

**Meeting:** Trust Board Meeting in Public**Date:** Wednesday, 26 May 2021**Time:** 9.00am – 11.30am**Venue:** Virtual Meeting via MS Teams and streamed live to the Public

| Start Time | Item | Subject  | Purpose     | Presenter | Encl.  |
|------------|------|--|-------------|-----------|--------|
| 09.00      | 1.   | <ul style="list-style-type: none"> <li>Chair's Welcome to the Meeting and Meeting Guidance</li> <li>Apologies for absence</li> </ul> | Information | Chair     | Verbal |
|            | 2.   | Declaration of Interests   | Assurance   | Chair     | Verbal |

### General Business

|       |    |                             |             |                         |       |
|-------|----|-----------------------------|-------------|-------------------------|-------|
| 09.05 | 3. | Patient Story               | Information | Chief Nurse             | Paper |
| 09.25 | 4. | Minutes of the last meeting | Approval    | Chair                   | Paper |
| 09.30 | 5. | Actions and Matters Arising | Approval    | Chair                   | Paper |
| 09.35 | 6. | Chief Executive's Report    | Assurance   | Chief Executive Officer | Paper |

### Performance

|       |    |  |           |                         |                    |
|-------|----|--|-----------|-------------------------|--------------------|
| 09.45 | 7. | Integrated Performance Report <ul style="list-style-type: none"> <li>Quality</li> <li>Workforce</li> <li>Finance</li> <li>Recovery and Renewal update</li> </ul> | Assurance | Chief Operating Officer | Paper<br><br>Paper |
|-------|----|--|-----------|-------------------------|--------------------|

### QUESTIONS FROM THE PUBLIC

**10.05 COMFORT BREAK** – 10 minutes

### Quality

|       |     |  |           |                  |       |
|-------|-----|--|-----------|------------------|-------|
| 10.15 | 8.  | Infection Prevention & Control Monthly Report          | Assurance | Chief Nurse      | Paper |
|       | 9.  | Quality and Clinical Governance Committee Chair Report | Assurance | Committee Chair  | Paper |
|       | 10. | Harm Review  | Assurance | Medical Director | Paper |
|       | 11. | Safe Staffing  | Assurance | Chief Nurse      | Paper |

### Finance

|       |     |   |           |                     |       |
|-------|-----|---|-----------|---------------------|-------|
| 10.45 | 12. | Month 1 Finance Report                                    | Approval  | Director of Finance | Paper |
|       | 13. | Finance and Business Performance Committee Chair's Report | Assurance | Committee Chair     | Paper |

## Workforce

|       |     |  |           |                 |       |
|-------|-----|--|-----------|-----------------|-------|
| 10.55 | 14. | Strategic Workforce Committee Chair Report | Assurance | Committee Chair | Paper |
|-------|-----|--|-----------|-----------------|-------|

## Risk and Governance

|       |     |                                |           |                         |       |
|-------|-----|--------------------------------|-----------|-------------------------|-------|
| 11.00 | 15. | Audit Committee Chair's Report | Assurance | Committee Chair         | Paper |
|       | 16. | Compliance with Legislation    | Assurance | Chief Nurse             | Paper |
|       | 17. | Annual Governance Statement    | Assurance | Chief Executive Officer | Paper |
|       | 18. | Self-Certification             | Assurance | Chief Executive Officer | Paper |
|       | 19. | Governance Manual              | Assurance | Chief Executive Officer | Paper |
|       | 20. | Corporate Risk Register        | Assurance | Chief Nurse             | Paper |

## Information

|  |     |   |             |                         |        |
|--|-----|---|-------------|-------------------------|--------|
|  | 21. | Board Attendance Record                   | Information | Chief Executive Officer | Paper  |
|  | 22. | Private Board Summary Report              | Information | Chief Executive Officer | Paper  |
|  | 23. | Risks identified through Board discussion | Discussion  | Chair                   | Verbal |

ANY OTHER BUSINESS

QUESTIONS FROM THE PUBLIC

Date of Next Meeting:  
28 July 2021, 9am

**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](http://www.buckshealthcare.nhs.uk)

## TRUST BOARD MEETINGS MEETING PROTOCOL

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

Copies of the agenda and papers are available on our website [www.buckinghamshirehealthcare.nhs.uk](http://www.buckinghamshirehealthcare.nhs.uk).

Members of the public will be given an opportunity to raise questions related to agenda items during the meeting or in advance of the meeting by emailing: [bht.communications@nhs.net](mailto:bht.communications@nhs.net)

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

When viewing the streamed live meeting please note that only nine directors can be visible at any time. When a director stops talking after a few minutes the system will automatically close their camera and show their initials until the director speaks again.

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

Hattie Llewelyn-Davies  
Chair

## THE SEVEN PRINCIPLES OF PUBLIC LIFE

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

### **Selflessness**

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

### **Integrity**

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

### **Objectivity**

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

### **Accountability**

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

### **Openness**

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

### **Honesty**

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

### **Leadership**

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

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

**Meeting:** Trust Board Meeting in Public

**26 May 2021**

|                              |  |  |
|------------------------------|--|--|
| <b>Agenda item</b>           | A patient experience story- Children's immunisations during Covid-19     |  |
| <b>Board Lead</b>            | Chief Nurse  |  |
| <b>Type name of Author</b>   | Amarjit Kaur- Head of Patient Experience and Involvement                 |  |
| <b>Attachments</b>           | Video link to film   |  |
| <b>Purpose</b>               | Information  |  |
| <b>Previously considered</b> | Executive Management Committee 4 May 2021, Quality Committee 11 May 2021 |  |

### Executive Summary

BHT's Immunisations team continued to provide immunisations for children throughout the pandemic, the only team in England to do so.

Samantha Smissens, Immunisations Team Lead talks about how the team worked to ensure children in Buckinghamshire continued to receive their immunisations during this challenging time, and we hear from a parent about their experience of getting their child vaccinated.

Link to patient experience story:

<https://youtu.be/-xdcUVIUeE8>

|  |   |                                       |
|--|---|---------------------------------------|
| <b>Decision</b>  | The Board is requested to endorse this story and celebrate the commitment and resourcefulness of the Immunisations team in ensuring that this important service continued through the pandemic.   |                                       |
| <b>Relevant Strategic Priority</b>                                 |   |                                       |
| <b>Quality</b> <input checked="" type="checkbox"/>                 | <b>People</b> <input type="checkbox"/>  | <b>Money</b> <input type="checkbox"/> |
| <b>Implications / Impact</b>                                       |   |                                       |
| <b>Patient Safety</b>  | Improved care in response to patient feedback and involvement   |                                       |
| <b>Risk: link to Board Assurance Framework (BAF)/Risk Register</b> | BAF 1.1: To listen to our patient's voice   |                                       |
| <b>Financial</b>   | Relevant but not applicable   |                                       |
| <b>Compliance CQC Standards</b>                                    | Person Centred Care   |                                       |
| <b>Partnership: consultation / communication</b>                   | Working in partnership with patients  |                                       |
| <b>Equality</b>  | The team must consider process demonstrating the difficulties in achieving health equity and social fairness. This includes barriers for accessing healthcare and prevention include poverty and social exclusion; discrimination and lower human |                                       |

|   |   |
|---|---|
|   | rights protection of marginalized groups; forced evictions and homelessness and how these might impact the vaccination process. |
| <b>Quality Impact Assessment [QIA] completion required?</b> | N/A   |

## Meeting: Trust Board Meeting in Public

**Date:** Wednesday, 31 March 2021

**Time:** 9.00 – 11.30am

**Venue:** Virtual Meeting via MS Teams and streamed live to the public

### MINUTES

#### Voting Members:

|                            |  |
|----------------------------|--|
| Ms H Llewelyn-Davies (HLD) | Trust Chair  |
| Mr N Macdonald (NM)        | Chief Executive Officer                              |
| Dr D Amin (DA)             | Non-Executive Director                               |
| Ms K Bonner (KB)           | Chief Nurse  |
| Mr D Gibbs (DG)            | Chief Operating Officer                              |
| Mrs N Gilham (NG)          | Non-Executive Director                               |
| Mr R Jaitly (RJ)           | Non-Executive Director                               |
| Mr B Jenkins (BJ)          | Director of Finance                                  |
| Mr G Johnston (GJ)         | Non-Executive Director / Senior Independent Director |
| Dr T Kenny (TK)            | Medical Director                                     |
| Mr T Roche (TR)            | Non-Executive Director                               |

#### Non-Voting Members:

|                     |   |
|---------------------|---|
| Mr M Girach (MG)    | Associate Non-Executive Director              |
| Mrs B O'Kelly (BOK) | Chief People Officer                          |
| Ms S Silva (SS)     | Board Affiliate                               |
| Ms A Williams (AW)  | Commercial Director                           |
| Mr D Williams (DW)  | Director of Strategy and Business Development |

#### In attendance:

|                    |   |
|--------------------|---|
| Mrs E Jones (EJ)   | Senior Board Administrator (minutes)                                    |
| Ms S Weech (SW)    | NED Isle of Wight (observing)   |
| Mr S Pollais (SP)  | Consultant Trauma and Orthopaedic Surgeon (for agenda item 3)           |
| Ms A Frigiyik (AF) | Consultant in Intensive Care Medicine & Anaesthesia (for agenda item 3) |
| Ms A Perring (AP)  | Ward Nurse Manager, Trauma and Orthopaedic Surgery (for agenda item 3)  |
| Ms J Eastman (JE)  | Physiotherapist (for agenda item 3)                                     |

#### 01/03/21 Chair's Welcome, introductions and apologies

The Chair welcomed Sara Weech to the meeting who was observing as part of the NHS Aspirant Chairs Group.

There were no apologies.

#### 02/03/21 Annual report of Declarations of Interest

BOK informed the Board her youngest daughter had registered as a volunteer with the Trust.

The Board **NOTED** the Annual Declarations of Interest Register.

#### 03/03/21 Patient Story

KB introduced Consultant Trauma and Orthopaedic Surgeon, Sakis Pollalis, who presented the Board with the Patient Story around the development of the Wycombe Arthroplasty Rapid-recovery Pathway (WARP) which improved patient care and recovery. The Board viewed a video of a patient who had been treated through the WARP pathway which highlighted how the new pathway allowed the patient to be mobilised rapidly after surgery; reduced the length of stay in hospital; provided improved patient satisfaction; allowed accelerated recovery and therefore allowed an increased volume of patients with the associated increase in clinical / financial / operational efficiency and revenue generation.

NM queried what follow up support was in place for patients going through the WARP pathway. It was explained patients were given contact details for staff and the team arranged video call follow ups on day 1 and day 4.

TR remarked on the fantastic story and asked what the next steps were. SP explained the goal was to make the pathway suitable for all patients.

DA queried how the rapid recovery pathway was affecting the total time spent by patients in hospital. It was explained the data showed significant reductions and had almost halved the length of stay for hip and knee replacements and patients have been very positive about the new process. There were lots of associated benefits to the rapid pathway for total hip and knee replacements; not only the reduced length of stay in hospital but patients feeling less nauseous, they are happier and more comfortable after their surgery. The team uses a different spinal anaesthetic for the rapid recovery pathway, patients do not feel washed out and are ready to get up and get moving straight after the surgery.

SS queried the role of educating the patient in the new pathway before surgery. SP confirmed it was extremely important for patients to be aware of the expectation but also the importance of informing GPs, so the new process was understood from the point of referral.

HLD thanked the team for presenting the patient story.

#### 04/03/21 Minutes of the last meeting

The minutes of the last meeting on 27 January 2021 were approved as an accurate record.

#### 05/03/21 Actions and matters arising

The Board noted the action log. There were no matters arising.

#### 06/03/21 Chief Executives Report

NM recognised it was the last working day of the 2021 financial year and time to pause and reflect on the previous year, noting the national incident response level had been stepped down from level 4 to level 3. NM thanked colleagues for their response to the pandemic and for the members of the public, colleagues and system partners who had supported the Trust.

The focus for the Board was to plan for the future; recognising the staff survey results, the recovery work and looking after the workforce and ensuring the Trust does everything it can to renew and move forward operationally and strategically.

Planning guidance for the year had been published by NHSI and the Trust was making strategic and operational plans. Preparation was underway for a potential third wave of Covid from the middle of May into June, noting it was important to plan for a worst-case scenario.

There was a large amount of work to do on the strategy and the Trust's objectives over the next five or ten years; the role in the county and the Trust's part to play in the health, social and economic recovery. Part of this will include ensuring appropriate waiting times for patients and working in partnership to look at productivity and digitalisation which would be significant changes to help address these challenges.

NM thanked TK who was attending her last public board meeting as Medical Director and for her tireless public service, she will be missed by all.

GJ commented on the planning guidance which had been received and queried how it compared with the Trust's own plans. NM explained the Trust had strong plans in place and some of the work was already being done however there was some practical work to do around budgetary requirements.

RJ queried how the Trust was tracking health outcomes for multi-ethnic women in maternity. NM responded signposting the Ockenden review and action plan and the Trust had an ambition to provide everyone with a dedicated midwife to provide continuity of care. The Head of Midwifery had joined the national network which was working to address some of the concerns.

DA referred to the performance metrics which implied the Trust had dealt with fewer patients although the Trust has been under strain from the pandemic. A different way of reporting this would be investigated that properly reflect the impact of the pandemic.

The Board **NOTED** the Chief Executive's report.

07/03/21

### Integrated Performance Report and Recovery

DG presented the operational performance report recognising the Trust was moving into full recovery phase. The impact of Covid has been dramatic and there were many patients waiting for planned care which needed to be addressed. A different way of working was required, and DG urged members of the public to honour their appointment if one was offered. The Trust has done everything it could to make its hospitals safe. DG recognised the digital changes and virtual clinics which will have an impact, making it easier for patients. There were currently significant pressures within the Emergency Department.

With regard to the those colleagues who had not taken up the offer of a Covid vaccine, TK informed the Board the Trust had run Q&A sessions for colleagues to delve into concerns around the vaccine for pregnant colleagues and BAME colleagues. In addition, the communications team had raised awareness and the occupational health team had contacted colleagues directly to address their concerns. As a result, hundreds more had since taken up vaccine. DA asked for thanks to be expressed to the teams involved in the vaccination programme.

NG questioned how patients would be managed who do not have a digital device. DG assured the Board face to face and telephone appointments would still be offered to those who do not have access to a digital device. DG recognised that having the correct communication in place was fundamental to success.

RJ queried how performance could be developed and improved in A&E and Refer to Treatment Times (RTT). DG recognised the significant risk with a potential wave 3 of Covid noting the modelling was variable and capacity plans were being worked through acknowledging what had been learnt so far. Work was being undertaken to expand capacity recognising the impact on staff who had been redeployed and needing to be more agile moving forward. DG acknowledged the separate facility at Wycombe for elective surgery would continue and the need to have good relationships with private providers to assist with capacity. Work was being undertaken with Oxford and Reading around managing elective activity and referrals across the system.

Regarding A&E performance, the Trust would need to focus on the following things to improve; manage patient flow on arrival; move patients to medical areas and resolve the issue of medically fit for discharge (MFFD). These are patients who are waiting for support at home or being placed in a care home. Work was being undertaken with the Council to identify extra opportunities and different ways of working.

DG recognised the new children's ED would also transform how ED functions by making space to allow change in the way care was delivered by bringing ambulatory and frailty care closer to ED allowing synergies.

DG noted the Board would receive information on the quality standards which would drive change.

Regarding finance, BJ explained new planning guidelines for the year had been received and the Trust would receive funding for the first half of the next financial year which would support the Trust deliver its required activity levels.

NM stressed the importance of performance and financial recovery.

The Board **NOTED** the Integrated and Recovery reports.

## QUESTIONS FROM THE PUBLIC

Jackie Glossop sent in the following question:

*Ever since the pandemic caused lockdown last March I have been either in doors and if out being very careful and somewhat foolishly didn't take advantage of the lifting of some restrictions during the Summer and then of course back to increases in R numbers and then more lock down. During this time, I seem to have had a social life entirely based around having consultations, investigations and blood tests at your Trust. I consider my complaint about the other Trust is not trivial, as it affects people without them knowing what might happen, like nothing. But I did not want my complaint to the other Trust to be misconstrued as being a criticism of the care given by your Trust which has been exemplary in every way. Even to the point I had a full body bone scan in the Summer on my birthday, when the sister who was standing guard at the front door looked at the date she said oh it is your birthday and they sang happy birthday to me, in one way I could have disappeared and yet it was such a nice thing to do and did make my day a bit more fun that it could have been. Everyone I have seen, porters, receptionists, specialist nurses, junior doctors, consultants and specialists in that field. Everyone has been polite, thoughtful and extremely nice. To say visiting was a pleasure is perhaps too far or was it because I was made to feel extremely comfortable and reassured. This comes from first class management, if the management is not good, the staff may be ok to patients, but the pervading mood is not good. So, despite the horrors that Covid has rendered upon so many including those selflessly trying to keep them comfortable but unable to offer the solace we want at that stage of our lives. We owe a great debt of thanks to all of you. So, from me thank you one and all for all you are doing to get us through this dreadful and quite unbelievable experience. **My question is how do you manage to have such a uniform standard of (don't like the phrase really) 'Customer Care'.***

NM thanked Ms Glossop for such an interesting question and responded by noting if staff were happy in their work, felt valued and supported they would be much more supportive and caring towards our patients. KB recognised the contribution of our outstanding staff working in such different and difficult times.

HLD thanked Ms Glossop for her question.

## 08/03/21 Infection Prevention & Control Monthly Report

KB presented the Infection Prevention & Control (IPC) Monthly Report highlighting nosocomial infections had increased which was challenging and the Trust was working closely with Public Health England and NHS England colleagues on IPC measures.

NG recognised the pressures and number of infections and queried how the Trust compared with peers regarding nosocomial infections. KB responded noting that within the local region, the levels were mixed. There were lessons to be learnt and the IPC team were working closely with the estates team to improve airflow and infection control. Colleagues were frequently reminded that social distancing and PPE must be continued despite the vaccination programme and the importance of lateral flow testing.

BOK acknowledged the need to adapt to different ways of working such as wearing masks and social distancing which would continue and help to keep everyone safe along with the vaccination programme and this would continue to be emphasised.

DS noted the cleaning scores had been maintained and non-Covid infections had been driven down which were positive outcomes despite the challenges of the pandemic.

The Board **NOTED** the report.

#### 09/03/21 Quality and Clinical Governance Committee Chair Report

The Board **NOTED** the Quality and Clinical Governance Committee Chair's report.

#### 10/03/21 Non-Executive Director Review of Complaints Process

GJ presented the review of the complaints process noting the complaint response letters were detailed, clear and compassionate. However, the response time was often too long. It was suggested the complaints team should identify the responsible department straight away, confirm receipt of the complaint and seek any clarity needed early on. In addition, GJ suggested the lessons learnt from the complaints, which were generally adjustments to procedures, should be audited by clinical audit.

KB thanked GJ and HLD for their review and assured the Board the suggestions would be taken forward.

SS queried how learning was shared from investigating a complaint. KB informed the Board there were forums for divisions to share learning from complaints, but this would be improved and expanded over the next year.

The Board **NOTED** the report.

#### 11/03/21 Month 11 Finance Report

BJ presented the Month 11 Finance report noting the Trust had reported a marginal surplus supported by Covid funding to cover Covid expenditure. The in-month run rate was marginally better than month 10; the full year forecast remained at break-even and the capital programme had closed at £69.3m. The finance team were working on budgets, the annual accounts and next year's capital programme and transformation work.

The Board **NOTED** the report.

#### 12/03/21 Finance and Business Performance Committee Chair's Report

RJ informed the Board that the Committee had discussed; finance; capital; transformation; IPR and the property services report.

