is asked to note the changes to the Risk management Policy and Strategy

Relevant strategic priority

Quality ☒	**People** ☒	**Money** ☒

Implications / Impact

Patient Safety	Identifies the management of risk in relation to any potential patient safety concerns
Risk: link to Board Assurance Framework (BAF)/Risk Register	Explains the process of risk management
Financial	Identifies the management of risk in relation to any potential financial concerns
Compliance Select an item. **Good Governance**	Meets all regulatory requirements
Partnership: consultation / communication	Consultation and Communication identified and in line with trust process on policy management
Equality	No adverse impact
Quality Impact Assessment [QIA] completion required?	Completed

Safe & compassionate care, every time

NHS Buckinghamshire Healthcare NHS Trust

Once printed off, this is an uncontrolled document. Please check the intranet for the most up to date copy.

RISK MANAGEMENT POLICY

Version 5.4

Version:	**5**
Issue:	**4**
Consultation:	Executive Management Committee; Audit Committee
Date:	
Approval by:	Trust Board
Date approved:	
Author:	Sue Manthorpe, Director for Governance
Lead Director:	Neil Macdonald, Chief Executive Officer
Name of responsible committee/individual:	Trust Board
Document reference:	**BHT Pol 079**
Date issued:	
Review date:	October 2020
Target audience:	All Trust staff
Equality Impact Assessment	Consistency Panel approved 24/03/09 Review July 11 Review October 2014
Location:	
	Swan Live Intranet/ Policies and Guidelines/Policies and Strategies/ Corporate/Quality & Safety

Document History

Risk Management Policy - BHT Pol 079

Version	Issue	Reason for change	Authorising body	Date
1		Author: John Hilton New Policy		
2		Authors: Elizabeth Hollman, Patient Safety Manager, Dorothea Reid, Associate Director of Governance, Mary Klaus & Sarah Langan-Hart		
2	**1**	Amendment to Version 2 to update the policy to reflect the changes in the organisation.	Governance Committee	October 2007
3		Authors: Elizabeth Hollman, Associate Director Healthcare Governance, Mary Klaus & Sarah Langan-Hart	Executive Management Healthcare Governance Committee	17.04.09 12.05.09
3	**1**	Authors: Elizabeth Hollman, Associate Director Healthcare Governance & Catherine Brown, Board Assurance Facilitator	Re-issued	30.07.10
3	**2**	Minor amendments to Trust name and Logo. Board Assurance Administrator	Re-issued	18.03.11
4		Full review. Elizabeth Hollman, Associate Director Healthcare Governance & Catherine Brown, Board Assurance Facilitator	Risk Monitoring Group	26.06.11
			Healthcare Governance Committee	12.07.11
			Trust Board	05.10.11
			Issued	24.05.11
4	**1**	Version 4 updated to reflect changes agreed by the Audit Committee in March 2012, and in the light of feedback from the NHS Litigation Authority. These changes constitute amendments to these versions rather than entirely new versions.	**Trust Board**	**30.05.12**
4	**2**	Formal Review	Audit Committee	**16.05.13**
			Risk Monitoring Group	**17.03.13**
			Healthcare Governance Committee	**07.05.13**
			Trust Board	**29.05.13**
5	0	Full Review	Trust Board	**November 2014**
5	1	Update to reflect organisational changes	Trust Board	
5	2	Annual Review	Trust Board	**May 2017**

5	3	Annual Review	Trust Board	**September 2018**
5	4	Annual Review and update to reflect internal audit review recommendations	Trust Board	**November 2019**

Associated documents

BHT Ref	Title	Location/Link
BHT S012	**Risk Management Strategy**	Swan Live Intranet/ Policies and Guidelines/ Policies and Strategies/ Corporate/Quality & Safety

Contents

INTRODUCTION

The Trust is required (by statute and Department of Health and Social Care guidance) to systematically identify and control all significant strategic and operational risks. These arise across the organisation and include clinical services and corporate services. The Board is required to ensure that robust systems exist and be assured that there are systems in place to control and reduce risk.

This involves both the proactive identification and management of principal risks that may threaten the achievement of Trust objectives and the response to adverse events or learning from audits.

The purpose of the Risk Management Policy is to set out the process for achieving the Risk Management Strategy. The Risk Management Strategy sets out the overall plan and direction for Risk Management in the Trust.

This policy describes the mechanisms and responsibilities for:

- Identifying risk
- Assessing and evaluating risk in a consistent manner using the Trust's Risk Assessment Tool (RAT)
- Controlling risk
- Recording risk within the Trust's risk documents – namely the Board Assurance Framework, Corporate Risk Register and Divisional Risk Registers.

Definitions

Acceptable / Tolerable Risk	Tolerability is a willingness to live with risk to secure certain benefits but with the confidence that it is being properly controlled. To tolerate risk does not mean to disregard it, but rather that it is reviewed with the aim of reducing further risk. This may also be referred to as 'risk appetite'. It is a fundamental principle that no person should be exposed to serious risk unless they agree to accept the risk. It is reasonable to accept a risk that under normal circumstances would be unacceptable if the risk of all other alternatives, including doing nothing, is even greater.
Adverse Event	Any event or circumstance leading to unintentional harm or suffering.
Co-employer	Another employing organisation which has links with the Trust (e.g. Sodexo, Medirest, Clinical Commissioning Groups, South Central Ambulance Foundation Trust, Oxford Health NHS Foundation Trust etc.)
Control	A procedure or arrangement that is implemented to prevent a risk, reduce the potential impact of such a risk, or detect a failure of internal or external control when it happens.
External	Refers to activities or documents which do not originate in the Trust
Internal	Refers to activities or documents within the Trust.
Patient Safety Incident	Any unintended or unexpected incident which could have harmed or did lead to harm for one or more patients receiving healthcare. It is a specific type of adverse event.
Residual Risk	The lowest possible level of risk remaining after reasonable control measures / actions have been implemented.
Risk	A risk is the chance of something happening that will have an adverse impact on the achievement of the Trust's objectives and the delivery of high quality patient care. It comprises a combination of adverse consequence and likelihood.
Risk Assessment	Identification of significant hazards which arise out of Trust activities and a judgement of the likelihood and severity of harm which might occur as a result of exposure to the hazard.
Risk Assessment Training	Training delivered either by the Healthcare Governance Team or by the Director for Governance.
Risk Assessor	Member of staff (manager or other) who has received risk assessment

	training.
Risk Management	Risk Management is the proactive identification, classification, communication and control of risks to which the Trust is exposed through its day to day activities and through pressures from external sources.
Risk Moderation	This is a mechanism whereby a designated group reviews risks recorded on a risk register and takes a view as to whether the risk has been scored at the right level and scored consistently when compared with other risks. The group can make the decision to adjust the risk score on the basis of the review.
Senior Manager	Someone who plays a significant role in making decisions regarding the management of the whole or a significant part of the organisation's activities and those who carry out those activities. This includes, but is not limited to, all managers who report to a Director.
Trust	Buckinghamshire Healthcare NHS Trust

SECTION ONE: OPERATIONAL RISK MANAGEMENT

THE CORPORATE RISK REGISTER

1. Identification and Control of Operational Risks

1.1. Identifying Potential Risks

Potential risks can be identified from a variety of sources for example:

- Internally generated information such as departmental meetings, internal audits, external audits, clinical audits, incidents reports, complaints, claims
- Externally generated information such as guidance from the Department of Health, the Care Quality Commission, the Health and Safety Executive and the Royal Colleges
- External inspections

Senior Managers should note that they have a duty within their areas of responsibility to:

- Identify risk
- Assess risk
- Establish risk management processes within their areas of responsibility, including actions plans to mitigate and monitor risks
- Allocate appropriate staff and resources to manage risk
- Control risks where possible and escalate to Executive Management Committee where risks are not controlled
- Maintain a risk register ensuring that it reflects a full range of risks and is up-to-date
- Communicate risks to staff

1.2. Risk Assessment and Evaluation

Risks must be assessed and graded using a common matrix (the National Patient Safety Agency [NPSA] risk matrix shown in Appendix A). Grading shall take into account **all existing controls** (e.g. fire alarm detection, maintenance, contracts, protocols, training etc.) and the effectiveness of these controls (e.g. how up-to-date the training is, when the last fire drill took place).

Grading requires skill and relevant knowledge, and involves the following process:

i) Determine the potential adverse consequence (also known as severity or impact) as objectively as possible and identify the most appropriate consequence score

ii) Determine the likelihood of this adverse consequence taking place, as objectively as possible, and identify the most appropriate likelihood score taking into account the existing controls

iii) Multiply the consequence score by the likelihood score to give the risk score.

Risk Assessments are carried out using the Risk Assessment Tool (RAT). A risk assessment may be carried out by any member of staff, preferably with risk assessor training, and must be signed off by a manager. It is the role of the manager to determine whether the current controls are sufficient to manage the risk to its lowest level, or whether further actions are required to reduce the risk level in which case this should be communicated and escalated through the risk register.

Risks scored at 15 or above (extreme) should be escalated to a senior manager for review and where the level of risk has been confirmed by a senior manager this should be immediately brought to the attention of the appropriate Executive Director at the time of recording the risk on the risk register.