Regarding the challenges around recovery, NM queried the approach required going forward for the Committee to receive assurance on recovery. RJ recognised the importance of understanding where efficiencies could be achieved going forward.

HLD thanked RJ for chairing the Committee for the last 6 years and welcomed NG as the new chair.

The Board **NOTED** the report.

#### 13/03/21 Charitable Funds Committee Chair's Report

- Investment portfolio & bid applications

RJ presented the investment portfolio and three bid applications for approval. RJ noted work with the associated charities would be considered further before coming back to the Board.

The Board **APPROVED** the investment portfolio and three bid applications.

HLD thanked RJ again, this time for chairing the Charitable Funds Committee and welcomed NG as the new chair.

#### 14/03/21 2019/2020 Staff Survey

BOK presented the annual National NHS Staff Survey results highlighting the increase on the previous year's response rate. The results had been positive in relation to health and wellbeing and being a great place to work however it was disappointing to see the increase in abuse experienced by BAME colleagues which was being addressed.

It was noted the response rate for medics and healthcare support workers was low compared to other work groups and what could be done to improve this. KB responded informing the Board a support worker forum and a student forum had been formed to look at how best to engage these colleagues.

DA queried how the action plan following these results would be structured. BOK explained the reports would be split by teams and monitored through divisional performance reviews and people structures and the Strategic Workforce Committee.

NM questioned from a strategic point of view how these results showed how the Trust had managed the pandemic and how they would help the Trust to recover and restore the workforce going forward.

BOK explained the health and wellbeing of colleagues both physical and psychological was paramount to being able to look after patients and the importance the Trust has placed on this had proved to be correct. The importance of teams and managers will be included in the plan for the next two years which would provide support and resilience for colleagues. In addition, getting equality, diversity and inclusion right would have a continued focus.

In response to a query from NG, BOK assured the Board that all colleagues who had been redeployed had received support during and after their redeployment.

The Board **NOTED** the report and the implementation of the action plan.

#### 15/03/21 Gender Pay Gap

BOK presented the annual gender pay gap report highlighting the reduction in the bonus pay gap, related to clinical excellence awards for certain medical employees. There was some work required around encouraging women into the senior roles both clinical and administrative.

DA queried what the barriers were for women taking on more senior roles in the organisation. BOK recognised the need to remove structural barriers and be open to flexible working, new ways of providing childcare and reduced hours. A staff network for women was being set up as part of the Trusts commitment to EDI and hopefully they will help us find solutions for some of these issues.

SS suggested having a Board champion for the gender pay gap issue. HLD requested SS and BOK reviewed and came back to the Board with a proposal.

**Action: BOK to provide a proposal to Board for a champion for the gender pay gap issue.**

The Board **APPROVED** the publication of the report subject to checking the numbers in the chart and including more detail in the change of the bonus payable.

#### 16/03/21 Strategic Workforce Committee Chair Report

NG highlighted the Committee had discussed the recovery of colleagues in the short and long term and the commencement of 'Thrive' which was a programme of interventions to help colleagues.

NG noted the Committee had expressed concern on the nurse vacancy rate recognising funding had been received and there had been international recruitment.

HLD thanked NG for chairing the Committee over the last year.

The Board **NOTED** the report.

#### 17/03/21 Audit Committee Chair's Report

GJ recognised that both internal and external audit allowed the Board to have confidence in the data that was used which ensured quality for both patients and staff. GJ was thanked for his role chairing the committee.

The Board **NOTED** the report.

#### 18/03/21 Board Attendance Record

The Board **NOTED** the report.

#### 19/03/21 Private Board Summary Report

The Board **NOTED** the report.

#### 20/03/21 Use of the Trust Seal

The Board **NOTED** the report.

#### 21/01/21 Risks identified through Board discussion

Risks identified through Board discussion as follows:

- Differentials in outcomes in maternity care
- Backlog of elective care pathway
- Nosocomial infections and PPE
- Shared learning
- Uptake of staff survey across all groups
- Addressing structural gender pay gap
- Concerns on the volume of workload relating to changes in requirements which would be reviewed by the executive management committee.
- Increase in BAME colleagues reporting bullying and harassment

#### 22/01/21 Any other Business

HLD informed the Board that the fixed terms of office for Associate Non-Executive Director, David Sines and Non-Executive Director, Graeme Johnston had expired, and this was their final day with the Trust.

HLD recognised Graeme as the most loyal and honourable senior independent director one could have. He never ducked and gently advised even when he was taken away from his passion for the quality of service and made chair of Audit Committee. Graeme was motivated by his determination to work for our patients and wider population and is a dear friend and colleague.

HLD recognised David as the consummate NHS Professional who knew everyone and was loved by everyone. He was warm and caring and understood NHS values. HLD noted she would never forget seeing him trim back some brambles at Wycombe hospital when she asked why he told her he often did it, it was about having pride in the organisation.

HLD thanked Balvinder Heran, who had left the Trust, for her vision for the Trust's and the county's new IT Strategy and for executing it to allow the Trust to come through the demands of lockdown. Thanks, were also expressed for the funding she won for the Trust for IT.

HLD thanked TK who was retiring and stepping down from the Board. HLD recognised TK was as brave as a lioness, with a strong sense of values and who really understood how to work across the disciplines at the organisation. She brought humour, drive and compassion to everything along with energy in abundance.

Mr Andrew McLaren, consultant surgeon and Deputy Medical Director, would be joining the Trust's Board from 1 April 2021 as Interim Chief Medical Officer.

John Lisle, former Chief Executive of East Berkshire CCG, has been appointed as a Non-Executive Director with a background in finance and Dr Adrian Hayter, joins the board as an Associate Non-Executive Director with a background in Primary Care.

## QUESTIONS FROM THE PUBLIC

There were no further questions from the public.

**Date of next Meeting: Public and Private Trust Board Meeting: 26 May 2021**

## Action Log

Meeting

Public Trust Board

|       |                              |
|-------|------------------------------|
| Green | Complete                     |
| Amber | In hand/not due              |
| Red   | Overdue/date to be confirmed |

| Min ref                  | Date opened | Subject                                   | Action   | Lead                    | Deadline                             | Update January 2021   | Update March 2021   | Update May 2021  | RAG | Date closed         |
|--------------------------|-------------|---|--|-------------------------|--------------------------------------|---|---|--|-----|---------------------|
|                          | 30/09/2020  | CEO report                                | DG to ensure good communication with patients on waiting lists   | Chief Operating Officer | 25/11/2020                           | The model is being revised due to wave 2                                | Text messaging has been restarted for long waiting non-admitted patients, all letters have been reviewed, all patients waiting for treatment are being contacted by clinical teams. COO will bring review paper through to April F&BPC & Q&GC.  | All long waiters have been written to as part of the validation project ongoing. |     |                     |
|                          | 29/07/20    | Integrated performance report             | Quality Committee to monitor the OPD letter process and ensure it is up to date  | Chief Operating Officer | 08/12/20                             | Will be coming to Quality Committee for review                          | Outpatient letters have been reviewed, work has started on training programme. COO will include review in update paper for F&BPC and Q&GC for April.  | Including in OPD transformation deep dive in work plan for F&BP                  |     |                     |
| 06/01/2020               | 29/01/20    | Trust Chair's Report                      | The Chair noted an action for agreeing a process by which the work undertaken by the Non-Executive Directors was triangulated. | Director for Governance | 16/12/2020 - revised date or 31/7/21 | Due to Covid-19 this has been delayed and will be reviewed in July 2021 | Not due   | Not due  |     |                     |
| 15/03/2021               | 31/03/21    | Gender Pay Gap                            | A proposal to come to Board for a champion for the gender pay gap issue  | Chief People Officer    | 31/07/21                             |   |   | Not due  |     |                     |
| <b>Completed Actions</b> |             |   |  |                         |                                      |   |   |  |     |                     |
| 21/01/2020               | 29/01/20    | Future arrangements for NHS Commissioning | The Board to have a discussion on the future of specialist commissioning.  | Director of Strategy    | 30/09/20                             | update on progress with commissioning in the CEO report                 | The recent white paper on NHS innovation and integration highlights potential changes to NHS Specialised Commissioning to enable NHS England to delegate or transfer the commissioning of certain specialised services to ICSs singly or jointly. Specialised commissioning policy and service specifications will continue to be led at a national level. Any future changes and risks for the Trust will be highlighted through the Finance and Business Performance Committee. |  |     | CLOSED<br>24/3/2021 |

|            |          |               |  |                      |                                      |  |   |  |  |        |
|------------|----------|---------------|--|----------------------|--------------------------------------|--|---|--|--|--------|
| 10/06/2020 | 24/06/20 | Digital Spend | Return on Investment on IT Strategy to come back to Board and to include reconciliation. | Director of Strategy | 30/10/2020 - revised date of 31/3/21 | due to operational pressures relating to Covid, this has been deffered to March 2021 | On private board agenda - deferred to April Private Board Meeting | Discussed at Private Board Meeting on 28 April |  | CLOSED |
|------------|----------|---------------|--|----------------------|--------------------------------------|--|---|--|--|--------|

**TRUST BOARD MEETING IN PUBLIC  
26 MAY 2021  
CHIEF EXECUTIVE'S REPORT**

**Introduction**

In this report I provide an update on key developments over the last couple of months in areas that will be of particular interest to the Board. Appended to this report is a list of the eight fantastic winners of our Trust CARE value awards for the last two months (Appendix 1), and a summary of Executive Management Committee and Transformation Board meetings to provide oversight of the significant discussions of the senior leadership team in other areas (Appendix 2).

**Quality, performance and recovery**

We recognise that we, like many others, have a significant road ahead to expand and transform our services so that we can see and treat the many patients who have been waiting for appointments or interventions in a safe way. Our clinical, operational and support service teams are working extremely hard both to see patients as quickly and safely as possible, while ensuring that those who are waiting continue to have clinical oversight. We are working together with Buckinghamshire, Oxfordshire & Berkshire West Integrated Care System (BOB ICS) colleagues to meet the required targets of a national initiative called the Elective Recovery Fund (ERF). This is a fund of £1 billion to support elective activity to incentivise increasing the value of activity delivered above 2019-20 baselines. There are monthly targets of increasing value. I am pleased to confirm we have been able to increase our activity levels, delivering the following for April:

|             | <b>Activity<br/>(% of 2019-20)</b> |
|-------------|------------------------------------|
| Outpatients | 94.2%                              |
| Day-case    | 73.0%                              |
| Elective    | 69.8%                              |

The ERF is also subject to the BOB ICS meeting a number of gateway criteria, including: addressing health inequalities; transforming outpatient services; implementing system-led elective working; tackling the longest waits; and supporting staff. Within the Trust we are confident that work is underway to meet these.

At the start of this month we submitted our operational plan for the first six months of 2021-22, which for the first time has been prepared together with BOB ICS partners across the system as per requirements from NHS England & Improvement (NHSE/I). The plan includes the following: workforce capacity and recovery; continuing to meet the needs of patients with COVID-19; maximising elective activity; delivering improvements in maternity care including the recommendations of the Ockenden Review; implementing population health management and personalised care approaches to address health inequalities and improve outcomes; transforming community services and improving discharge of patients from hospital. I would like to take this opportunity to thank the teams involved for all the hard work in pulling this plan together in collaboration with our BOB ICS partners.

In our emergency department (ED), work continues to improve how the department and the pathways that support it perform. Though we continue to have challenges, we have made improvements since my last report, reporting 82.6% for March and 82.0% in April against the 4-hour target of 95%. Focus has also been on reducing the number of people in department with a total length of stay of twelve hours, reducing our Medically Optimised for Discharge numbers and our ambulance handover times.

Performance of Cancer services has improved as measured by the 62 day cancer treatment standard. Whilst we have not achieved the standard, we have overachieved the faster diagnostic standard, which requires us to have diagnosed or excluded cancer within 28 days of referral. This reduces the amount of time patients carry uncertainty about their condition and as well as being an important quality improvement it allows more time to arrange treatment.

In April I was pleased to meet with the Regional Chief Midwife at NHS England and Improvement alongside our Head of Midwifery and clinical teams to review our submission and action plan in response to the Ockenden review of maternity services. A clear area of focus was the current and future challenges relating to midwifery staffing and I am pleased to report that we have recently been successful in recruitment of our third year midwifery students, who expressed interest in remaining at the Trust following registration. This is the highest number of entrants we have had in the last few years.

## Learning

In March we recorded two instances of *clostridioides difficile* infection and six in April. We reported zero instances of MRSA bacteraemia infection in March and April, and zero never events in the same months. In March we recorded 422 births and 426 in April; in the same months we recorded 114 and 87 deaths respectively.

We continue to learn from what we have done right as well as where our patient care may not have met the high standards that we aspire to. In March and April we recorded 47 and 48 formal complaints respectively, and 43 and 31 excellence reports. The following is an excellent example of the patient-centric care we aspire to deliver at all times:

“Dr \*\*\* conducted a thorough assessment of a gentlemen with Parkinson’s disease who had repeatedly expressed a wish to die. Dr \*\*\* demonstrated excellent interpersonal skills, navigating some exceptionally challenging verbal behaviour by the patient, to allow the patient to honestly reflect the true impact of his illness on his quality of life. The assessment, which was excellently documented in the medical notes, reflected advanced care planning, the physical and psychological impact of the patient’s illness and a through capacity assessment. Dr \*\*\* had liaised with the patient’s GP and next of kin to gain a thorough understanding of the patient’s psychological and physical condition prior to his admission to hospital, providing essential background knowledge for the assessment.”

## People

In my last report I introduced Thrive@BHT, our two-year programme to support the recuperation of our colleagues following the significant challenges of 2020-21 and our ongoing ambition of making our Trust a great place to work for all. As well as dedicated wellbeing support to some of our most affected teams, one of the first components of this programme is the Trust-wide rollout of ‘REACT’ mental health training for all managers. REACT stands for: Recognise, Engage, Actively Listen, Check Risk, Talk about a plan, and this comprehensive rollout is designed to ensure managers can identify individuals in their teams who would benefit from wellbeing and/or mental health support, as we know it can be difficult to identify it in oneself.

I am also pleased to share that we are once again offering £15 to all colleagues to spend on something that supports their wellbeing, and in recognition of the extraordinary events of 2020-21, are giving all individuals an additional day’s leave as a Wellbeing Day. We have received lots of positive feedback from colleagues and hope that these two initiatives will both encourage our people to invest in their personal wellbeing and give them the opportunities to do so.

Recognition of our people when they excel or go the extra mile is an extremely important part of our organisation and this year more than ever it will be a delight to celebrate those who have been so fundamental to our story of the COVID-19 pandemic: on 20 May we will be announcing, albeit in a slightly different way this year, the winners and runners up in our annual Staff Awards. I look forward to sharing more in my next report to the Board.

As digital transformation will be a continued key focus for the Trust, I am delighted to welcome Ross Fullerton who has joined the Buckinghamshire Integrated Care Partnership as Interim Chief Digital & Information Officer. Ross joins us from the London Ambulance Service where the projects he was responsible for included the digital technology underpinning 999 services and more recently leading the strategic recovery from COVID-19.

Finally, we have all been shocked and saddened by the news from India over the last few weeks. Many colleagues have friends and family in India, as well as in other countries, where COVID-19 is having a devastating impact. In addition to our existing wellbeing support services, we have asked managers to be flexible in meeting requests from their team to call friends and family for compassionate reasons during work hours as we know that this can be a problem with different time zones around the world. We have been hosting weekly ‘drop in’ virtual meetings during May with a focus on linking up with and supporting colleagues who have friends and family overseas. We have also put in place a fund to support colleagues who need to travel to countries on the “Red List” at short notice and may have difficulties in meeting the additional costs of travelling to these countries.

## Place and System

Domestic Violence and Abuse (DVA) was discussed at the ICP Board Chairs’ meeting in April where lead officers for DVA proposed a post lockdown strategy and communications plan. This is an area that affects all partners in the ICP and has been highlighted as a priority for collaboration this year. A new Domestic Abuse Board has been formed and met in shadow form in March. Key leads across the ICP will also be involved in a DVA strategy working group to drive forward this area of work.

Over the last few months, our investment in infrastructure is helping us to transform the way that we can deliver care to our patients as we traverse the pandemic landscape. We have been actively building on the work we started with our integrated care partners in the delivery of Carecentric, the local shared care record. All partners now have access to this record embedded within their systems allowing access to shared information at the point of care. Over the next few months, we look forward to working collaboratively to use this platform to transform the way we deliver care across Buckinghamshire. The ICP has recently signed up to the Combined Intelligence for Population Health Action (CIPHA) collaborative, enabling access to national data analytics dashboards fed from the information held within our local shared record dataset. We are working with our partners to develop novel ways to use our population health information to deliver efficiencies in reducing our waiting lists and identifying any potential areas of health inequalities.

### **Financial reporting**

The 2020-21 financial year ended with the Trust reporting a full year break even position in line with the plan agreed with NHS England & Improvement and BOB ICS. The group consolidated Trust position including our wholly owned subsidiary, Buckinghamshire Healthcare Projects Ltd, was reported as £0.1m surplus.

For the first month of the new financial year 2021-22, the Trust reported a break even position in line with plan. This included £0.8m spend on COVID-19-related expenditure. Our full year forecast was reported at £22.3m deficit, in line with our draft annual plan which includes delivery of a £16m efficiency plan.

### **Proud to be BHT**

May has been a time to recognise and celebrate some of our wonderful colleagues and raise awareness of just some of the careers opportunities that exist within the Trust. We have had the International Day of the Midwife, International Nurses Day and Operating Department Practitioners Day.

We held our very first virtual nursing conference, 'The Courage of Compassion', on the 7th May 2021. We would like to extend our thanks to all our guest speakers who included Professor Dame Elizabeth Nneka Anionwu, Dr Crystal Oldman CBE, CEO Queens Nursing Institute, Andrea Sutcliffe CBE, CEO and Registrar of the Nursing and Midwifery Council and Professor Jacqueline Dunkley-Bent OBE.

In April, we marked the 20th anniversary of the Trust's first cohort of Filipino nurses. In April 2001, over 35 nurses made the long journey from the Philippines to Buckinghamshire to start a new life followed by a further group later that year. Two decades later, over 30 of these nurses still work for the Trust and are key members of the local Filipino community. The community has grown considerably and in October 2020 the Kalinga Bucks Filipino Health Professional Organisation launched. It now has over 200 members and is open all Filipino healthcare professionals who live and work within Buckinghamshire.

Many congratulations to our colleagues who have been shortlisted for the Bucks Health & Social Care Awards. The four people and two teams who have been nominated are: the research & innovation team, the critical care team, school immunisation team, Ornella Ortensi (trauma and orthopaedics), Megan Howe (A&E and NICU), Marianne Reyes, (dialysis unit) and Hazel Nyack-Kaseke (ophthalmology). The results will be announced on the 21st May 2021.

Finally, many of colleagues have taken time to reflect on the last year and we have launched our own internal virtual wall of reflections with blogs, poems and pictures to capture their experiences and feelings about the pandemic. Our Junior Doctors Forum has also organised an art exhibition with drawings and paintings created by our colleagues during lockdown. The standard is outstanding and you will be able to view some of their work on the Trust's website.

### **Neil Macdonald**

Chief Executive

Appendix 1 – Trust CARE value awards

Appendix 2 – Executive Management Committee and Transformation Board

## Appendix 1 – Trust CARE values awards

I am delighted to share this summary of the winners of our Trust CARE value awards. Every month from all nominations received from colleagues and members of the public, the Executive Management Committee award four winners, one for each of four categories, which are: Collaborate, Aspire, Respect, and Enable.

March 2021

| Category    | Name & role   | Nomination   | Nominated by    |
|-------------|---|--|-----------------|
| Collaborate | Aylessia Boardman, Physiotherapist Respiratory      | Aylessia has been a positive influence, motivating and uplifting any of her team members and any of the redeployed physiotherapy staff on the respiratory wards. She notices if colleagues are not themselves, checks in, offers a space for them to discuss their issue should they want to. She approachable and generous with her already pressured time when it comes to providing insight, advice, treatment discussion, case based discussions and any other issues that may be adding pressure or stress to the respiratory team or to any redeployed staff who may be feeling out of their depth. She is knowledgeable, friendly and always has a way of de-escalating the situation, simplifying it to an understandable means and reinforcing your confidence in the matter. Always joyful, inspiring and providing holistic care where she can.   | Member of Staff |
| Aspire      | Karen O'Rourke, Support Secretary to ENT Department | Karen has wanted to undertake her Medical Terminology course for some time and achieved this last year. She was an attentive and diligent student who was always willing to help and support her classmates. To register for the AMSPAR qualification she needed to pass the additional exams, and despite two attempts unfortunately she had not passed. The AMSPAR awarding body frustratingly does not feedback which areas of the exam are unsuccessful, making it challenging for individual students to improve. Karen has been understandably very disappointed by this, and her confidence took a bashing. However, in true BHT style, she picked herself up and registered onto a Diploma in Medical Secretary Skills course, which she self-funded and completed in her own time. Karen was awarded a Distinction on 4th March! Her Aspirations have been achieved!  | Member of Staff |
| Respect     | Andy Cotrell and Rebecca Pearce, ODP                | I have PTSD and huge anxiety. I came into theatre awake for procedure to desensitise my nerve. I was terrified and this has been the 8th or so time I have been into theatre awake. Andy and Rebecca could not have been more amazing. They treated me as an individual, had a great sense of humour which I use to mask fear and they certainly picked this up quickly and ran with it. They were patient, funny, respectful and very compassionate. This is the first time I have managed a procedure without sedation, or a major panic attack. I honestly could not have been so brave without them. Shame that not all the staff could get this right in previous visits. Mental health is severely overlooked.   | Service User    |
| Enable      | Member of IT staff                                  | This member of staff recently volunteered to go onto a ward as a ward clerk during the recent covid surge. This was no easy task as they had to be retrained for this role. They also stayed in accommodation provided by the acts of kindness team isolating from loved ones due to not wanting to risk their health whilst being redeployed. They also stayed in accommodation provided by the acts of kindness team isolating from loved ones due to not wanting to risk their health whilst being redeployed. They never moaned, always smiled and was an asset to the ward during the recent covid surge in the Trust. As her line managers we would like to nominate them to receive one of the monthly CARE awards for all they have sacrificed whilst being redeployed. They missed their partners birthday, valentine's day and a few other memorable dates and could only catch up with loved ones via a video call due to being redeployed. | Member of Staff |

| Category    | Name & role  | Nomination   | Nominated by    |
|-------------|--|--|-----------------|
| Collaborate | Rhinna Young,<br>HCA                                   | Whilst on call as the medical registrar on the weekend, Rhianna showed exemplary clinical and communication skills when she recognised a deteriorating patient. She had sought advice from a staff nurse and did not feel her response met with her clinical concern for the patient. Rhianna therefore approached me as the medical registrar on the ward (reviewing a different patient) and effectively highlighted her concerns. An emergency call was soon put out and this patient transferred to ITU. Without her confident and appropriate escalation of her concerns this would not have happened in such a timely way. An excellent example of how as a whole medical team, we should feel empowered to escalate and raise our concerns for patients in the most appropriate way we feel suits the clinical need.  | Member of Staff |
| Aspire      | Gemma Heath,<br>Paediatric<br>Theatre Liaison<br>Nurse | Gemma works tirelessly and always with a smile, she has so much on her shoulders but never lets it show! she has worked on ICU through the pandemic dealing with unspeakable trauma but has also been the voices of hundreds of children requiring surgery who have been delayed due to such unprecedented circumstances. She arranges all the lists/staffing/covid swabs everything! & She is a ray of sunshine to work with and deserves a shout out for all that she does. I look up to her as her knowledge base is amazing! She is an unsung hero!  | Member of Staff |
| Respect     | Simon Nesbeth,<br>IT engineer                          | With reluctance, I joined a queue and called the IT desk and spoke to Simon who talked me through the computer issues I was having. Simon was patient and kind, and although I am sure he could sense my frustration, was calm in helping me resolve the issue. He did not rush me, and I was able to resolve the problem with his instruction and guidance. He told me he really enjoyed his job and even stayed late to ensure the problem was solved. He gave me his undivided attention, he made me feel competent and able - which I really appreciated! It struck me afterwards that perhaps the IT team do not get much recognition in all they do to help, so I just wanted to say a big thank you.  | Member of Staff |
| Enable      | Michelle James,<br>Workforce<br>Manager                | I want to nominate and thank Michelle for not only working with us collaboratively, but also for ENABLING myself and a colleague to do our jobs and ensure that we can recognise and acknowledge colleagues for their long service, without her support we couldn't do our job. Michelle is the manager of the ESR team but takes on a lot of this work herself. Her ESR team provide a huge amount of data and business intelligence to the rest of the organisation and everyone's need for workforce data is a huge task, but Michelle always delivers. However, when there are queries and there are usually loads once we have delivered a quarter, her role continues as we ask staff to complete a reckonable service form to update their record and make it correct - Michelle then validates the data on the form by going back to and scrutinising the individual files for staff, before updating the record - not an easy task when having to deal with all the other data reports and returns the ESR team have to deliver every month, hundreds of updates and changes. Thank you Michelle. | Member of Staff |

## Appendix 2 – Executive Management Committee and Transformation Board

### Executive Management Committee 30 March to 11 May 2021

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. During recent months this has also included important updates relating to our COVID-19 pandemic response. The meeting is chaired by the Chief Executive Officer and attended by Executive Directors 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 30 March 2021.

#### **Quality and Performance**

Maternity safety report  
Infection Prevention & Control (IPC) monthly reports  
24/7 Outreach business case  
IPC Board Assurance Framework  
Cancer services report  
Clinical audit  
Summary Emergency Department Indicator Table  
Patient experience report  
Ophthalmology mobile theatre site  
Young people mental health  
Paterson and Cumberlege report  
Research and Innovation committee  
Covid-19 inpatient visiting  
Ageing well pilots  
Patient safety surveillance and safeguarding vulnerable patients report  
Safe staffing  
Integrated care and disability sport  
Nursing Midwifery and Allied Health Professional Board  
Covid-19 third wave divisional planning  
Internal professional standards  
Midwifery workforce  
Divisional operational committee  
Care Quality Commission quality improvement plan  
Spinal cord injury service transformation  
Fluoroscopy replacement in radiology  
Quality Impact Assessments  
Robotic surgery business case  
Speech and Language Services provision for Children & Young People  
Maternity bid  
Hospital at night audit  
Lateral flow testing across Buckinghamshire  
Quality accounts annual report

#### **People**

CARE value awards  
Thrive @ BHT people recovery programme  
Education and training to health & social care workforce  
HR processes  
Agile working  
Health Education England  
Wellbeing day  
Staff travel  
Appraisal framework

#### **Money**

Monthly finance report  
Transformation update  
Covid-19 cost-tracking  
Purchase Order approval  
Cost Improvement Plan targets  
IT equipment procurement  
Business planning prioritisation  
Recovery resourcing  
Contract activity and income review  
Annual business planning 2021/22  
Capital 5-year programme  
Annual report and accounts

#### **Strategy, Estates & Commercial**

Operational planning  
Subsidiary social enterprise application  
Integration and innovation  
Population Health Programme  
Audiology tender  
Buckinghamshire Healthcare Projects Ltd 3 year strategy  
Text messaging service  
Commercial strategy  
ICS Operational Plan  
Buckinghamshire frailty strategy  
Security strategy

#### **Governance**

EMC Terms of Reference review  
Caldicott & Information Governance  
Legal services annual report  
Data Security & Protection toolkit  
Risk management strategy  
Internal audit plan  
Corporate risk register  
Annual Governance Statement  
Self-certification  
Governance manual –  
Standing Orders and Standing Financial Instructions  
Summary of internal audit

The following policies were approved:

- BHT Pol 030 – Data Quality Policy v4.3
- BHT Pol 240 – Antimicrobial Prescribing Policy
- BHT Pol 122 – Ionising Radiation Policy
- BHT Pol 004 – Bed Management, Patient Flow & Escalation Policy v7.0

Established in 2020-21 as an Executive-level meeting with clinical leads from across the Trust, Transformation Board is dedicated to strategic projects and meets on a monthly basis covering transformation portfolio updates, strategic business cases, and quality improvement. Below is an overview of some of the areas considered in the last two months:

Outpatient transformation

Urgent and emergency care transformation

Transformation measures

Consolidation of ophthalmology outpatients business case

Quality Improvement huddles rollout update

Buckinghamshire Integrated Care Partnership integration vision and priorities

Cost improvement update

Quality Improvement projects on a page:

- Rapid Response Intermediate Care named clinician of the day
- Falls task and finish group
- Incorporating Comprehensive Geriatric Assessment into admission clerking
- Quality Improvement training plan

# Performance: April 2021 in numbers



## A&E attendances

7,393  
April 2021

Number of people arriving in March: 6,763



## Emergency admissions

3,497  
April 2021

The number of patients admitted to a hospital bed March 2021: 3,475



## Planned procedures

3,268  
April 2021  
(3,324 - March 2021)

The number of elective day case and elective inpatient procedures carried out



## Outpatients contacts

35,497  
April 2021

The number of patients receiving treatment in an outpatient clinic vs March 2021 33,911



87

The number of deaths during April 2021 vs 114 March 2021

Crude mortality: 1.5%  
- deaths expressed as % of the number of admissions (1.6% March 2020)



A&E patients seen within 4 hour target  
82 %

Percentage of A&E patients seen within 4 hour national target in April 2021 (82.% in March 2021)



Friends & family test approval  
27%

Percentage of patients who would be likely or extremely likely to recommend our services to their friends & family in April 2021 (39.4% in March 2021)



Referral to treatment  
52.6%  
52.6% (Feb 2021)

National target for patients receiving treatment within 18 weeks of being referred in Apr 2021



## Total Falls

53 - Apr 2021  
0 causing severe harm

(59 - March 2021, 0 severe)

We monitor the number of patient falls and grade the severity of harm each month



## Cancer 2 week wait for referral

99.1%  
(98.3% March 2021)

Percentage of cancer patients referred receiving first appointment within 2 weeks March 2021 (reported 1 month in arrears)



## Cardiac arrests

1 - Apr 2021  
(2 - Feb 2021)

We are committed to achieving the elimination of all avoidable cardiac arrests



## Pressure ulcers

4 grade 3&4 Apr 2021  
(3 grade 3&4 - March 2021)

We monitor the number of pressure ulcers acquired each month and grade the severity

**Joiners total: 174**  
Nursing: 27  
Clinicians: 26  
Health care assistants: 31  
Administrative: 35 Support: 43  
Allied health professional: 12

Number of staff who joined/left in March & April 2021

**Leavers total: 175**



## Training modules delivered

9684  
9724 (March 2021)

Number of staff training modules delivered by our learning and education team in Apr 2021

**Meeting:** Trust Board Meeting in Public

**26 May 2021**

|                              |  |
|------------------------------|--|
| <b>Agenda item</b>           | Integrated Performance Report          |
| <b>Board Lead</b>            | Dan Gibbs                              |
| <b>Type name of author</b>   | Wendy Pocknell                         |
| <b>Attachments</b>           | None                                   |
| <b>Purpose</b>               | Information                            |
| <b>Previously considered</b> | EMC – 18.05.2021<br>F&BPC – 18.05.2021 |

### Executive Summary

- Performance and Clinical Risk update against national targets and guidelines
- Spotlight Reporting for key domains
- Quality and Workforce updates and improvement actions

Enclosed is the Integrated Performance Report (IPR) including exception slides and spotlight reporting. The IPR has been updated to include metrics to measure impact of COVID on standards including risk assessments which are instrumental to support recovery planning.

|                 |  |
|-----------------|--|
| <b>Decision</b> | The Board is requested to consider performance and virus risk impact |
|-----------------|--|

### Relevant strategic priority

|                  |                 |                |
|------------------|-----------------|----------------|
| <b>Quality</b> ☒ | <b>People</b> ☒ | <b>Money</b> ☒ |
|------------------|-----------------|----------------|

### Implications / Impact

|   |   |
|---|---|
| <b>Patient Safety</b>   | Impact on quality and safety standards and patient experience                                     |
| <b>Risk: link to Board Assurance Framework (BAF)/Risk Register</b>              | BAF 4.2 Improve our operational productivity  |
| <b>Financial</b>  | BAF 4.2 Improve our operational productivity  |
| <b>Compliance</b> <small>Select an item. Select CQC standard from list.</small> | National Standards and Quality targets  |
| <b>Partnership: consultation / communication</b>                                | Buckinghamshire ICP   |
| <b>Equality</b>   | Equality metrics trust-wide included herein. Access in particular has a number of equality risks. |
| <b>Quality Impact Assessment [QIA] completion required?</b>                     | Individual actions require QIA to be undertaken   |

# Integrated Performance Report

April 2021

*CQC rating (June 2019)*

-

*GOOD*

**Safe & compassionate care,**

**every time**

# Integrated Performance Report

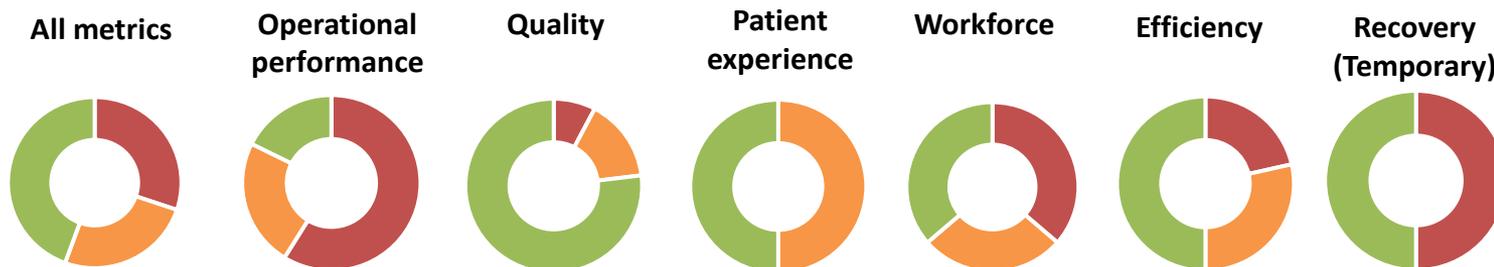
## Contents

### Section

- |                             |                                    |
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| 4. Demand Trends            | 11. Finance                        |
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| 1. RTT                      | 13. Appendix: Tables of Metrics    |
| 2. A&E                      |                                    |
| 3. Cancer                   |                                    |
| 4. Diagnostics              |                                    |
| 5. Community                |                                    |
| 6. Harm Review              |                                    |
| 6. Quality and Safety       |                                    |
| 7. Patient Experience       |                                    |

# Executive Summary

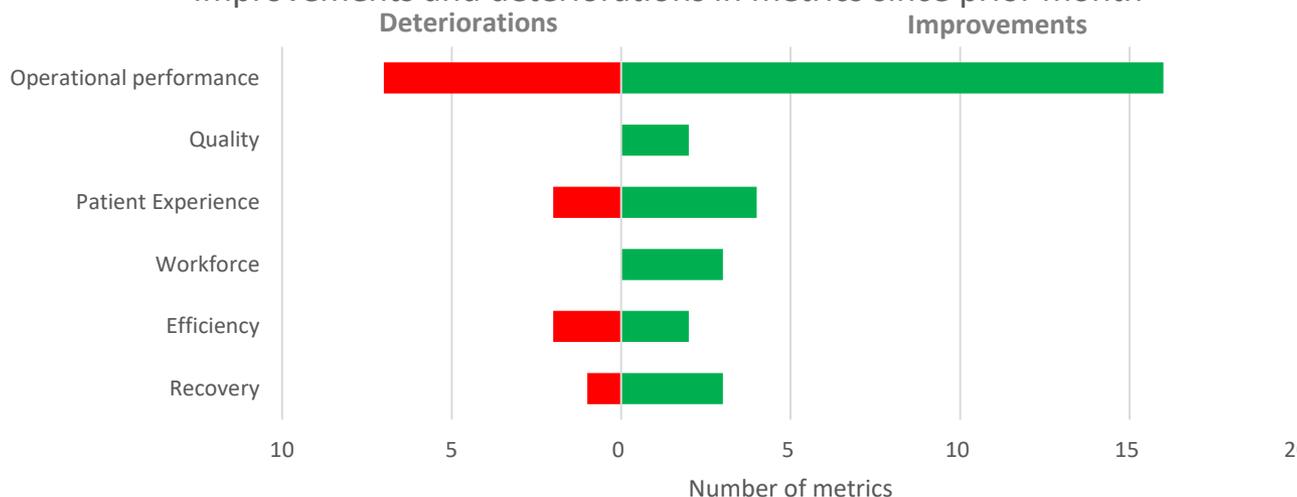
## Summary of RAG ratings for latest reporting period:



Showing a proportional split of the RAG ratings within each reporting domain.

## Prior month comparison:

### Improvements and deteriorations in metrics since prior month



This chart sets out the number of metrics in each reporting domain that have moved in a positive and negative direction from the previous reporting period.

Safe & compassionate care,

every time

## Operational Performance

### Spotlight Report from Chief Operating Officer (1/3)

April has been a month of recovery for the Trust, with elective services completing their restarts. 3 theatres at Wycombe remain closed for estate backlog reasons but will be coming back on stream in month subject to completed works. It is pleasing to report our ERF threshold status as 71% (in pure activity terms), however there is much work to do. The Trust remains an outlier in long waiters compared to the remainder of the region and the numbers of people being referred to care and (subsequently) being added to the waiting list has increased (NB we will be commissioning a review to unlock learning to improve our position in the future). Significantly, however, the overall number of 52 week + waiters has reduced by 630 in month through a combination of virtual review, treatment and validation. Our long waiter position still includes patients who have chosen to delay their treatment due to the pandemic – NHSE&I guidance is to retain these patients on the waiting list rather than enacting access policy and referring back to their GP until they are ready to come back for care. This proportion is significant – 19% of all people waiting over a year are those that have chosen not to come in.

At the front of house in our emergency department, work continues to improve how the department and the pathways that support it perform. Focus for April has been on reducing the number of people in department with a total length of stay of twelve hours, reducing our MOFD (medically optimised for discharge) numbers and our ambulance handover times. Whilst the total LOS has deteriorated marginally, it is worth noting that for the last week of April, only 14 people stayed in ED for more than twelve hours.

Safe & compassionate care,

every time

## Operational Performance

### Spotlight Report from Chief Operating Officer (2/3)

Work is ongoing to sustain and improve this throughout May, adding renewed focus on non-admitted pathways examining processes and aiming to improve efficiency and reduce duplication. It is worth noting, however, that the enabling works for the paediatric emergency department development may impact on front-of-house flow as we move the obstetric and gynaecology department into the corridors adjacent to ED.

Cancer performance has improved for this reporting period (March data). Whilst we have not achieved the 62-day standard, we have overachieved the faster diagnostic standard, which requires us to have diagnosed or excluded cancer within 28 days of referral. This is a great achievement and should be celebrated – reducing the amount of time patients carry uncertainty about their condition is an important quality improvement as well as allowing more time to arrange treatment.