The Trust's Risk Assessment Tool is shown in Appendix A.

Copies of the completed RATs should be held by the manager responsible for the area from which the risk has emerged.

1.3. Reducing the Risk

The purpose of identifying and assessing risk is to ensure that measures are put in place to reduce the risk to the **residual risk** level.

Table indicating level of risks and acceptable timescales for commencing action:

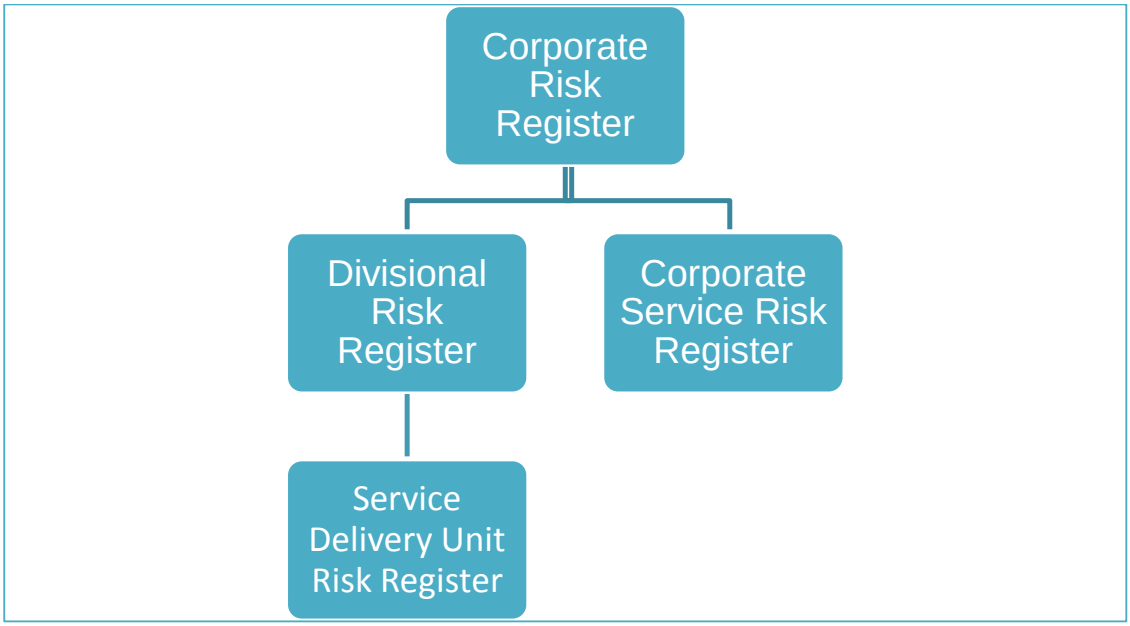
Table 1: Timescales for commencing action

Level of Risk	Target time for commencing action
Extreme (15-25)	**Immediately or within 48 hours**
High (8-12)	Up to two weeks
Moderate (4-6)	Up to 6 weeks
Low Risk (1-3)	**Up to 12 weeks**

2. Recording Risks on a Risk Register

In the case where following identification, assessment and initial control of a risk, the risk controls are not holding the risk at the lowest level of residual risk this must be included within the relevant risk register and accompanying actions should be recorded. To minimise administration 'low' risks do not need to be included in the register. There is a hierarchy of risk registers used in the organisation as shown on the diagram below. More detail about the management of these registers is shown in the following sections.

Diagram 1: Hierarchy of risk registers



2.1 Risk Register Format

There is a standardised format for the Risk Register which must be followed and maintained across the organisation. An Example is given in Appendix C. It is important to be consistent with version control and each time the risk register is updated the version number should be updated.

2.2 Service Delivery Unit Risk Registers

Risks identified at Service Delivery Unit (SDU) or ward level should be recorded by a Senior Manager on a Service Delivery Unit Risk Register. Review of the SDU Risk Register should take place on a monthly basis at the SDU clinical governance meeting and therefore is included on the standardised agenda template for these meetings. It is essential all discussions regarding the risk register are recorded in the minutes of the meeting. The SDU lead is accountable for ensuring that there is a process within the SDU for identifying and managing risk.

2.3 Divisional Risk Registers

The Divisional Chair, Divisional Director and Divisional Chief Nurse should have sight of the SDU risk registers and ensure that risks scored at 12 or above are recorded on the Divisional Risk Register. Other risks may also be recorded if the Divisional Board deems this to be appropriate. The Divisional leads may delegate the function of managing the risk registers to the Divisional Governance Facilitator but remain accountable for ensuring that risks are being identified and managed across the Division.