Covid demand has reduced significantly. Initial modelling indicates that the Trust may see a rise in demand in the summer months. Whilst we have escalation and continuity plans in place and have opportunity to expand critical care and respiratory capacity quickly, medical capacity remains our biggest challenge. Hence these plans are under review, adapting all learning from earlier waves of the pandemic. Our focus, working with system partners, on discharge to assess models will certainly help in this regard, however the Board must note the risk of future derogation of elective or specialist services to create capacity.

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# Operational Performance – Community Services Buckinghamshire Healthcare Spotlight Report from Chief Operating Officer (3/3)

Frailty is a clinically recognisable state of increased vulnerability resulting from aging-associated decline in reserve and function across multiple physiological systems such that the ability to cope with every day or acute stressors is compromised. Nationally there has been a steady increase in the volume of patients aged over 75 years who are admitted with one or more of the frailty groups present. BHT has seen a similar increasing trend although in the last 2 years the trend has increased at a flatter gradient than the national. Bucks Healthcare shows a peak in frailty patients at around 84. This group of patients may benefit from increased input and support to enable them to be discharged and to stay at home

To support the frailty agenda, we have developed:

A Short Stay Frailty Unit' where patients will be admitted from the emergency pathway when they cannot return to their residence due to requiring minor medical treatment or therapy assessments or while waiting for packages of care to be arranged.

- Discharge lounge in response to the NHSE Discharge Guidance 2020, for all patients once a decision has been made for them to be discharged from hospital
- SDEC, CATS and MuDAS to support a Virtual Ward Model (programmed by NHS Elect) across county (Oct 2021), avoiding unnecessary attendance and admission to hospital

Urgent Community Response: Ageing Well

- Staff consultation launched for registered staff in RRIC regarding working hours 8am-8pm, 7 days a week.
- Communication with PCNs informing of phased roll out plan and go live dates.
- Ongoing engagement with SCAS and front door to drive referrals for in-hours 2 hour crisis response and 2 day referrals.
- Scoping with other community services delivering 2 hour crisis response underway.
- Redesign of triage pathway has enabled clinicians to have better quality of information gathering, faster decision making, and quicker deployment of staff to attend to the patient at risk of admission.

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# Quality & Safety

## Spotlight Report from Medical Director and Chief Nurse

### Chief Nurse

Infection Prevention and Control have planned a rolling programme Back to Basics campaign to commence May 17<sup>th</sup> 2021. To cover education and awareness of infection prevention and control procedures with a focus on hand hygiene, appropriate use of gloves, and use of PPE in line with national PPE guidance.

The Chief Nurse’s Office and Communications have have been working closely with the Head of Medical Quality, and corporate Medical Directorate to produce a final draft of the Quality Account due for sharing with partners in mid May 2021, and published end of 30<sup>th</sup> June 2021.

Overdue incidents have significantly reduced since December with sustained focus from Divisions – see table, demonstrating an improved position for the trust governance process.

|        | 10/5/21 | 4/5/21 | 6/4/21 | 29/3/21 | 1/3/21 |
|--------|---------|--------|--------|---------|--------|
| Totals | 374     | 398    | 514    | 465     | 765    |

# Patient Experience

## Spotlight Report from Medical Director and Chief Nurse

Approval ratings inpatient and community services have begun to improve after declining during the second lockdown. The Trust reintroduced visiting to general wards in mid-April on the basis of one visitor per patient for one hour every day from Monday to Friday. This has begun to impact on inpatient approval ratings which began to decline in January.

For the first time since the start of the pandemic partners are now able to accompany women to all appointments and scans and women are able to have two birth partners. The exclusion of partners from all but the 12-week scans during the pandemic has been a source of a number of complaints, and the change to allow partners has been welcomed by families.

The Trust received 48 complaints in April which is within the normal range; we have not yet seen a surge in complaints such as happened as we came out of the first lockdown. Treatment & procedure, staff attitude & behaviour, and communication were the top three categories for complaints in April.

# Workforce

## Spotlight Report from Director of Workforce



### **COVID-19 vaccinations**

Uptake of the vaccine for all BHT colleagues first dose is 88% and second dose is currently 79% as we have not yet completed second dose clinics. The lowest uptake is in our 240 Black British colleagues, 75% of whom have had a 1<sup>st</sup> dose. The difference in uptake difference between staff groups of different ethnicity is reducing overall (from 9% to 3%) the reduction is the result of positive actions, including Webinars with expert panels and the support of our BAME Network and offer of the Astra Zeneca vaccine, as an alternative to Pfizer. Occupational Health have had one to one calls with all frontline staff that have not yet had the vaccine and we continue to have regular communication updates to all colleagues. All that required a second dose of the Pfizer vaccine were completed by 25 April and we will run a second dose Astra Zeneca clinic the week of 17 May .

### **Sickness absence**

Sickness absence levels continue to stabilise following the January peak .In April, 1 staff member tested positive for COVID-19 compared with 10 in March, 71 in February and 273 in January. We continue to use lateral flow testing, which is available to all staff, to monitor Covid-19 rates. The sickness absence data available in real time via First Care is enabling us to provide focused interventions in response to absence trends, with psychological and Muscular-skeletal absence issues a key theme, for which we have specialist support in place in-house and a dedicated ICS mental health hub for further support when required.

### **Occupational health stress referrals.**

As anticipated, the management referrals for stress have increased as the pressures of the pandemic begin to reduce in many areas, and people are now taking an opportunity to seek support. Proactive support is in place through the Thrive @BHT initiative, with an emphasis on team support to support psychological wellbeing will help mitigate the number of individuals being referred.

### **Temporary staffing**

We have had a decrease in demand this month, due to closure of escalation areas. Bank fill rate has decreased, reflecting an anticipated seasonal trend, however we have assured safe staffing levels daily. We have seen a further decrease in our usage of off-framework agency for hard to fill positions and we are working at pace to reduce this further.

### **Turnover**

Turnover rate is statistically remaining stable. We had 86 fte leavers in April, of which 11.5 fte were registered nurses. We had 5 retirees, 2 of whom then returned to work in the Trust. We are using leaver interview data to address key issues through new initiatives, including a new focus on promoting internal opportunities for both educational and career opportunities.

### **Statutory training**

Our compliance has increased by 1.6% in April Additional steps were introduced from April as part of our THRIVE@BHT programme to support further compliance.

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# Finance

## Spotlight Report from Director of Finance

- 1. 2021/22 I&E month 1 year to date (YTD) headline position of break even** in line with the provisional annual budget agreed by Board in April 2021. This is supported by £3.3m of non-recurrent Block top-up income funding, this income has been accrued based on the latest guidance from NHSE/I. This income is subject to their review and approval.
- 2. Position includes £0.8m of Covid-19 related incremental expenditure and income**, resulting in a neutral impact to the year to date position. There are ongoing discussions with Bucks CCG and BOB ICS which may result in a reduction to the total income assumed in the H1 Plan.
- 3. Full year forecast of £22.0m deficit in line with plan.** This plan is based on a number of key assumptions and an assessment of risk undertaken in April 2021. Due to the level of uncertainty and additional risk created by the Covid-19 pandemic, this is a draft plan and it remains subject to final review and approval by the Board.
- 4. The Trust is continuing to develop the CIP efficiencies plan.** This may result in a final plan and forecast that is materially different to the current plan.

# Demand Trends

| Metric  | Latest reporting period | Previous reporting period | Reporting period | Movement since last month | RAG | 12-month trend |
|---|-------------------------|---------------------------|------------------|---------------------------|-----|----------------|
| <b>A&amp;E</b>  |                         |                           |                  |                           |     |                |
| A&E attendances   | 7,393                   | 6,763                     | Apr-21           | ↑                         |     |                |
| <i>Total number of A&amp;E attendances at Stoke Mandeville Hospital</i>             |                         |                           |                  |                           |     |                |
| CSRU attendances  | 420                     | 456                       | Apr-21           | ↓                         |     |                |
| <i>Total number of attendances at the Cardiac and Stroke Unit, Wycombe Hospital</i> |                         |                           |                  |                           |     |                |
| CAT clinic activity   | 148                     | 76                        | Apr-21           | ↑                         |     |                |
| <i># of Patient contacts at the Community Assessment and Treatment Service</i>      |                         |                           |                  |                           |     |                |
| <b>Cancer</b>   |                         |                           |                  |                           |     |                |
| Cancer - 2 week wait referrals  | 1,996                   | 1,436                     | Mar-21           | ↑                         |     |                |
| <i># of urgent 2 week wait cancer referrals received.</i>                           |                         |                           |                  |                           |     |                |

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# Demand Trends

| Metric   | Latest reporting period | Previous reporting period | Reporting period | Movement since last month | RAG | 12-month trend |
|--|-------------------------|---------------------------|------------------|---------------------------|-----|----------------|
| <b>RTT</b>   |                         |                           |                  |                           |     |                |
| GP referrals   | 6,478                   | 7,876                     | Apr-21           | ↓                         |     |                |
| <i># of GP referrals received in month</i>                                   |                         |                           |                  |                           |     |                |
| <b>Community</b>   |                         |                           |                  |                           |     |                |
| Total referrals  | 6,821                   | 7,298                     | Apr-21           | ↓                         |     |                |
| <i># of patients referred to Community Services (all)</i>                    |                         |                           |                  |                           |     |                |
| Covid Referrals  | 6                       | 46                        | Apr-21           | ↓                         |     |                |
| <i># of suspected COVID 19 patients referred to Community Services (all)</i> |                         |                           |                  |                           |     |                |
| Non Covid Referrals  | 6,815                   | 7,252                     | Apr-21           | ↓                         |     |                |
| <i># of non COVID 19 patients referred to Community Services (all)</i>       |                         |                           |                  |                           |     |                |

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# Operational Performance Overview

Summary of RAG ratings:



Summary of metrics:

| Metric  | Target | Latest reporting period | Previous reporting period | Reporting period | MoM mvmt<br>G = Improvement<br>R = Deterioration | RAG    | SPC threshold breach | Exception report |
|---|--------|-------------------------|---------------------------|------------------|--|--------|----------------------|------------------|
| <b>A&amp;E</b>                                |        |                         |                           |                  |  |        |                      |                  |
| A&E - 4 hour performance                      | 95.0%  | 82.0%                   | 82.6%                     | Apr-21           | ↓  | Red    |                      |                  |
| A&E - Child under age one - triage in 15 mins | 95.0%  | 83.6%                   | 89.4%                     | Apr-21           | ↓  | Grey   |                      | ✓                |
| A&E - Patients over 12 hours in A&E           | 0      | 394                     | 366                       | Apr-21           | ↑  | Red    |                      |                  |
| A&E - Delayed ambulance handovers             | 0      | 48                      | 53                        | Apr-21           | ↓  | Orange |                      |                  |
| A&E - Patients returning within 72 hours      |        | 4.0%                    | 4.7%                      | Apr-21           | ↓  | Grey   |                      |                  |
| <b>Cancer</b>                                 |        |                         |                           |                  |  |        |                      |                  |
| Cancer - 2ww - first appt within 2 weeks      | 93.0%  | 99.1%                   | 98.3%                     | Mar-21           | ↑  | Green  |                      |                  |
| Cancer - 2ww - treatment within 62 days       | 85.0%  | 82.9%                   | 69.6%                     | Mar-21           | ↑  | Orange |                      |                  |
| Cancer - screening - treatment within 62 days | 90.0%  | 100.0%                  | 80.0%                     | Mar-21           | ↑  | Green  |                      |                  |
| Cancer - 31 days to first treatment           | 100.0% | 98.3%                   | 96.4%                     | Mar-21           | ↑  | Green  |                      |                  |
| Cancer - 104 day waits                        | 0      | 11                      | 9                         | Mar-21           | ↑  | Red    |                      | ✓                |

[Link to appendix](#)

Constitutional targets are highlighted blue

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# Operational Performance Overview



## Summary of metrics:

| Metric  | Target | Latest reporting period | Previous reporting period | Reporting period | MoM mvmt<br>G = Improvement<br>R = Deterioration | RAG | SPC threshold breach | Exception report |
|---|--------|-------------------------|---------------------------|------------------|--|-----|----------------------|------------------|
| <b>RTT</b>  |        |                         |                           |                  |  |     |                      |                  |
| RTT - Open Pathway performance  | 92.0%  | 52.6%                   | 52.6%                     | Apr-21           | →  |     |                      |                  |
| RTT - Number of open pathways   | 31,024 | 35,497                  | 33,911                    | Apr-21           | ↑  |     | ×                    |                  |
| RTT - Patients open pathways over 52 weeks  | 0      | 6,048                   | 6,678                     | Apr-21           | ↓  |     | ×                    |                  |
| RTT - Patients open pathways over 26 weeks  | 0      | 12,017                  | 11,801                    | Mar-21           | ↑  |     |                      |                  |
| RTT - Diagnostic waits under 6 weeks  | 99.0%  | 59.6%                   | 58.9%                     | Mar-21           | ↑  |     |                      |                  |
| <b>Community</b>  |        |                         |                           |                  |  |     |                      |                  |
| % of EHCP completed in 6 weeks  |        | 70.0%                   | 44.1%                     | Mar-21           | ↑  |     |                      |                  |
| % of births offered a face to face appointment with a Health Visitor within 14 days |        | 80.0%                   | 81.1%                     | Apr-21           | ↓  |     | ×                    |                  |
| % of LAC seen within 20 days (in county)  |        |                         |                           | Feb-21           | →  |     |                      |                  |
| % of LAC seen within 20 days (out of county)  |        |                         |                           | Feb-21           | →  |     |                      |                  |

[Link to appendix](#)

Constitutional targets are highlighted blue

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# Operational Performance Overview



Buckinghamshire Healthcare  
NHS Trust

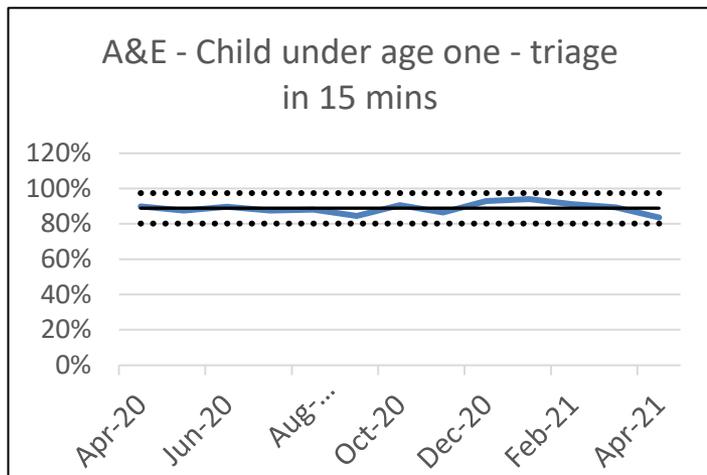
## Summary of metrics:

| Metric   | Target | Latest reporting period | Previous reporting period | Reporting period | Direction = MoM mvmt<br>Green = Improvement<br>Red = Deterioration | RAG | SPC threshold breach | Exception report |
|--|--------|-------------------------|---------------------------|------------------|--|-----|----------------------|------------------|
| <b>Harm review</b>                                     |        |                         |                           |                  |  |     |                      |                  |
| Cancer - COVID delays                                  |        | 15                      | 21                        | Apr-21           | ↓  |     |                      |                  |
| Elective referrals                                     |        | 19,068                  | 22,391                    | Apr-21           | ↓  |     |                      |                  |
| Clinical Harm assessment - category P1 waiters         |        | 3                       | 2                         | Apr-21           | ↑  |     |                      |                  |
| Clinical Harm assessment - category P2 waiters         |        | 305                     | 297                       | Apr-21           | ↑  |     |                      |                  |
| <b>Other Operational</b>                               |        |                         |                           |                  |  |     |                      |                  |
| Reablement - median urgent response time (hours)       | 8      | 2.1                     | 2.1                       | Apr-21           | ↓  |     |                      |                  |
| District Nursing - median urgent response time (hours) | 8      | 2                       | 2                         | Apr-21           | →  |     |                      |                  |
| Average bed occupancy (G&A)                            |        | 91.8%                   | 91.7%                     | Apr-21           | ↑  |     |                      |                  |
| Emergency readmission within 30 days                   | 5.0%   | 7.9%                    | 6.6%                      | Mar-21           | ↑  |     |                      |                  |
| Patients with expected discharge date                  |        | 63.2%                   | 57.8%                     | Apr-21           | ↑  |     |                      |                  |
| Neck of femur fracture to theatre in 36 hours          |        | 83%                     | 60%                       | Apr-21           | ↑  |     |                      |                  |
| % of beds occupied by MFFD                             |        |                         |                           | Feb-21           | →  |     |                      |                  |
| Average length of stay post-MFFD                       |        |                         |                           | Feb-21           | →  |     |                      |                  |

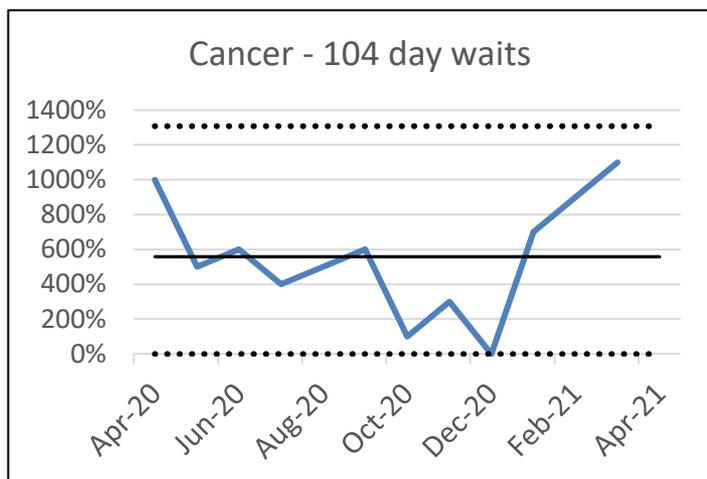
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# Performance Exceptions



| Risk  | Resolution Action   | Improvement timeline | Owner  |
|---|---|----------------------|--|
| Children triaged to GP streaming and minors may have some delay in pathway. | Children's pathway being remapped in anticipation of paed's A&E build | End June 21          | Divisional Director for Women & Children / Divisional Director for Integrated Medicine |

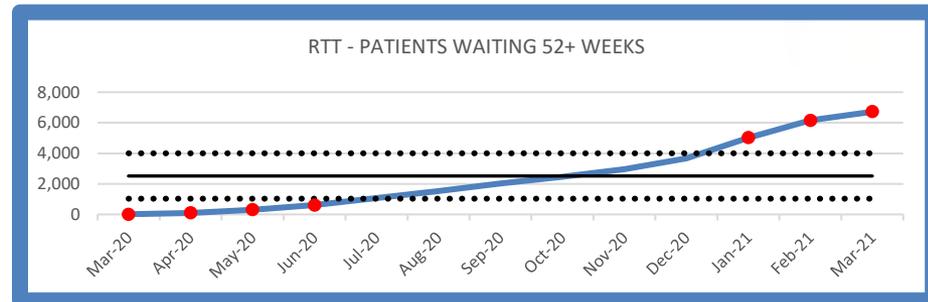
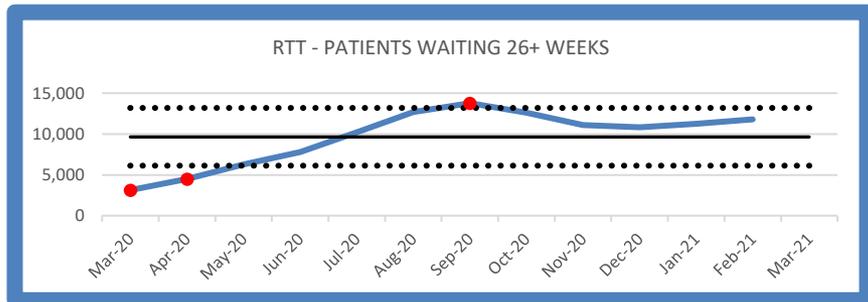


| Risk  | Resolution Action   | Improvement timeline | Owner                                  |
|---|---|----------------------|--|
| Patients come to harm due to delayed cancer treatment | Weekly escalation of waiting patients.<br><br>Current breaches due to complexity of treatments and patient choice.<br><br>Delivery of FDS | End June 21          | General Manager for Cancer Performance |

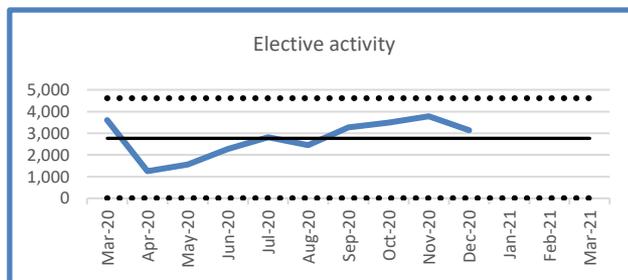
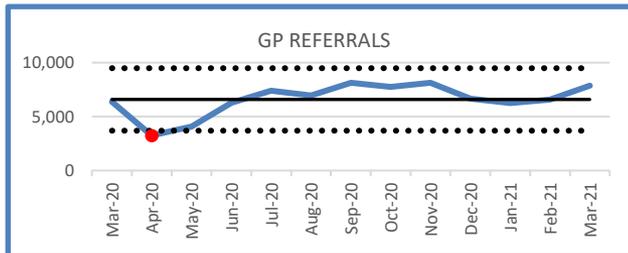
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# Operational performance

## RTT



| Breakdown of waiting list | Booked      | Not booked   | Total        |
|---------------------------|-------------|--------------|--------------|
| >=105 weeks               | 6           | 28           | 34           |
| 53-104 weeks              | 849         | 5093         | 5942         |
| 41-52 weeks               | 205         | 1446         | 1651         |
| 27-40 weeks               | 552         | 4318         | 4870         |
| 18-26 weeks               | 956         | 3856         | 4812         |
| <b>Total</b>              | <b>2568</b> | <b>14741</b> | <b>17309</b> |



|              | Patient choice |
|--------------|----------------|
| >=105 weeks  | 70%            |
| 53-104 weeks | 19%            |

**Performance commentary**

March has seen an increase in referrals from GPs, many of them for urgent assessment. This is likely to continue in the coming months and relevant outpatient, diagnostic and theatre capacity is identified in the recovery plan to meet demand.