Divisional Risk Registers should be **moderated** at Divisional Board meetings. The work associated with this may be carried out in Divisional Quality Meetings but the Divisional

Board should be aware of the range and scale of risks in the Division. A record of the discussion on the risk register must be recorded in the meeting notes or minutes.

The Divisional Risk Registers will be included in the Divisional Performance Reviews as one mechanism to ensure the quality of the document.

Divisional Risk Registers are accessible to all senior managers, clinical governance leads, lead clinicians and matrons in a shared drive entitled 'directorate risk registers'. Access and administration of this drive is managed by the Director for Governance.

2.4 Corporate Service Risk Registers

Each Executive Director is accountable for assessing and managing risk associated with their corporate service. By nature of their business many of these risks will be strategic and this is covered in Part 2 of the risk policy. However some corporate services have very specific operational risks and these risks will be recorded on the Corporate Service Risk Register.

2.5 Corporate Risk Register

The Divisional Director or their representative, will on a monthly basis identify all new and current risks scored at 15 or above on the Divisional and Corporate Service risk registers and will also bring these to the attention of the Director for Governance and the Risk and Compliance Monitoring Group on a monthly basis. The Terms of Reference for this group are shown in Appendix B. The Risk and Compliance Monitoring Group will review the Corporate Risk Register and make recommendations to the Executive Management Committee to guide its moderation of the document. The Group has a role in cross organisational challenge at service level with a view to continuous improvement in the way risk is presented and managed in the organisation. The risk discussion will not be limited to risks currently showing on the registers but a wider consideration of whether there are known risks which have not yet been recorded on the risk documentation and should therefore be included.

The Corporate Risk Register will be **moderated** on a monthly basis by the Executive Management Committee (EMC) including all risks scored at 15 or above on divisional/corporate service risk registers. Other risks not at the extreme level but having a wider organisational impact will also be considered by the Executive Management Committee.

The moderated version of the Corporate Risk Register (CRR) will be submitted to the Quality and Clinical Governance Committee, Finance and Business Performance Committee, Strategic Workforce Committee and the Audit Committee on a bi-monthly basis.

Top risks from the Corporate Risk Register will also be reported to the Trust Board at least four times a year.

In some cases it is clear that an operational risk showing on the CRR has significant implications for the delivery of a Trust Objective. In these cases consideration will be given by EMC as to whether a related strategic risk should be recorded on the Board Assurance Framework.

SECTION TWO: STRATEGIC RISK MANAGEMENT

THE BOARD ASSURANCE FRAMEWORK

3. Identification and Control of Strategic Risks

3.1. Assessing Strategic Risk

The Board agrees a set of Corporate Objectives on an annual basis as the means by which the overall Vision and Strategy of the organisation will be achieved. Each of these Corporate Objectives is allocated an Executive Director lead.

Working with the Director for Governance each Executive Director will identify the controls in place to ensure delivery of their Corporate Objectives and the sources of assurance that these controls are working effectively. This information should be recorded on the Board Assurance Framework (BAF) for each Corporate Objective.

In consideration of the relevant controls and assurances the Executive Director will then determine the risk to delivery of the Corporate Objectives for which they are the lead and this shall be recorded on the Board Assurance Framework.

3.2. Moderating the Board Assurance Framework

The Board Assurance Framework will be moderated by the Executive Management Committee at least 4 times a year.

3.3. Communicating Strategic Risk

The Board Assurance Framework will be submitted to the Audit Committee at least four times a year for consideration. As part of the review process individual Executive Directors will be invited to the Audit Committee to present a ‘deep dive’ on the assurances recorded against individual Corporate Objectives.

The Trust Board will receive the Board Assurance Framework at least four times a year.

TRAINING

4. Levels of risk training available to staff

4.1. Training for Board members

Risk training for Board members will be provided through the Board Development Programme at least annually and will be reinforced through risk discussions at Board and Committees.

Where individual members of the Board have not attended risk training within a 12 month period the Director for Governance will liaise with the individual Board member to provide training.

The Director for Governance is available to provide training on an individual basis to any member of the Board on request.

4.2. Training for Managers and Clinicians

Training for senior managers will be provided by the Director for Governance at the request of any of the Divisional leads or the Governance Co-ordinator. This training will focus on risk assessment and communication.

The Director for Governance will review the entire divisional risk register with at least one of the Divisional leads on a quarterly basis and provide feedback and support in relation to risk management processes.

4.3. Training for Health and Safety Risk Assessors

Health and Safety risk assessors will be trained through the Risk Assessor Training Course run by the Health and Safety Facilitator with the support of the training department.

Divisional leads will be asked to confirm on an annual basis to the Director for Governance that they have sufficient numbers of trained risk assessors to identify, assess and report risks.

In the case of non compliance with attendance at training the Director for Governance will escalate this to the Chief Operating Officer to deal with through the performance monitoring route.

4.4. Training for All Staff

All staff will receive risk related training as part of induction and annual statutory training. This will be monitored through annual appraisal.

Line managers are responsible for ensuring that their staff have fulfilled all their statutory training requirements each year and for escalating through a disciplinary route where there is persistent non-compliance.

MONITORING THIS POLICY

The Board Assurance Framework will be the subject of an Internal Audit on an annual basis.

Risk management processes are audited on an annual basis by Internal Audit.

The Audit Committee reviews the level of assurance provided by these audits, and through a series of 'deep dives'.

This policy will be reviewed every year.

APPENDICES

APPENDIX A: RISK ASSESSMENT TOOL

(This can also be downloaded from the Intranet in a Word version http://swanlive/policies-guidelines/healthcare-governance-0)

Generic Risk Assessment Tool (April 2017)

Section 1 – Understanding the Risk	
Name of Person Completing the Risk Assessment	
Job role of Person Completing the Risk Assessment	
Date Risk Assessment Completed	
Subject of the Risk Assessment	
Where is the Risk?	
What are the potential negative consequences / impacts from this Risk?	

Using the NPSA Risk Matrix, identify a numerical score for consequence / impact.	
What do you have in place already to prevent the potential negative outcome from this risk? (Controls)	
Taking into account the controls you already have in place, what is the likelihood of the negative consequence that you have identified actually occurring?	
Using the NPSA Risk Matrix, identify a numerical score for the likelihood.	
Record the total risk score (Consequence score x Likelihood score)	

Section 2 – Management review of risk	
Name of manager reviewing the risk	
Job role of manager reviewing the risk	
Date manager reviewed risk assessment	
Are there any gaps in control? If yes, please list them. If no, please record that the risk is at its lowest level and does not need to go on the risk register. If no, the rest of this tool does not need to be completed.	

What actions will you initiate to address the gaps in control?	
Who is leading on these actions?	
When will these actions be complete?	
What score do you think this risk could be reduced to once gaps in control are eliminated? (Residual risk score)	
Who is responsible for monitoring delivery of the actions?	
When will the risk next be reviewed?	
Date added to risk register and risk register reference.	
Section 3 – Final risk sign off	
Date risk signed off as reaching residual risk score.	
Name of manager signing off risk for removal from the register.	

	Consequence Score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/ psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/ audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
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 <0.1 %	Do not expect it to happen/ recur but it is possible it may do so **<0.1 – 1%**	Might happen or recur occasionally 1 – 10%	Will probably happen/ recur but it is not a persisting issue **10 – 50%**	Will undoubtedly happen/ recur, possibly frequently >50%

APPENDIX A CONTINUED

Risk Scoring Matrix

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

Target Times for Controls

Level of Risk	Target Time for Commencing Controls
Extreme (15-25)	Immediately or within 48 hours
High (8-12)	Up to 2 weeks
Moderate (4-6)	Up to 6 weeks
Low Risk (1-3)	Up to 12 weeks

Safe & compassionate care, every time

NHS Buckinghamshire Healthcare NHS Trust

Appendix B: Risk and Compliance Monitoring Group Terms of Reference

RISK AND COMPLIANCE MONITORING GROUP TERMS OF REFERENCE v2 July 2019

Reports to: Executive Management Committee **Chaired by: Director for Governance**

Meetings: Every calendar month 2 hours long Monitor information, make recommendations to EMC, take action	**Purpose:** The overarching purpose of this group is to provide a forum where executive directors, divisional and departmental representatives can review compliance with legislation including CQC standards, review the outputs of risk processes, and take actions to improve or make recommendations to the Executive Management Committee.
Members: Director for Governance (Chair) Chief Operating Officer (Deputy Chair) Chief Nurse (or representative) Divisional lead from each Division (either Chair, Director or Chief Nurse) Property Services Risk Manager Head of Medical Records Head of Midwifery Head of Patient Safety and Litigation Chief Pharmacist Head of Allied Health Professionals Emergency Planning Officer Others by invitation depending on agenda **Quorum:** one director, two reps from clinical divisions and one departmental rep from the corporate division, notes/action taker	**Duties:** **Compliance** Monitor compliance against self-assessments Prepare for information request for the CQC Prepare for external reviews Oversight of compliance against statutory requirements, including CQC regulatory standards Oversight of Health and Safety compliance Support co-ordination of inspection preparation Annual review of minutes **Risk** Challenge around length of time to resolve risks Recommendations to Executive Management Committee on moderating the Corporate Risk Register Understand organisational risk gaps Voice of clinical services in informing the Corporate Risk Register
Success Criteria: Improved assurance of compliance with legislation Better quality risk registers – division, department, corporate Evidence of effective risk management	**Outputs:** Record of actions Record of decisions Notes to EMC through the Chair
Inputs: Minutes of Health and Safety Committee Corporate Risk Register Divisional Risk Registers External review register	**Method of working** Culture of openness and frank discussion and challenge with a solution focus Trust values will be adhered to and the group will be mutually supportive Paper at each meeting containing Corporate Risk Register and highlighting risks scored at 15 or above on Divisional and Corporate Service Risk Registers (EH) Rotation of review of each Division's risk register