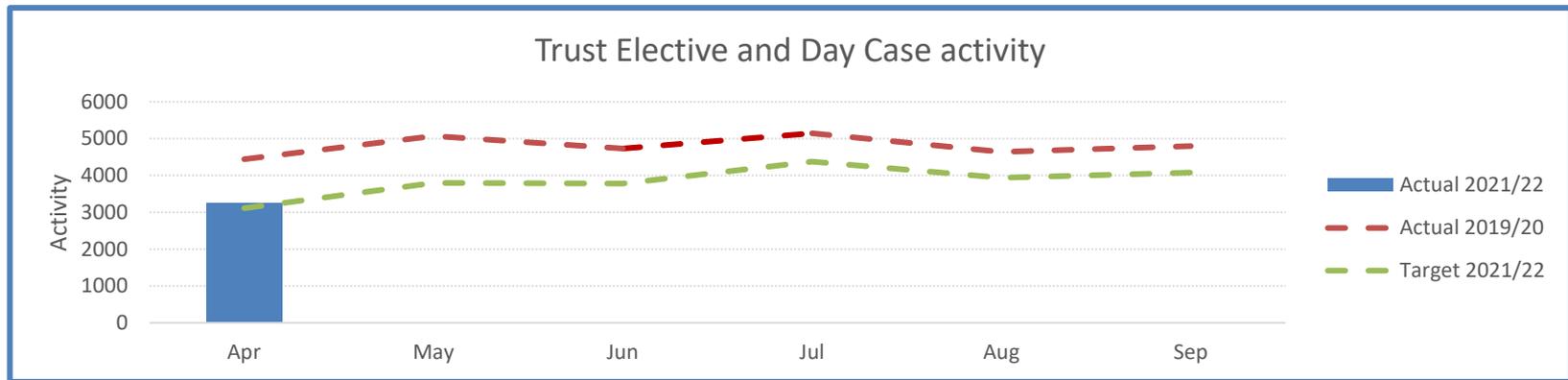
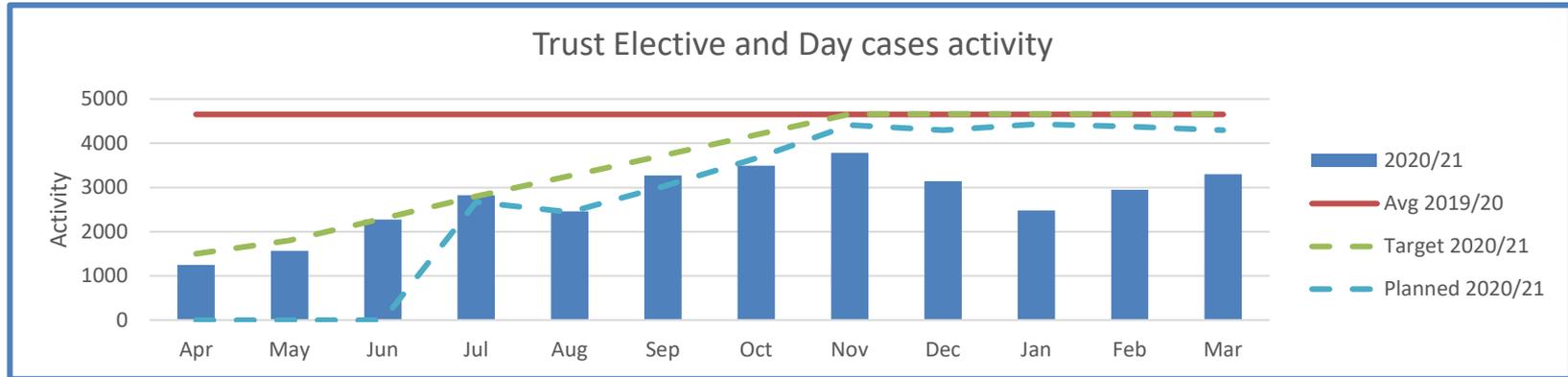
Patients continue to wait longer for their first appointment and treatment but patients over 52 weeks has now stabilised. This will start to decrease as services are able to increase capacity.

Some patients are still concerned about the risk of infection and do not want to attend hospital currently, BHT continue to monitor these patients and communicate with them regularly.

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# Operational performance

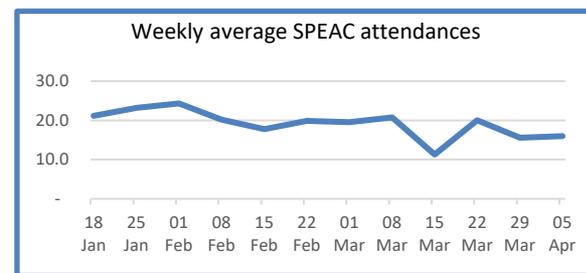
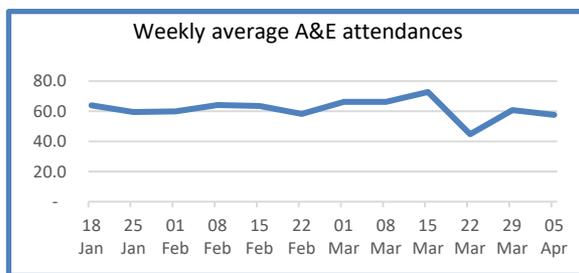
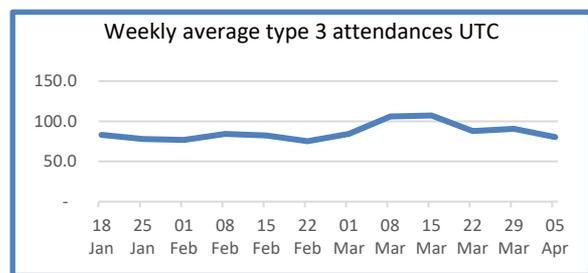
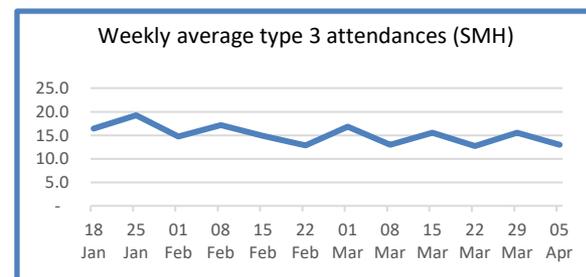
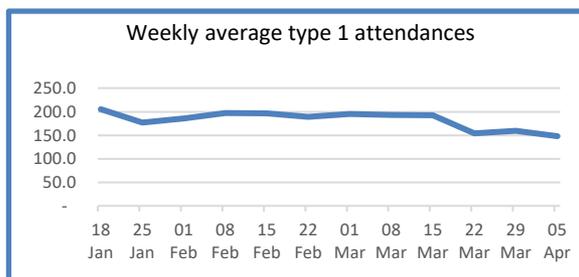
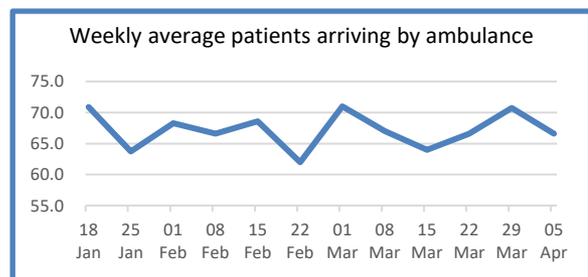
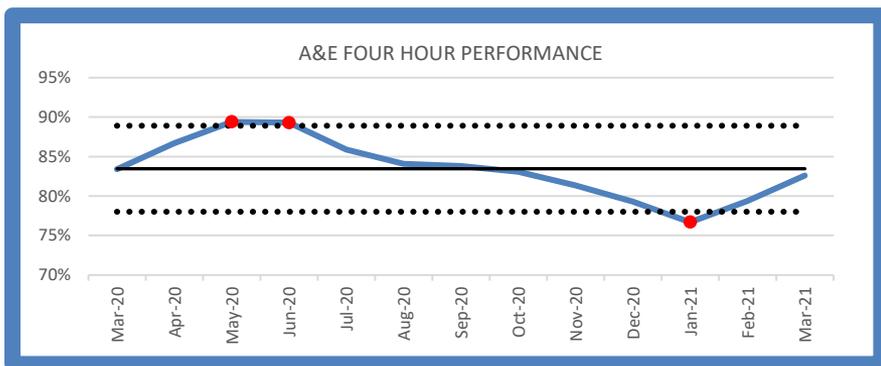
## RTT – Recovery Trajectory



The Trust finished March 21 recovering to 71% of 19/20 activity. Additional theatres and facilities are expected to open to extend capacity further, aiming to meet a minimum of 85% by September 21. Infection control regulations must be adhered to which does restrict the level of capacity, but BHT will continue to optimise opportunities to expand services wherever possible.

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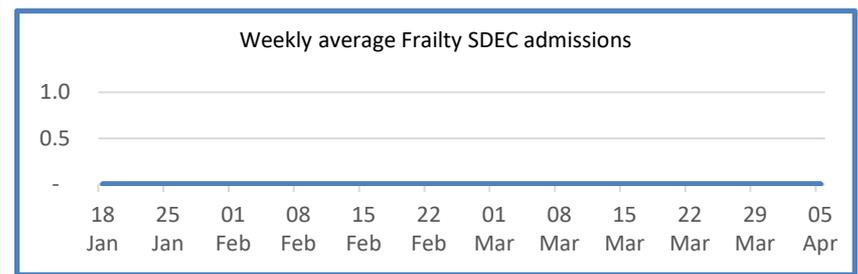
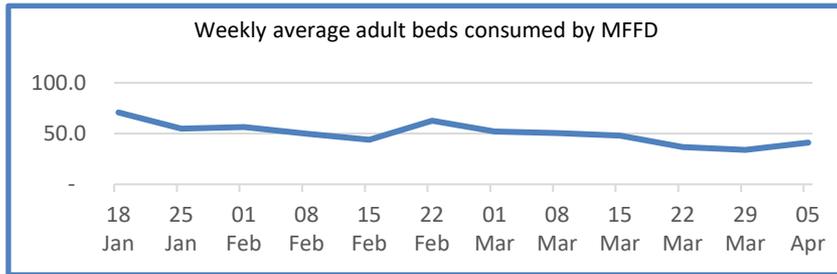
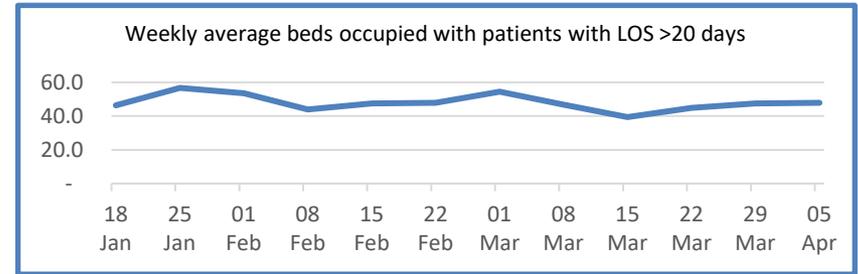
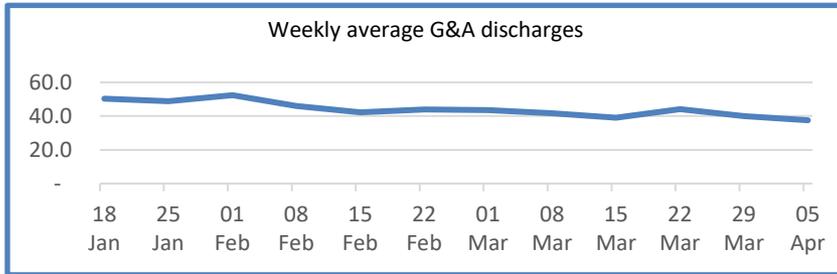
# Operational performance A&E



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# Operational performance

## A&E



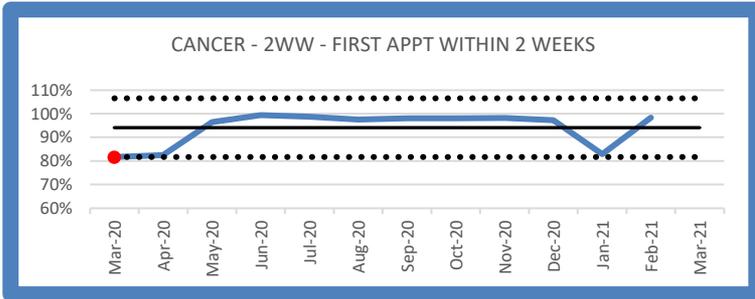
### Performance commentary

The four hour performance throughout winter was impacted by flow: frequently > 50% ED Majors space was occupied by patients under other specialties. More recently, attendances have increased dramatically. On one day in May, 330 pts attended, which is the highest since Winter 2019. Of those, 268 pts were discharged without being referred to another specialty, with a significant number reporting that they had been sent to A&E by their GP.

The marked improvement in flow seen throughout April and May has had a profound effect on ambulance handover times. The dept is focussing on reducing ambulance handover times, total length of stay and non-referred performance, with an 'ED Manager of the day' now in place to support the Nurse in Charge and the Emergency Physician in Charge to manage issues stopping them from achieving this.

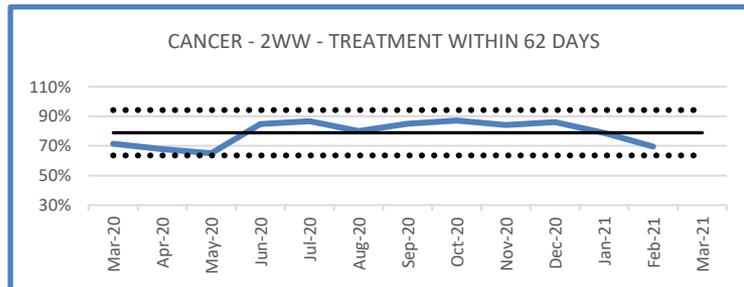
# Operational performance

## Cancer



### Breakdown of waiting list:

|                         | <31 days | >31 days | >62 days | >104 days |
|-------------------------|----------|----------|----------|-----------|
| <b>All tumour sites</b> | 1,649    | 243      | 93       | 41        |
| Lung                    | 49       | 9        | 9        | 3         |
| Lower Gastro            | 300      | 68       | 26       | 7         |
| Gynae                   | 154      | 11       | 13       | 11        |
| Urological              | 166      | 34       | 7        | 1         |



### Performance commentary

Cancer pathways remain open and safe. Patients continue to receive telephone or face to face contacts within two weeks and diagnostic procedures offered as appropriate.

The **2WW** performance recovered in February and BHT remain compliant. The 2WW referrals from GPs increased in Feb 2021 and we continue to watch the challenging areas such as radiology support in the Breast one stop.

Although we failed the **62-day** target in March we had an 11% increase on performance. All the other standards were passed and there were no subsequent treatment breaches.

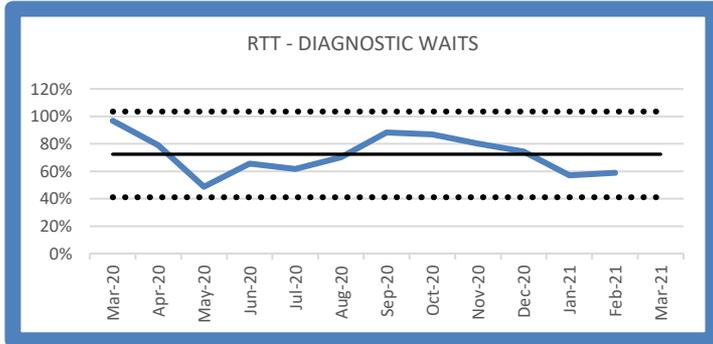
The Trust passed the **Faster Diagnostic Service** target by 6%. This is supported by dedicated trackers who closely track and manage the progress of patients through this pathway.

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# Operational performance

## Diagnostics



### Performance commentary

An increase in cancer referrals has led to increased demand for diagnostic procedures. The radiology and endoscopy team are working to offer weekend capacity and increase appointment options for patients.

Estates issues are still prohibiting Radiology installing new equipment, which is having a negative impact on the service, both MRI and Fluoroscopy. Demand for imaging is increasing but due to these issues Radiology is struggling to meet this demand.

The current, risks driven by the current estates issues, include a failure of the MRI and Interventional Radiology services at SMH. Mitigations are being sought, but would likely lead to outsourcing patients to neighbouring trusts, if they accept, and large financial burdens in the use of mobile equipment.

All patients that do not yet want to attend are held pending and will be contacted again, while cancer and urgent patients continue to be offered their procedures within two weeks.

Infection control regulations are in force in required areas and BHT are working to provide additional capacity to improve the waiting time and return to a 6 week target.