Appendix C Standard Risk Register Format

All risk registers are formatted on to an Excel spread sheet. It is important to ensure strict version control by updating the version number each time the risk register is updated.

SDU Risk Register

SDU	Date added to SDURR	Trust Objective	Description of risk	Unmiti-gated 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

Divisional Risk Register

Date added to DRR	Trust Objective	Description of risk	Unmiti-gated 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

Corporate Risk Register

Corporate Risk Register reference	Divisional Risk Register reference	Division	Date added to CRR	Trust Objective	Description of risk	Unmiti-gated 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

Safe & compassionate care, every time

Buckinghamshire Healthcare NHS Trust

Meeting: Trust Board Meeting in Public

27 November 2019

Agenda item	Board Attendance Record
Board Lead	Sue Manthorpe
Type name of Author	Elisabeth Jones
Attachments	None
Purpose	Information
Previously considered	

Executive Summary

To keep the Board informed of the attendance of Board members at Board meetings and Board committees.

Decision	The Board is requested to note the contents of the report.

Relevant Strategic Priority

Quality ☐	**People** ☐	**Money** ☐

Implications / Impact

Patient Safety	Type in box
Risk: link to Board Assurance Framework (BAF)/Risk Register	Type in box
Financial	Type in box
Compliance Select an item. Select CQC standard from list.	Type in box
Partnership: consultation / communication	Type in box
Equality	Type in box
Quality Impact Assessment [QIA] completion required?	Type in box

Buckinghamshire Healthcare NHS
NHS Trust

Board Attendance Record: September to November 2019

	Strategic Workforce Committee	Finance and Business Performance Committee		Quality & Clinical Governance Committee			Trust Board Seminars	Commercial Development Committee	Audit Committee	Trust Board
	1 Oct	24 Sep	29 Oct	3 Sep	1 Oct	5 Nov	23 Oct	10 Oct	5 Sep	25 Sep
Hattie Llewelyn-Davies Trust Chair *	✓	✓	x				✓			✓
Neil Macdonald, Chief Executive Officer *	✓	✓	✓	✓	x	✓	✓			✓
Dipti Amin NED*				✓	✓	✓	✓		✓	✓
Dan Gibbs Chief Operating Officer*			✓		✓	✓	✓			✓
Rajiv Jaitly NED *		✓	✓				✓		✓	✓
Barry Jenkins Director of Finance*		✓	✓				✓		✓	✓
Graeme Johnston NED * (SID)		✓	✓				✓		✓	x
Tina Kenny Medical Director *		x	✓	✓	✓	✓	✓			✓
Carolyn Morrice Chief Nurse *	x			x	✓		✓			✓

	Strategic Workforce Committee	Finance and Business Performance Committee		Quality & Clinical Governance Committee			Trust Board Seminars	Commercial Development Committee	Audit Committee	Trust Board
	1 Oct	24 Sep	29 Oct	3 Sep	1 Oct	5 Nov	23 Oct	10 Oct	5 Sep	25 Sep
Bridget O'Kelly Director of Workforce & Organisational Development	✓	✓	✓				✓			✓
Jenny Ricketts Interim Chief Nurse*(from 1 November)						✓	✓			
Tom Roche NED*	✓	✓	✓				✓	✓	✓	✓
David Sines Associate NED	✓			✓	✓	✓	x			✓
David Williams Director of Strategy & Business Development	✓	✓	✓	✓ As COO			✓			✓
Ali Williams Commercial Director	✓	✓	✓				✓	✓		✓

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

Safe & compassionate care, every time

NHS
Buckinghamshire Healthcare
NHS Trust

19

Meeting: Trust Board Meeting in Public

27 November 2019

Agenda item	Private Board Summary 25 September 2019
Board Lead	Sue Manthorpe
Type name of Author	Elisabeth Jones
Attachments	None
Purpose	Information
Previously considered	

Executive Summary

The purpose of this report is to provide a summary of matters discussed at the Board in private on the 25 September 2019. The matters considered at this session of the Board were as follows:

- Financial Update
- Workforce Transformation Plan
- Integrated Care System / Integrated Care Partnership Update
- Buckinghamshire Integrated Care Partnership Winter Plan
- NHS Oversight Framework
- Serious Incident Report and Tracker
- Excluded Practitioners
- Extension request for risk policy

Decision	The Board / Committee is requested to note the contents of the report.