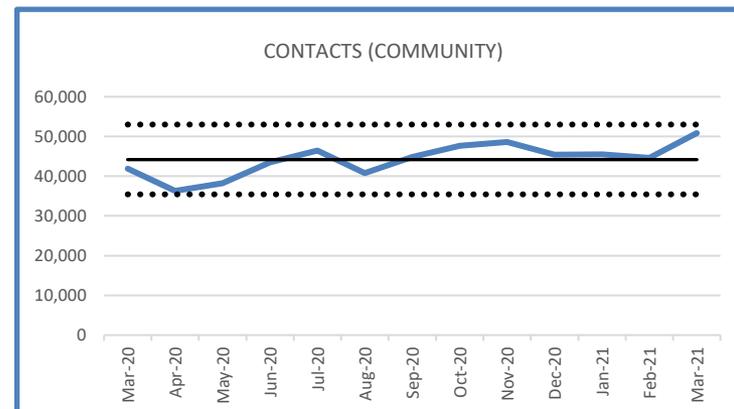
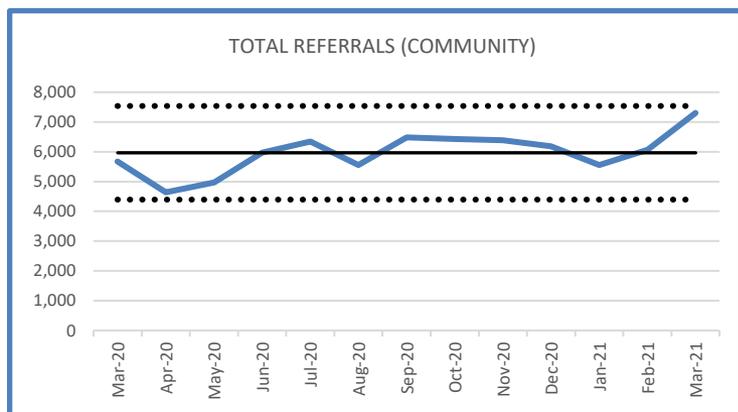
| Modality                  | Service                                      | Activity                        |   | Waiting List |              |              |
|---------------------------|--|---------------------------------|---|--------------|--------------|--------------|
|                           |  | Total tests / procedures latest | Total tests / procedures previous month | < 6 Weeks    | > 6 Weeks    | Total WL     |
| Imaging                   | Magnetic Resonance Imaging                   | 1,857                           | 1,759                                   | 565          | 7            | 572          |
|                           | Computed Tomography                          | 3,707                           | 3,243                                   | 612          | 1            | 613          |
|                           | Non-obstetric ultrasound                     | 3,471                           | 3,090                                   | 1,105        | 887          | 1,992        |
|                           | Plain film                                   | 0                               | 0                                       | 0            | 0            | 0            |
|                           | DEXA Scan                                    | 0                               | 13                                      | 114          | 260          | 374          |
| Physiological Measurement | Audiology - Audiology                        | 353                             | 304                                     | 207          | 0            | 207          |
|                           | Cardiology - echocardiography                | 296                             | 256                                     | 389          | 462          | 851          |
|                           | Cardiology - electrophysiology               | 0                               | 0                                       | 0            | 0            | 0            |
|                           | Neurophysiology - peripheral neurophysiology | 0                               | 0                                       | 0            | 0            | 0            |
|                           | Respiratory physiology - sleep studies       | 0                               | 0                                       | 25           | 0            | 25           |
| Urodynamics - pressures & | 0  | 0                               | 0                                       | 0            | 0            |              |
| Endoscopy                 | Colonoscopy                                  | 191                             | 188                                     | 159          | 344          | 503          |
|                           | Flexi sigmoidoscopy                          | 95                              | 87                                      | 79           | 156          | 235          |
|                           | Cystoscopy                                   | 323                             | 252                                     | 280          | 0            | 280          |
|                           | Gastroscopy                                  | 238                             | 247                                     | 177          | 400          | 577          |
| <b>Total</b>              |  | <b>10,531</b>                   | <b>9,439</b>                            | <b>3,712</b> | <b>2,517</b> | <b>6,229</b> |

| Radiology complete to report turnaround times   | Reporting month |        |        |        |        | Apr-21 | Trend |
|---|-----------------|--------|--------|--------|--------|--------|-------|
|   | Week 1          | Week 2 | Week 3 | Week 4 | Week 5 |        |       |
| Actual % for 2WW 5 days                         | 91%             | 96%    | 94%    | 97%    | 90%    |        |       |
| Actual % for GP 14 days                         | 96%             | 98%    | 56%    | 65%    | 61%    |        |       |
| Actual % for OP 21 days                         | 96%             | 96%    | 94%    | 89%    | 90%    |        |       |
| Actual % for A&E & IP Cross Sectional 1 day     | 99%             | 99%    | 99%    | 100%   | 99%    |        |       |
| Actual % for A&E & IP Plain Film Exc CXR 3 days | 89%             | 98%    | 83%    | 82%    | 90%    |        |       |
| Actual % for A&E & IP Plain Film CXR 21 days    | 100%            | 100%   | 100%   | 99%    | 100%   |        |       |

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# Operational performance Community



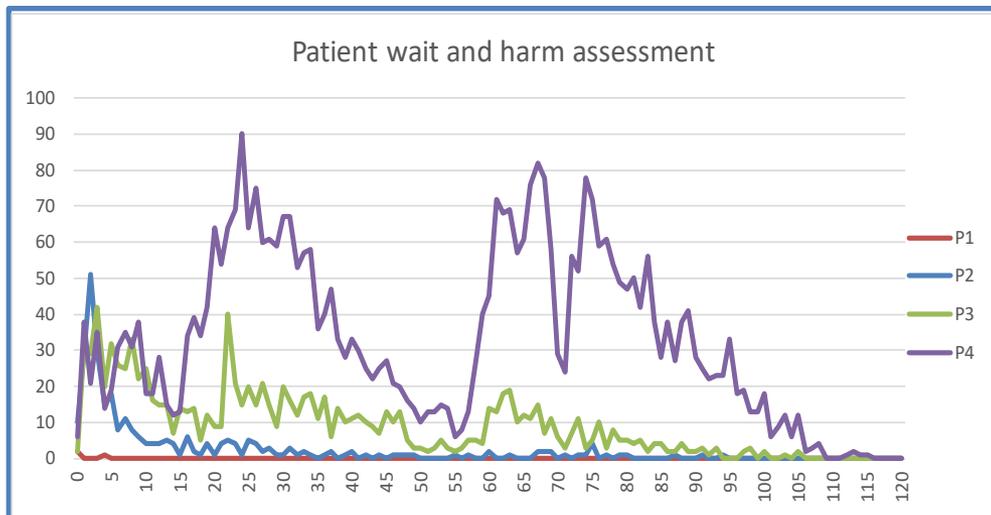
### Performance commentary

Referrals to community services continue to rise, as does patient contacts. This is stretching the community nursing services and the team are hoping that an easing of lockdown will allow patients to utilise the services within the GP practices more rather than requiring home visits.

Demand and staffing levels continue to be monitored to ensure the service retains the ability to manage the demand safely and appropriately.

# Operational performance

## Harm review



### Patients waiting for first treatment

The Trust is committed to ensuring all patients who have the highest level of risk are offered treatment within 72 hours. We aim to offer patients considered the second highest risk (P2), treatment within 4 weeks after the decision to admit them. Some patients choose to defer this treatment and are booked later, however there are some areas that are challenged for capacity. Recovery of the services to a higher level of capacity will support booking patients earlier.

All patients who are P4 have been contacted and can access a telephone line if they are concerned or their symptoms have changed. The clinician responsible will return their call.

Harm reviews are regularly reviewed, and theatre capacity allocated in line with those most at risk, and in this way BHT aim to keep their patients as safe as possible.

| Cod e   | Description  |
|---------|--|
| P1<br>■ | Patients whose lives are at risk if not treated urgently   |
| P2<br>■ | Patients who have severe or life threatening conditions needing an operation in a matter of weeks  |
| P3<br>■ | Patients who do not need to be treated urgently as their condition is not life threatening or rapidly changing but need to be operated on within 3 months as their condition may become severe or life threatening if they have to wait any longer |
| P4<br>■ | Patients who's condition is more stable.   |

### Patients waiting for follow up

Many patients had their follow up appointments cancelled in 20/21 and are being held pending another one being booked. Other patients received a telephone appointment but now need to be seen. BHT plan to continue offering telephone contacts but also ensure those that need to be seen face to face have the opportunity to come to the hospital.

Although there are a lot of patients waiting, we do need to be sure that the appointment is still required and patients are booked in priority order. After a short period of validation, BHT intend to follow the P categorisation for follow up patients and consider urgency and length of time waiting. Communication with waiting patients is a priority.

Patients who were due to be seen prior to 20/21 will be part of the validation and prioritisation process, involving clinicians and patients in next steps decisions.

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# Quality & Safety Overview

## Summary of RAG ratings: Summary of metrics:



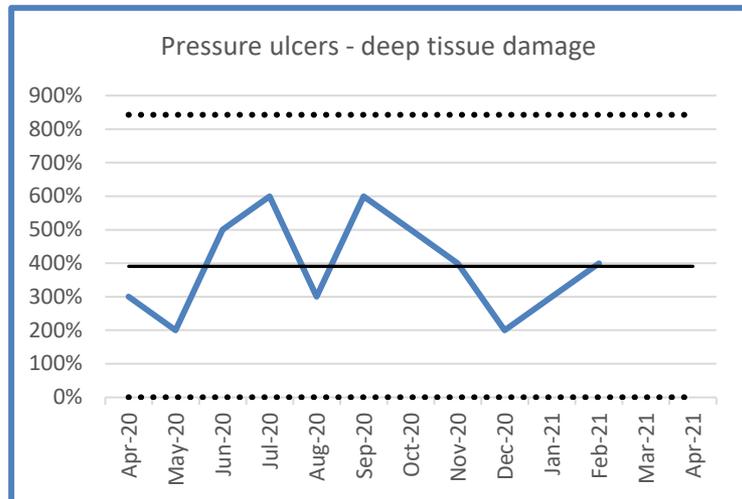
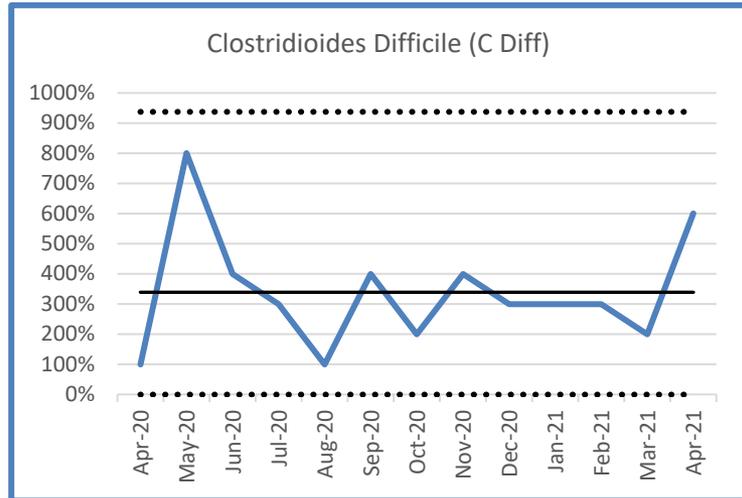
| Metric  | Target | Latest reporting period | Previous reporting period | Reporting period | MoM mvmt<br>G = Improvement<br>R = Deterioration | RAG    |
|---|--------|-------------------------|---------------------------|------------------|--|--------|
| MRSA  | 0      | 0                       | 0                         | Apr-21           | →  | Green  |
| Clostridioides Difficile (C Diff)                                   | 0      | 6                       | 2                         | Apr-21           | ↑  | Orange |
| Never Events  | 0      | 0                       | 0                         | Apr-21           | →  | Green  |
| Falls causing severe harm   | 0      | 0                       | 0                         | Apr-21           | →  | Green  |
| Medication errors causing severe harm                               | 0      | 0                       | 0                         | Apr-21           | →  | Green  |
| Line infections   | 0      | 0                       | 2                         | Mar-21           | ↓  | Green  |
| Failures to isolate   |        | 6                       | 11                        | Apr-21           | ↓  | Grey   |
| Crude mortality (rolling 12 months)                                 |        | 1.5%                    | 1.6%                      | Apr-21           | ↓  | Grey   |
| Hospital Standardised Mortality Ratio (HSMR) (rolling 12 months)    |        | -                       | -                         | Feb-21           | →  | Grey   |
| Medical Examiner screens selected for further review                |        | 14.1%                   | 12.0%                     | Apr-21           | ↑  | Red    |
| Sepsis Compliance - Suspicion to needle time (STNT) within one hour | 80.0%  | 88.0%                   | 71.0%                     | Mar-21           | ↑  | Grey   |
| Extended perinatal mortality (per 1000 cases)                       |        | 5                       | 5                         | Feb-21           | ↑  | Green  |
| Stillborn 24 weeks or later (per 1000 cases)                        |        | 4                       | 4                         | Feb-21           | ↓  | Green  |
| Avoidable cardiac arrests   | 0      | 2                       | 1                         | Feb-21           | ↑  | Green  |
| VTE assessment  | 95.0%  | 96.7%                   | 95.3%                     | Mar-21           | ↑  | Grey   |
| Pressure ulcers - deep tissue damage                                |        | 4                       | 3                         | Feb-21           | ↑  | Grey   |
| Safeguarding training (C&YP Level 2)                                |        | 83.0%                   | 81.5%                     | Apr-21           | ↑  | Orange |
| A&E - median time to triage (minutes)                               |        | 17                      | 14                        | Apr-21           | ↑  | Orange |

[Link to appendix](#)

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# Quality & Safety Exceptions



| Risk   | Resolution Action   | Improvement timeline  | Owner   |
|--|---|---|---|
| IPC measures are not controlling the risk of C diff cases.   | RCAS have been completed for the 3 cases which were hospital acquired IPC are undertaking a Back to Basics campaign to educate and facilitate increased awareness of all IPC procedures which will include prevention of C Diff infection | End of June 2021 with benefits of campaign evident by end of Q2 2021/22 | Head of Nursing, Infection Prevention and Control, Hannah Nursing     |
| <b>This reports February data. Risk and resolutions stated in March IPR:</b><br>Normal variation around current mean . Predicted risk, primarily related to COVID patients and proning procedures and high flow oxygen delivery via tight fitting face masks; managed on Corporate Risk Register CRR137 CRR score = 15 | <b>Risk and resolutions stated in March IPR repeated here for information :</b><br>TVN team visit all wards and community teams weekly to support pressure ulcer prevention and provide extra training as needed.                         | July 2021   | Tissue Viability Team, and Lead Tissue Viability Nurse, Julie Sturges |

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# Patient Experience Overview

## Summary of RAG ratings:

## Summary of metrics:



| Metric   | Target       | Latest reporting period | Previous reporting period | Reporting period | MoM mvmt<br>G = Improvement<br>R = Deterioration | RAG | SPC threshold breach | Exception report |
|--|--------------|-------------------------|---------------------------|------------------|--|-----|----------------------|------------------|
| New complaints                                   |              | 48                      | 47                        | Apr-21           | ↑  |     |                      |                  |
| Complaints - still outstanding after 90 days     | 0            | 6                       | 1                         | Apr-21           | ↑  |     |                      | ✓                |
| Complaints - response within 25 days             | <b>85.0%</b> | Suspended during Covid  | 69.0%                     | Feb-21           | →  |     |                      |                  |
| Compliments - total received                     |              | 506                     | 403                       | Mar-21           | ↑  |     |                      |                  |
| Patients discharged before noon                  |              | 18.0%                   | 19.4%                     | Apr-21           | ↓  |     |                      |                  |
| Outstanding patient safety alerts                | 0            | 0                       | 0                         | Apr-21           | →  |     |                      |                  |
| 12 hour trolley waits in A&E                     | 0            | 0                       | 0                         | Apr-21           | →  |     |                      |                  |
| Friends & Family - overall response rate         |              | 27.0%                   | 39.4%                     | Apr-21           | ↓  |     |                      |                  |
| Friends & Family - Inpatient - positive response | 95.0%        | 92.3%                   | 89.2%                     | Apr-21           | ↑  |     |                      |                  |
| Friends & Family - A&E - positive response       | 95.0%        | 82.3%                   | 86.4%                     | Apr-21           | ↓  |     |                      |                  |
| Friends & Family - Maternity - positive response | 95.0%        | 78.8%                   | 88.0%                     | Apr-21           | ↓  |     |                      | ✓                |

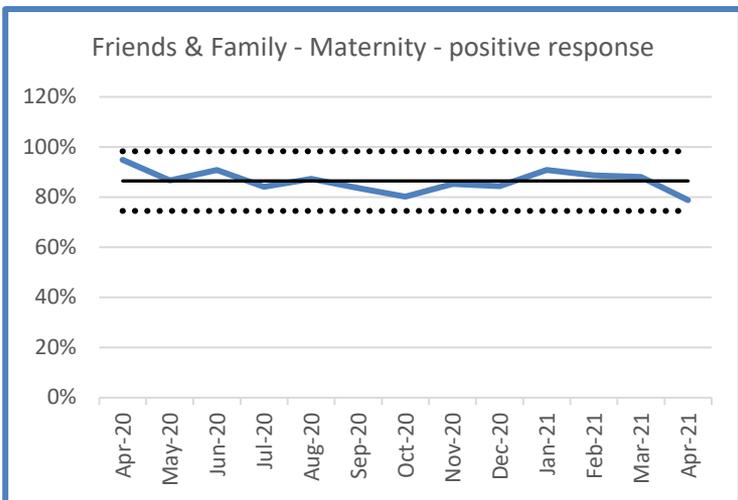
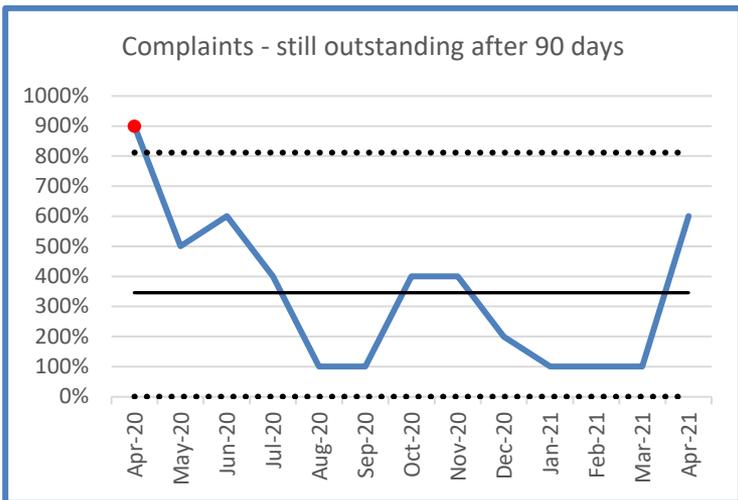
[Link to appendix](#)

Constitutional targets are highlighted blue

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# Patient Experience Exceptions



| Risk   | Resolution Action   | Improvement timeline | Owner                          |
|--|---|----------------------|--------------------------------|
| Low capacity issues caused by illness in the complaints team are impacting on the ability of the team to meet statutory targets.   | Secondment to support the complaints team. Moving resource from the PALS team to support the complaints team. Recruitment to replace staff that are leaving | May - July           | Amarjit Kaur<br>Anthony Banton |
| Risk   | Resolution Action   | Improvement timeline | Owner                          |
| Two of the maternity indicators not sending data to patients. Issue identified as being an outstanding data transfer issue from Medway to the BI data warehouse platform following an Maternity upgrade. | System repair   | June                 | Business information team      |

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# Workforce Overview

## Summary of RAG ratings:

## Summary of metrics:



| Metric   | Target | Latest reporting period | Previous reporting period | Reporting period | MoM mvmt<br>G = Improvement<br>R = Deterioration | RAG    | SPC threshold breach | Exception report |
|--|--------|-------------------------|---------------------------|------------------|--|--------|----------------------|------------------|
| <b>Substantive</b>   |        |                         |                           |                  |  |        |                      |                  |
| Staff Turnover   | 12.0%  | 12.3%                   | 12.2%                     | Apr-21           | ↑  | Orange |                      |                  |
| Sickness   | 3.5%   | 3.5%                    | 3.8%                      | Apr-21           | ↓  | Green  |                      |                  |
| Nursing vacancy rate   | 12.0%  | 17.9%                   | 16.5%                     | Apr-21           | ↑  | Red    | ×                    | ✓                |
| Wards with 30%+ nursing vacancies  | 0      | 11                      | 8                         | Mar-21           | ↑  | Red    | ×                    |                  |
| Statutory training   | 90.0%  | 86.2%                   | 84.6%                     | Apr-21           | ↑  | Orange |                      |                  |
| Occupational Health referrals - stress   | 20     | 79                      | 107                       | Apr-21           | ↓  | Red    |                      |                  |
| <b>Temporary</b>   |        |                         |                           |                  |  |        |                      |                  |
| Temporary staff - % spend  | 10.0%  | 17.5%                   | 14.9%                     | Apr-21           | ↑  | Red    | ×                    |                  |
| Temporary staff (all nursing) - shifts requested   | 6,000  | 5,552                   | 6,857                     | Apr-21           | ↓  | Green  |                      |                  |
| Temporary staff (all nursing) - shifts breaching Agency Cap  | 575    | 52                      | 83                        | Apr-21           | ↓  | Green  |                      |                  |
| Nursing - Bank fill rate   |        | 49.7%                   | 51.3%                     | Apr-21           | ↓  | Grey   |                      |                  |
| Average time to replace vacancy (days)   | 56     | 53                      | 54                        | Apr-21           | ↓  | Green  |                      |                  |
| <b>Equality &amp; Diversity</b>  |        |                         |                           |                  |  |        |                      |                  |
| Relative likelihood of White staff being appointed from shortlisting compared to BAME staff            |        | #N/A                    | #N/A                      | #N/A             | ↑↔↔  | Grey   |                      |                  |
| Relative likelihood of Disabled staff being appointed from Shortlisting compared to non-Disabled staff |        | #N/A                    | #N/A                      | #N/A             | ↑↔↔  | Grey   |                      |                  |

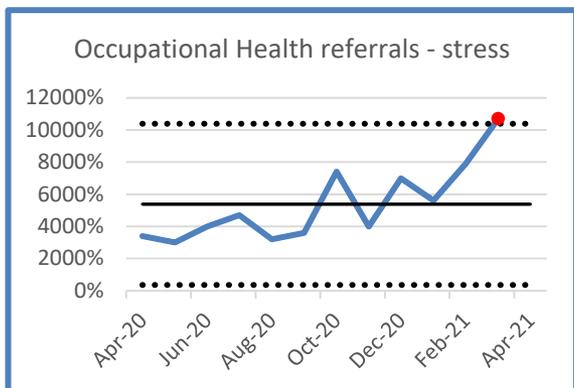
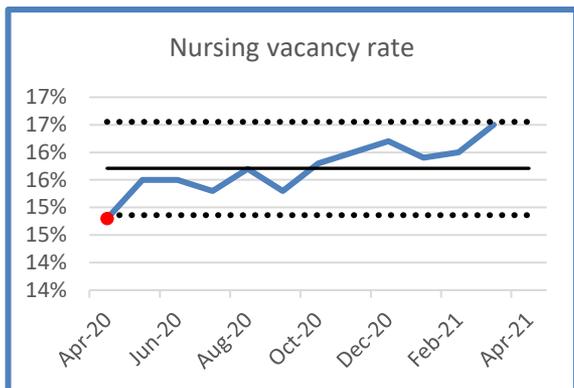
[Link to appendix](#)

Constitutional targets are highlighted blue

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## Workforce Exceptions



| Risk  | Resolution Action   | Improvement timeline  | Owner               |
|---|---|---|---------------------|
| Shortage of qualified nursing & Midwifery 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. | International campaign: 222 nurses to be recruited across 2021-22. We are bringing in regular cohorts each month, although this does fluctuate due to any international travel restrictions in place and quarantine rules.<br>UK and local campaigns underway including targeting Summer 2021 newly qualified and social media campaign for "hot spot" areas. | 2021-22<br>Monthly international recruitment<br>Autumn recruitment of graduating students | Head of recruitment |

| Risk  | Resolution Action   | Improvement timeline | Owner                                    |
|---|---|----------------------|--|
| Health & wellbeing of colleagues: both physical and psychological<br>Performance in role (presenteeism) | OH/Wellbeing proactively supported re-deployed colleague and OH have oversight of risk assessment reviews for colleagues where needed.<br>We are running drop in sessions for priority areas.<br>Psychological support referrals are increasing due to 2 key reasons: <ul style="list-style-type: none"> <li>We are encouraging more informal referrals</li> <li>Proactive team work can highlight needs for individual support</li> </ul> We have in house expert wellbeing support available<br>We have extra resource in place from April via BOB ICS funding for wellbeing<br>We have a referral pathway to ICS mental health hub for signposting of BHT colleagues.<br>We have extended provision of our Employee Assistance 24/7 phone line.<br>Wellbeing provision enhanced through Thrive@BHT | 2021-23              | Deputy Director of Workforce & Wellbeing |

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# Efficiency Overview

## Summary of RAG ratings: Summary of metrics:



| Metric   | Target | Latest reporting period | Previous reporting period | Reporting period | MoM mvmt<br>G = Improvement<br>R = Deterioration | RAG    | SPC threshold breach | Exception report |
|--|--------|-------------------------|---------------------------|------------------|--|--------|----------------------|------------------|
| <b>Theatres/Other</b>  |        |                         |                           |                  |  |        |                      |                  |
| Theatre utilisation  | 85.0%  | 87.6%                   | 89.5%                     | Mar-21           | ↓  | Green  |                      |                  |
| Clinical coding within target                                    | 95.0%  | 97.1%                   | 96.0%                     | Mar-21           | ↑  | Green  |                      |                  |
| Coding depth - avg no. of diagnosis codes per FCE - Elective     | 5.2    | 3.6                     | 3.5                       | Mar-21           | ↑  | Red    |                      |                  |
| Coding depth - avg no. of diagnosis codes per FCE - Non Elective | 5.4    | 4.2                     | 5.6                       | Mar-21           | ↓  | Red    | ×                    |                  |
| Coding depth - % of R codes in primary diagnosis (per FCE)       | 25.0%  | 13.6%                   | 12.6%                     | Mar-21           | ↑  | Grey   |                      |                  |
| Receipts without a purchase order                                | 250    | 314                     | 124                       | Apr-21           | ↑  | Orange |                      |                  |
| Elective operations cancelled on the day                         | 20     | 16                      | 16                        | Apr-21           | →  | Green  |                      |                  |
| <b>Outpatients</b>   |        |                         |                           |                  |  |        |                      |                  |
| Outpatient appointments - DNAs                                   | <5%    | 6.7%                    | 6.3%                      | Apr-21           | ↑  | Orange |                      | ✓                |
| Outpatient appointments - not cashed up                          | 2.0%   | 2.7%                    | 2.3%                      | Apr-21           | ↑  | Orange |                      |                  |
| Outpatient letters to GPs within 14 days                         | 90.0%  | 76.5%                   | 83.1%                     | Apr-21           | ↓  | Orange |                      | ✓                |
| Outpatient appointment disruption                                | 15.0%  | 14.9%                   | 17.1%                     | Apr-21           | ↓  | Green  | ×                    |                  |
| <b>Flow</b>  |        |                         |                           |                  |  |        |                      |                  |
| Stranded patients at 7 days                                      |        | 258                     | 265                       | Apr-21           | ↓  | Grey   |                      |                  |
| LoS > 21 days - patients in acute hospitals                      | 80     | 52                      | 60                        | Apr-21           | ↓  | Green  |                      |                  |
| LoS > 21 days - patients in community hospitals                  | 18     | 17                      | 24                        | Apr-21           | ↓  | Green  |                      |                  |
| SMH - Average medical length of stay (days)                      | 6.5    | 7.7                     | 9.0                       | Apr-21           | ↓  | Red    |                      |                  |
| Community Hosps - Average length of stay (days)                  | 28     | 24                      | 23                        | Apr-21           | ↑  | Green  |                      |                  |
| <b>Investment Case Performance</b>                               |        |                         |                           |                  |  |        |                      |                  |
| Ageing Well step up activity                                     |        |                         |                           | Feb-21           | →  | Grey   |                      |                  |
| Aylesbury post code over 75 ED admission rate                    |        |                         |                           | Feb-21           | →  | Grey   |                      |                  |
| Ageing Well step down activity                                   |        |                         |                           | Feb-21           | →  | Grey   |                      |                  |
| Frailty SDEC activity  |        |                         |                           | Feb-21           | →  | Grey   |                      |                  |

[Link to appendix](#)

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# Recovery Overview

## Summary of RAG ratings:

## Summary of metrics:



| Metric  | Target         | Latest reporting period | Previous reporting period | Reporting period | MoM mvmt<br>G = Improvement<br>R = Deterioration | RAG   | SPC threshold breach | Exception report |
|---|----------------|-------------------------|---------------------------|------------------|--|-------|----------------------|------------------|
| Activity to pre COVID levels - Outpatients (baseline is 19/20)      | 90.0%          | 99.9%                   | 108.4%                    | Apr-21           | ↓  | Green |                      |                  |
| Activity to pre COVID levels - Elective/Daycase (baseline is 19/20) | 90.0%          | 74.7%                   | 76.2%                     | Apr-21           | ↓  | Red   |                      | ✓                |
| Waiting list size at pre COVID levels                               |                | 115.7%                  | 101.4%                    | Mar-21           | ↑  | Grey  | ✗                    |                  |
| Transition to virtual appointments                                  | 30.0%          | 30.0%                   | 33.7%                     | Apr-21           | ↓  | Grey  | ✗                    | ✓                |
| RTT - Average weeks wait on waiting list                            | 20/21<br>19/20 | 26<br>13                | 26<br>11                  | Mar-21           |  | Grey  |                      |                  |

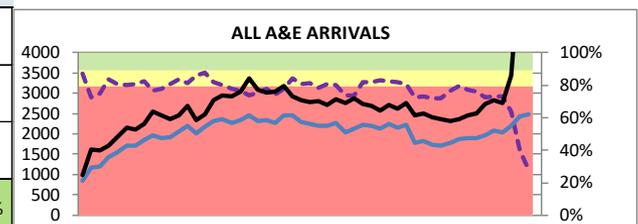
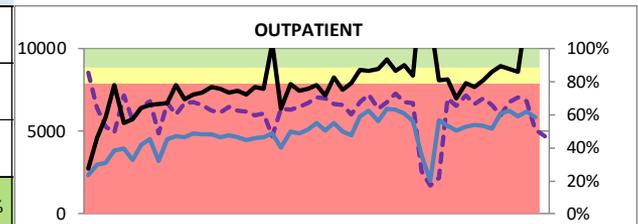
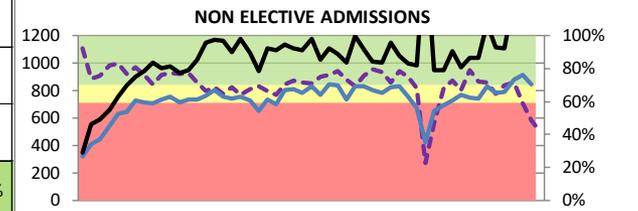
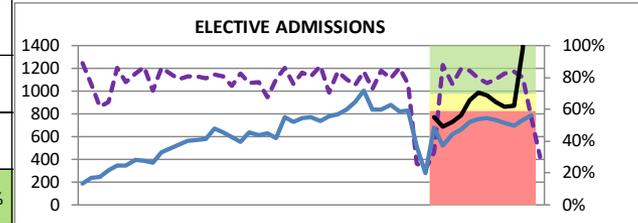
[Link to appendix](#)

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# COVID Recovery

|                     |                                 | Fin Year 20/21          |        |        |        |        |        |        |        |        |
|---------------------|---------------------------------|-------------------------|--------|--------|--------|--------|--------|--------|--------|--------|
|                     |                                 | Week Ending Sunday      |        |        |        |        |        |        |        |        |
|                     |                                 |                         | 07-Feb | 14-Feb | 21-Feb | 28-Feb | 07-Mar | 14-Mar | 21-Mar | 28-Mar |
| <b>ELECTIVE</b>     | All Elective Specific Acute     | <b>Financial Period</b> | 45     | 46     | 47     | 48     | 49     | 50     | 51     | 52     |
|                     |                                 | 2019/20                 | 1183   | 1111   | 1071   | 1108   | 1153   | 1171   | 1123   | 761    |
|                     |                                 | 2020/21                 | 733    | 756    | 760    | 747    | 720    | 700    | 747    | 791    |
|                     |                                 | <b>RECOVERY</b>         | 66.0%  | 70.6%  | 68.6%  | 64.8%  | 61.5%  | 62.3%  | 98.2%  | 189.2% |
| <b>NON ELECTIVE</b> | All Non Elective Specific Acute | <b>Financial Period</b> | 45     | 46     | 47     | 48     | 49     | 50     | 51     | 52     |
|                     |                                 | 2019/20                 | 948    | 864    | 862    | 777    | 840    | 858    | 709    | 582    |
|                     |                                 | 2020/21                 | 747    | 745    | 833    | 782    | 791    | 877    | 912    | 844    |
|                     |                                 | <b>RECOVERY</b>         | 86.5%  | 86.4%  | 107.2% | 93.1%  | 92.2%  | 123.7% | 156.7% | 168.5% |
| <b>OUTPATIENT</b>   | 1st and FU activity combined    | <b>Financial Period</b> | 45     | 46     | 47     | 48     | 49     | 50     | 51     | 52     |
|                     |                                 | 2019/20                 | 6675   | 6993   | 6596   | 5976   | 6792   | 7087   | 6860   | 5102   |
|                     |                                 | 2020/21                 | 5377   | 5338   | 5149   | 6106   | 6244   | 5928   | 6218   | 5885   |
|                     |                                 | <b>RECOVERY</b>         | 76.9%  | 80.9%  | 86.1%  | 89.9%  | 88.1%  | 86.4%  | 121.8% | 125.9% |
| <b>AE ACTIVITY</b>  | All AE Locations                | <b>Financial Period</b> | 45     | 46     | 47     | 48     | 49     | 50     | 51     | 52     |
|                     |                                 | 2019/20                 | 3095   | 3039   | 2890   | 2931   | 2930   | 2559   | 1591   | 1138   |
|                     |                                 | 2020/21                 | 1898   | 1894   | 1971   | 2074   | 2025   | 2199   | 2437   | 2477   |
|                     |                                 | <b>RECOVERY</b>         | 61.3%  | 62.3%  | 68.2%  | 70.8%  | 69.1%  | 85.9%  | 153.2% | 217.7% |

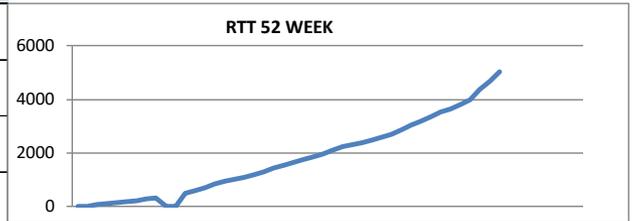
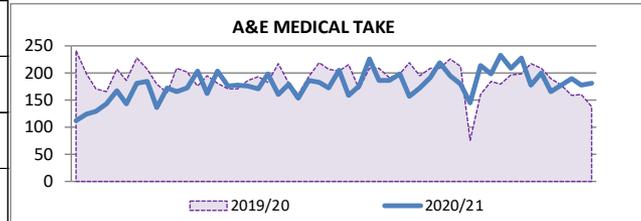
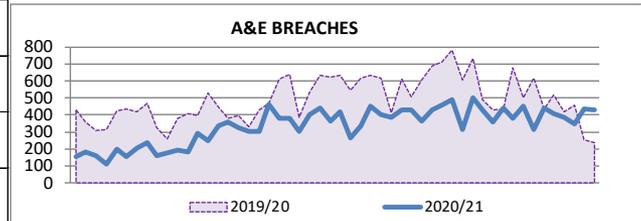
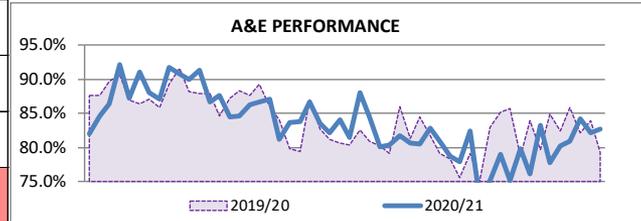
--- 2019/20    — 2020/21    — RECOVERY



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# COVID Recovery

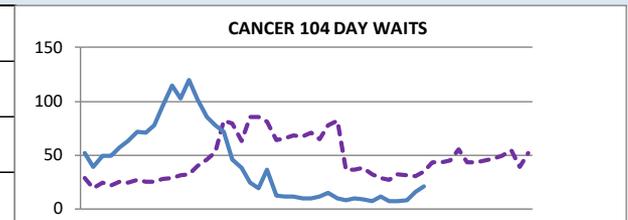
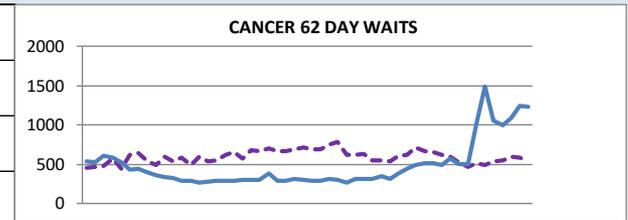
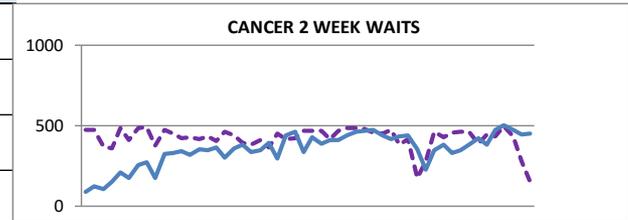
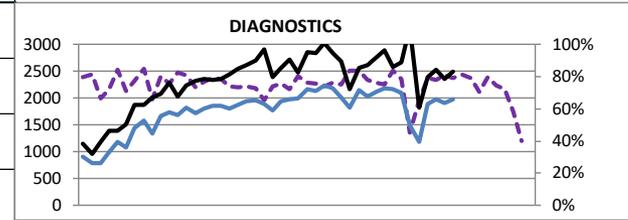
|                        |   | Fin Year 20/21          | Week Ending Sunday |        |        |        |        |        |        |        |
|------------------------|---|-------------------------|--------------------|--------|--------|--------|--------|--------|--------|--------|
|                        |   |                         | 07-Feb             | 14-Feb | 21-Feb | 28-Feb | 07-Mar | 14-Mar | 21-Mar | 28-Mar |
| <b>AE PERFORMANCE</b>  | All AE Locations  | <b>Financial Period</b> | 45                 | 46     | 47     | 48     | 49     | 50     | 51     | 52     |
|                        |   | 2019/20                 | 83.9%              | 79.7%  | 84.9%  | 82.4%  | 85.8%  | 82.1%  | 83.9%  | 79.3%  |
|                        |   | 2020/21                 | 76.2%              | 83.3%  | 77.8%  | 80.3%  | 80.9%  | 84.2%  | 82.2%  | 82.7%  |
|                        |   | <b>MOVEMENT</b>         | -7.7%              | 3.6%   | -7.2%  | -2.1%  | -4.9%  | 2.1%   | -1.8%  | 3.3%   |
| <b>AE BREACHES</b>     | Patients breaching discharge guidance across all AE Locations | <b>Financial Period</b> | 45                 | 46     | 47     | 48     | 49     | 50     | 51     | 52     |
|                        |   | 2019/20                 | 499                | 617    | 435    | 515    | 416    | 457    | 256    | 235    |
|                        |   | 2020/21                 | 452                | 317    | 438    | 409    | 386    | 347    | 435    | 429    |
|                        |   |                         |                    |        |        |        |        |        |        |        |
| <b>AE MEDICAL TAKE</b> | Medical Specialty Referrals Admitted                          | <b>Financial Period</b> | 45                 | 46     | 47     | 48     | 49     | 50     | 51     | 52     |
|                        |   | 2019/20                 | 199                | 217    | 209    | 190    | 177    | 158    | 161    | 138    |
|                        |   | 2020/21                 | 228                | 178    | 200    | 166    | 178    | 189    | 177    | 181    |
|                        |   | <b>COMPARISON</b>       | 105.1%             | 85.2%  | 105.3% | 93.8%  | 112.7% | 117.4% | 128.3% | 124.8% |
| <b>RTT 52 WEEK</b>     | Patients Waiting more than 52 Weeks                           | <b>Financial Period</b> | 45                 | 46     | 47     | 48     | 49     | 50     | 51     | 52     |
|                        |   | 2019/20                 | 0                  | 0      | 0      | 1      | 2      | 1      | 3      | 4      |
|                        |   | 2020/21                 | 0                  | 0      | 0      | 0      | 0      | 0      | 0      | 0      |
|                        |   |                         |                    |        |        |        |        |        |        |        |