Relevant Strategic Priority

Quality ☒	**People** ☐	**Money** ☐

Implications / Impact

Patient Safety	Type in box
Risk: link to Board Assurance Framework (BAF)/Risk Register	Type in box
Financial	Type in box
Compliance Select an item. Select CQC standard from list.	Type in box
Partnership: consultation / communication	Type in box
Equality	Type in box
Quality Impact Assessment [QIA] completion required?	Type in box

Safe & compassionate care, every time

NHS Buckinghamshire Healthcare NHS Trust

BOARD COMMITTEE ASSURANCE REPORT FOR PUBLIC BOARD
Wednesday 27th November 2019

20.1

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:	1st October 2019 and 5th November 2019
Was the meeting quorate?	Yes
Any specific conflicts of interest?	None
Any apologies	1st October 2019: Mr Macdonald, Mrs Brooke. 5th November 2019: Mr Shorten, Dr Sithamparanathan, Mr Williams, Mrs Atkins, Mrs Manthorpe, Mrs Brandon, Mrs Kennedy, Ms Fabre, Mrs Brooke.

KEY AREAS OF DISCUSSION:

1st October 2019

The Committee focused its discussions around the following areas:

- Service Review: Division of Women, Children and Sexual Health, including Triage audit results
- CQUIN recovery plans
- Management of risks identified by Specialist Services
- Patient story; Surgery and Critical Care
- Patient experience/voice annual report
- Clinical audit update, including quarterly National Audit Results
- Integrated Performance report and exception reports: Dermatology cancer referrals, deep dive pressure ulcer, deep dive complaints
- Corporate Risk Register quarterly
- Compliance with legislation quarterly
- CIP Quality assurance process quarterly
- External reviews relating to quality
- Safeguarding Committee exception quarterly report
- Confidential section: Serious incident bi-monthly report

5th November 2019

The Committee focused its discussion around the following areas:-

- Corporate objective: Clinical Accreditation Quarter Two
- Corporate objective: Patient Voice Quarter Two
- Corporate objective: Culture of Quality Improvement Quarter Two
- Corporate objective: Getting It Right First Time and reduce clinical variation Quarter Two
- Medicines Management
- Ward to Board reporting Quarter Two
- Review of CQUIUN Quarter Two
- Integrated Performance Report and exception reports
- Pressure ulcer pathway review
- CQC Improvement Plan Quarter Two
- Clinical Strategy Quarter Two
- Infection Prevention and Control report
- 7-day Services Autumn/Winter Survey report

- Quality and Patient Safety group Chair's report

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

1st October 2019

- Service Review: Women, Children and Sexual Health Medication errors
- Management of Looked After Children: 40% increase in Education, Health and Care Plan (EHCP) submissions over the past six months; as EHCP must be completed within six weeks
- Integrated Performance Report: pressure ulcer and falls, and complaint action plans

5th November 2019

- Clinical Accreditation (CA): inability for an information technology platform and information technology support to the CA programme
- Exception reports: Dermatology cancer, Complaints and Pressure ulcer
- CQUIN report: challenges are full compliance with falls, and alcohol and tobacco although complete Quarter 2 data has not been received. Potential financial risk needs to be understood
- Integrated Performance Report: elevation of compassion fatigue of staff, particularly within the emergency department and within community services. JR identified compassion fatigue has been highlighted within Cardiology and Stroke services
- Increase within the 90-day complaints responses
- Deterioration reporting within clinical coding; high sickness levels
- Pressure ulcer: assessment of wound care
- CQC Improvement Plan: World Health Organisation (WHO) assurance, Patients presenting in ED and across the organisation with a mental health need, and Medical equipment maintenance

ANY EXAMPLES OF OUTSTANDING PRACTICE OR INNOVATION:

1st October 2019

- Women, Children and Sexual Health service review: pilot scheme of Children's Community hubs initial success and, skilful response to recent CQC concerns regarding post-partum haemorrhages
- Patient experience: significant decrease in the use of NSIC beds outside of St Joseph and, the positive transformation of patient experience and involvement in processes
- Serious incident report: department's success in a national reporting and learning system

5th November 2019

- Patient voice: Trust risen within the top 25% of Picker survey, and 95% Friends and Family approval rating from a 30% response rate

AUTHOR OF PAPER:	Jenny Ricketts, Chief Nurse (interim)

Safe & compassionate care, every time

NHS Buckinghamshire Healthcare NHS Trust

BOARD COMMITTEE SUMMARY REPORT

20.2

Name of Committee	Finance and Business Performance Committee
Committee Chair	Mr Rajiv Jaitly
Meeting date:	24th September 2019
Was the meeting quorate?	Yes
Any specific conflicts of interest?	None
Any apologies	Dr Tina Kenny, Mrs Carolyn Morrice, Mr Gary Heneage

KEY AREAS OF DISCUSSION:

Month 5 finance report
The Trust reported on plan YTD delivering a £2.1m deficit. , with comment from the committee around the high level of regulatory scrutiny. Committee noted position.

ICS Financial Position
The committee noted the high level summary with the suggestion that a session is held to brief the CCG on Trust finances following a successful session on CCG finance.

IFRS16 – Lease Accounting
A paper was presented for early oversight with further consideration suggested in light of the managed equipment service work.

Aged Debt Report
The Committee noted the significant work conducted by the finance team with the on-going actions to address recovery.

National Reference Cost Submission
The committee noted a paper and confirmed retrospective approval for the recent submission.

Drivers of Deficit
The staff costs were discussed with reflection on the multiple site challenge and the reminder of the process acknowledged as per the report.

Long Term Financial Plan (LTFM)
A summary was provided on the work to provide a multiyear plan with forecast models as the data is inputted.

Efficiency Programme 2019/2020
The Committee recognised the £4m gap to delivering the year end position. A discussion was held around the vacancies challenge and the tighten controls on temporary staffing.

Performance Floodlight Integrated Performance Report
Discussion focused on A&E performance, cancer and RTT targets.

Report on collaborative work with NHSI around A&E attendance
The Committee recognised the significant increase in demand for type 3 (GP care) activity and the increase in acutely unwell patients.

Digital Strategy Quarterly Update
The Committee recognised the completion of the digital strategy and the risk around funding for the Windows 10

project.

Commercial and corporate services transformation update
Challenges around overseas patients were articulated along with revised processes and new procedures where required. The on-going work with billing for private patients to reduce under recovery was also discussed.

Commercial Committee Update
The challenge in prioritising the committee's attention was discussed in view of the numerous available opportunities. The risks and considered to governance challenges were noted by the committee.

Estates Compliance Quarterly Update
The Committee commented on the positive steps taken to review estates compliance, recognising the on-going work.

Managed Equipment Services Business Case (1)
The Committee reviewed a paper describing the economic value and opportunities for a managed equipment service, giving agreement in principal to continue further work to explore this option.

AREAS OF RISK REVIEWED IN THE MEETING

- Drug spend
- Private patients – recovering income and risks around EU Exit
- Estates capital projects – delays
- Risk profile for estates report and rag rating
- Liability of managed equipment services and cost benefit analysis
- System deficit against plan – block contract
- IFRS16 impact on resources
- LTFM
- Risks on pace and efficiency of the efficiency programme
- IT
- Demand for emergency services

ANY EXAMPLES OF OUTSTANDING PRACTICE OR INNOVATION:

AUTHOR OF PAPER:	Barry Jenkins, Director of Finance

Safe & compassionate care, every time

Buckinghamshire Healthcare NHS Trust

BOARD COMMITTEE ASSURANCE REPORT FOR PUBLIC BOARD
27 November 2019

20.3

Details of the Committee

Name of Committee	Strategic Workforce Committee
Committee Chair	Hattie Llewelyn-Davies
Meeting dates:	1 October 2019
Were the meetings quorate?	Yes
Any specific conflicts of interest?	No
Author of the paper	Bridget O'Kelly

1 October 2019

Apologies: Mrs Lesly Clifford

KEY AREAS OF DISCUSSION:

The key areas of discussion were:

- Trust Corporate Objective: Workforce: Innovate with new models of care and/or staffing to tackle gaps in workforce.
- Launch of the 2019 National NHS Staff Survey
- HR Performance Reports
- Update on compliance against CQC Regulation 18
- Well-Led Improvement Plan
- NHS Pension issues

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

- Delay to the delivery of phase 2 of flu vaccines for staff

ANY EXAMPLES OF OUTSTANDING PRACTICE OR INNOVATION:

- The Committee noted that the Trust had been shortlisted in three categories in the annual Health Service Journal (HSJ) Awards; Freedom to Speak Up and the Community Hubs Teams for Service Redesign in two categories