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# COVID Recovery

|                    |                                 | Fin Year 20/21          |        |        |        |        |        |        |        |        |
|--------------------|---------------------------------|-------------------------|--------|--------|--------|--------|--------|--------|--------|--------|
|                    |                                 | Week Ending Sunday      | 07-Feb | 14-Feb | 21-Feb | 28-Feb | 07-Mar | 14-Mar | 21-Mar | 28-Mar |
| <b>DIAGNOSTICS</b> | Total MRI CT & Non Obstetric US | <b>Financial Period</b> | 45     | 46     | 47     | 48     | 49     | 50     | 51     | 52     |
|                    |                                 | 2019/20                 | 2438   | 2370   | 2121   | 2398   | 2230   | 2161   | 1753   | 1208   |
|                    |                                 | 2020/21                 | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      |
|                    |                                 |                         |        |        |        |        |        |        |        |        |
| <b>CANCER</b>      | 2 WEEK WAITS                    | <b>Financial Period</b> | 45     | 46     | 47     | 48     | 49     | 50     | 51     | 52     |
|                    |                                 | 2019/20                 | 467    | 391    | 448    | 435    | 498    | 435    | 281    | 155    |
|                    |                                 | 2020/21                 | 384    | 422    | 385    | 477    | 507    | 474    | 446    | 454    |
|                    |                                 |                         |        |        |        |        |        |        |        |        |
| <b>CANCER</b>      | 62 DAY WAITS                    | <b>Financial Period</b> | 45     | 46     | 47     | 48     | 49     | 50     | 51     | 52     |
|                    |                                 | 2019/20                 | 475    | 512    | 494    | 541    | 550    | 603    | 582    | 538    |
|                    |                                 | 2020/21                 | 504    | 1026   | 1496   | 1064   | 995    | 1092   | 1241   | 1235   |
|                    |                                 |                         |        |        |        |        |        |        |        |        |
| <b>CANCER</b>      | 104 DAY WAITS                   | <b>Financial Period</b> | 45     | 46     | 47     | 48     | 49     | 50     | 51     | 52     |
|                    |                                 | 2019/20                 | 43     | 43     | 45     | 47     | 49     | 54     | 39     | 52     |
|                    |                                 | 2020/21                 | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      |
|                    |                                 |                         |        |        |        |        |        |        |        |        |



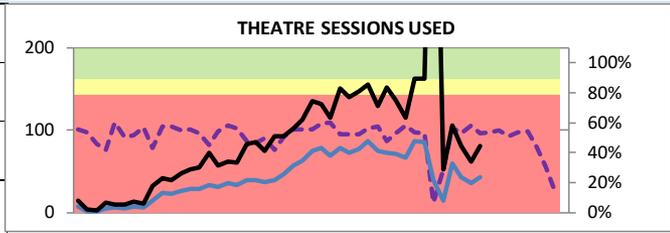
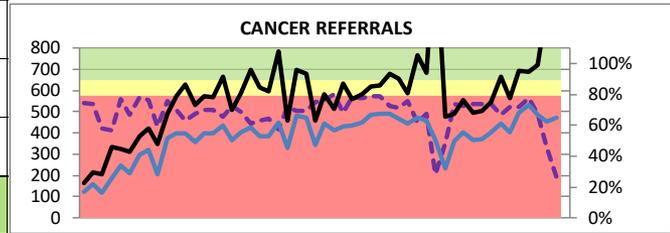
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# COVID Recovery



Buckinghamshire Healthcare  
NHS Trust

|                     |                       | Fin Year 20/21          | Week Ending Sunday |        |        |        |        |        |        |        |
|---------------------|-----------------------|-------------------------|--------------------|--------|--------|--------|--------|--------|--------|--------|
|                     |                       |                         | 07-Feb             | 14-Feb | 21-Feb | 28-Feb | 07-Mar | 14-Mar | 21-Mar | 28-Mar |
| <b>CANCER</b>       | New Referrals         | <b>Financial Period</b> | 45                 | 46     | 47     | 48     | 49     | 50     | 51     | 52     |
|                     |                       | 2019/20                 | 538                | 486    | 520    | 522    | 562    | 492    | 334    | 192    |
|                     |                       | 2020/21                 | 404                | 445    | 402    | 496    | 530    | 486    | 455    | 474    |
|                     |                       | <b>RECOVERY</b>         | 75.1%              | 91.6%  | 77.3%  | 95.0%  | 94.3%  | 98.8%  | 136.2% | 246.9% |
| <b>PRODUCTIVITY</b> | Theatre Sessions Used | <b>Financial Period</b> | 45                 | 46     | 47     | 48     | 49     | 50     | 51     | 52     |
|                     |                       | 2019/20                 | 97                 | 100    | 93     | 97     | 99     | 80     | 56     | 24     |
|                     |                       | 2020/21                 | 0                  | 0      | 0      | 0      | 0      | 0      | 0      | 0      |
|                     |                       |                         |                    |        |        |        |        |        |        |        |



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# Finance: income and expenditure

## Key Highlights

- The Trust reports a break-even position for month 1 in line with plan.
- The plan used in this report is based on NHSE/I planning guidance issued at the end of March 2021 which covers guidance for the first six months of the year (referred to as H1).
- NHSE/I has issued providers with pre-populated plans for H1 based on a continuation of the emergency financial regime. In calculating the Trust's income and expenditure, NHSE/I has applied a simple high level methodology of Q3 (2020/21) multiplied by 2. NHSE/I's expectation is that this funding settlement will allow the ICS, commissioners and providers to deliver break even for this period. The plan for the second half of the year currently (referred to as H2) indicates a £22.3m deficit. The H2 plan is subject to final approval by the Trust Board and agreement with BOB ICS and NHSE/I.
- The plan assumes a £16m efficiency plan will be delivered. This plan is phased equally throughout the year at £1.3m per month.
- Covid-19 expenditure totals £0.8m YTD and is reported within the overall expenditure position for this financial year. Income to cover covid-19 expenditure is assumed to be within the block values received, reported within contract income in the table below.
- Pay costs in month total £26.3m, £1.6m adverse to plan. Key drivers of this adverse position include medical staffing spend and shortfalls in CIP delivery due to the plan being phased equally across the year. The pay position continues to include year end provisions held for the Flowers legal case, working time directive payments, annual leave and BHT Thrive pay expenditure.
- Non-pay costs total £13.7m for the month, £1.3m favourable to plan. Key drivers of this underspend include drugs and clinical supply expenditure being lower than plan.
- The non-recurrent I&E adjustment removes the benefit of H1 Block income top-up funding receivable from NHSE/I and Bucks CCG. This would result in an underlying normalised deficit of £42m for the full year.

## Trust I&E Performance (£M)

| (£m)  | In Mth Plan   | In Mth Actuals | In Mth Variance | YTD Mth Plan  | YTD Actuals   | YTD Variance | Annual Plan    | Forecast       |
|---|---------------|----------------|-----------------|---------------|---------------|--------------|----------------|----------------|
| Contract Income                               | 40.8          | 40.8           | 0.0             | 40.8          | 40.8          | 0.0          | 467.3          | 467.3          |
| Other income                                  | 2.3           | 2.4            | 0.1             | 2.3           | 2.4           | 0.1          | 27.9           | 27.9           |
| <b>Total income</b>                           | <b>43.1</b>   | <b>43.2</b>    | <b>0.1</b>      | <b>43.1</b>   | <b>43.2</b>   | <b>0.1</b>   | <b>495.3</b>   | <b>495.3</b>   |
| Pay   | (24.7)        | (26.3)         | (1.6)           | (24.7)        | (26.3)        | (1.6)        | (296.4)        | (296.4)        |
| Non-pay                                       | (15.0)        | (13.7)         | 1.3             | (15.0)        | (13.7)        | 1.3          | (179.9)        | (179.9)        |
| <b>Total operating expenditure</b>            | <b>(39.7)</b> | <b>(40.0)</b>  | <b>(0.3)</b>    | <b>(39.7)</b> | <b>(40.0)</b> | <b>(0.3)</b> | <b>(476.3)</b> | <b>(476.3)</b> |
| <b>EBITDA</b>                                 | <b>3.4</b>    | <b>3.2</b>     | <b>(0.2)</b>    | <b>3.4</b>    | <b>3.2</b>    | <b>(0.2)</b> | <b>19.0</b>    | <b>19.0</b>    |
| Non Operating Expenditure                     | (3.4)         | (3.2)          | 0.3             | (3.4)         | (3.2)         | 0.3          | (41.3)         | (41.3)         |
| <b>Retained Surplus / (Deficit)</b>           | <b>0.0</b>    | <b>0.0</b>     | <b>0.0</b>      | <b>0.0</b>    | <b>0.0</b>    | <b>0.0</b>   | <b>(22.3)</b>  | <b>(22.3)</b>  |
| Non Recurrent I&E                             | (3.3)         | (3.3)          | 0.0             | (3.3)         | (3.3)         | 0.0          | (19.7)         | (19.7)         |
| <b>Normalised I&amp;E Surplus / (Deficit)</b> | <b>(3.3)</b>  | <b>(3.3)</b>   | <b>0.0</b>      | <b>(3.3)</b>  | <b>(3.3)</b>  | <b>0.0</b>   | <b>(42.0)</b>  | <b>(42.0)</b>  |

## Divisional I&E Performance (£M)

| Division / (£m)                     | YTD Variance against Plan | Outturn Plan   | Total for Domain (Finance) | Finance YTD Sector Rating | Current Month Run Rate |               |               |
|-------------------------------------|---------------------------|----------------|----------------------------|---------------------------|------------------------|---------------|---------------|
|                                     |                           |                |                            |                           | M11                    | M12           | M01           |
| Integrated Medicine                 | (0.0)                     | (85.9)         | 2                          | 1                         | (6.7)                  | (8.2)         | (7.2)         |
| Integrated Elderly Care             | (0.1)                     | (41.1)         | 4                          | 1                         | (3.0)                  | (3.0)         | (3.5)         |
| Surgery And Critical Care           | 0.3                       | (101.1)        | 2                          | 1                         | (8.0)                  | (8.7)         | (8.1)         |
| Women and Children                  | (0.0)                     | (44.7)         | 2                          | 1                         | (4.2)                  | (3.8)         | (3.7)         |
| Specialist Services                 | 0.3                       | (78.0)         | 2                          | 1                         | (6.1)                  | (7.2)         | (6.2)         |
| <b>Total Clinical Divisions</b>     | <b>0.5</b>                | <b>(350.8)</b> |                            |                           | <b>(28.0)</b>          | <b>(30.8)</b> | <b>(28.7)</b> |
| Chief Executive                     | 0.1                       | (3.8)          | 2                          | 1                         | (0.3)                  | 0.2           | (0.2)         |
| Chief Operating Off-Management      | (0.1)                     | (4.1)          | 4                          | 1                         | (0.3)                  | (0.5)         | (0.4)         |
| Corporate Services                  | (0.1)                     | 1.2            | N/A                        | N/A                       | (2.4)                  | 4.6           | (0.1)         |
| Commercial Director Mgmt            | (0.1)                     | 1.0            | 4                          | 1                         | (0.1)                  | (0.0)         | (0.0)         |
| Finance Dept.                       | (0.1)                     | (6.8)          | 4                          | 1                         | (0.4)                  | (0.4)         | (0.7)         |
| Information Technology              | (0.3)                     | (10.1)         | 4                          | 1                         | (1.1)                  | (4.5)         | (1.1)         |
| Performance and Delivery            | 0.0                       | (4.1)          | 2                          | 1                         | (0.6)                  | (0.3)         | (0.3)         |
| Property Services                   | (0.2)                     | (55.6)         | 4                          | 1                         | (4.1)                  | (6.1)         | (4.8)         |
| Human Resources                     | 0.2                       | 4.0            | 2                          | 1                         | 0.1                    | 0.3           | 0.5           |
| Medical Director                    | 0.0                       | (0.5)          | 2                          | 1                         | 0.0                    | (0.1)         | (0.0)         |
| Nursing Director                    | 0.1                       | (17.4)         | 2                          | 1                         | (1.3)                  | (1.3)         | (1.4)         |
| PDC And Depreciation                | 0.0                       | (32.3)         | N/A                        | N/A                       | (1.8)                  | 0.1           | (2.7)         |
| Covid-19 Division                   | (0.8)                     | 0.0            | N/A                        | N/A                       | (2.6)                  | (4.5)         | (0.8)         |
| Strategy And Business Dev.          | 0.0                       | (0.2)          | 2                          | 1                         | 0.0                    | (0.0)         | (0.0)         |
| <b>Total Corporate</b>              | <b>(1.4)</b>              | <b>(128.7)</b> |                            |                           | <b>(14.8)</b>          | <b>(12.5)</b> | <b>(12.2)</b> |
| Contract Income                     | 0.0                       | 467.3          |                            |                           | 42.7                   | 43.9          | 40.8          |
| Provisions                          | 0.8                       | (10.1)         |                            |                           | 0.0                    | 0.0           | 0.0           |
| Donated Asset Reporting Adj         | 0.2                       | 0.0            |                            |                           | 0.1                    | (0.8)         | 0.2           |
| <b>Retained Surplus / (Deficit)</b> | <b>0.0</b>                | <b>(22.3)</b>  |                            |                           | <b>0.1</b>             | <b>(0.2)</b>  | <b>0.0</b>    |

# Communications and engagement APRIL 2021

## Comms in numbers

| Channel            | Measurement       | MAR         | APR        |
|--------------------|-------------------|-------------|------------|
| Staff              | BHT today         | 23          | 20         |
| Press              | Enquiries         | 12          | 8          |
|                    | Statements issued | 2           | 0          |
|                    | Press releases    | 2           | 3          |
| Twitter            | New followers     | 116         | 130        |
|                    | Tweets            | 73          | 15         |
|                    | Retweets          | 82          | 21         |
|                    | Likes             | 537         | 96         |
|                    | Replies           | 44          | 5          |
| Facebook           | Followers         | 6104        | 6332       |
|                    | Posts             | 13          | 4          |
|                    | Shares            | 136         | 12         |
|                    | Likes             | 1005        | 235        |
|                    | Comments          | 64          | 12         |
| Videos - YouTube   | Created by Comms  | 8           | 2          |
|                    | Published         | 6           | 14         |
|                    | Channel views     | 37300       | 21600      |
| Website            | Updates posted    | 2227        | 1768       |
|                    | Users             | 53946       | 48537      |
|                    | events            | 1 (18 att.) | 3(22 att.) |
| Patient engagement | CAP               | 0           | 0          |

## Media roundup:

- Hospital Times: [Rethinking Cataract Service Provision](#)
- Greatest Hits Radio: [Covid hospitalisations drop 92% in Buckinghamshire's hospitals](#) (also covered by BFP)
- Structural Timber Magazine: [NHS Staff Welcome Modular Wellbeing Pod](#)
- HTN: [South 4 Pathology Partnership picks laboratory information management system](#) (also covered by other trade media)
- Bucks Herald: [Missed appointments may have cost Bucks Healthcare Trust more than £3 MILLION during pandemic](#)
- BFP: [More than 100 Bucks Covid-19 patients believed to have contracted virus in hospital](#)
- Nursing Times: [Opportunities to support nurse wellbeing 'have been missed', finds report](#)
- National World: [Worst hospitals in England for 'superbug' infections as antimicrobial resistance cases rise in latest NHS figures](#)

## Social media:

Top mention earned 1,439 engagements



I spent the morning with Sonia Sha 1st Year student nurse @BNUNursing I learnt loads today - what a wonderful aspiring nurse who was also celebrating the holy month of #Ramadan & sporting one of @BucksHealthcare disposable hijabs pic.twitter.com/J1qgWDkVEk



3 8 82

## Key activities:

### Events

- 1<sup>st</sup> Public, Patient Equality, Diversity and Inclusion Meeting
- Rainbow Badge Workshop
- QSIR Virtual classes

### Digital and social media:

- Ongoing work on new website and intranet
- Changes to visiting guidelines
- Changes to maternity support guidelines
- Charity thanks yous: Marlow running club / Hurst estate agency
- Social media support – WH children's play room reopens

### Internal:

- Issued invitation for staff representative to the Charitable Fund committee

### Campaigns and Media:

- 20<sup>th</sup> anniversary of Filipino nurses at BHT
- Phlebotomy support comms with GPs
- New NEDs welcomed to Board
- Staff awards support
- Launched video of recruitment co-mentoring programme
- Worked on Pinewood Studios 'Thank you NHS' outdoor screening proposal



# Appendix:

## Report Structure

## Appendix: Report Structure

**Executive summary** - a snapshot of overall trust-wide performance, by reporting domain, showing a proportional picture of the domain RAG ratings and a snapshot of the month to month performance trend.

**Demand trends** – key demand trends over 12 months which will impact performance across the reporting domains.

**Domain Summaries** – a scorecard to summarise the performance in each domain. SPC charts are not provided in this section but are included in the appendix. A link to the relevant appendix section is provided on this page.

Information definitions for each metric:

- 1. Target** – constitutional, advisory or trust performance target.
- 2. Latest reporting period** – the metric performance for the current reporting period
- 2. Previous reporting period** – the metric performance for the previous reporting period
- 3. Reporting period** – the reporting month for the metric
- 4. Deterioration/Movement** – Month on month movement of the metric. Green and red arrows are used to indicate whether an improvement or deterioration.
- 6. RAG** – rating against constitutional, advisory or trust target.
- 7. SPC threshold breach** – this flag indicates whether the current reporting period represents a statistical anomaly outside of normal volatility.
- 8. Exception report** – indicates whether the metric has been selected for exception reporting. Exceptions are selected based on a combination of statistical volatility, performance trend and targets.

## Appendix: Report Structure

**Domain exception reports (quality and safety, patient experience, workforce and efficiency domains)** – for each metric selected as an exceptions the report will include a 12 month performance trend (SPC chart) and narrative on risks, resolution actions and resolution timeframe. NB. In the workforce domain nurse vacancy rates and staff turnover metrics will always be reported as an exception

**Domain reports (Operational Performance)** – this is not reported on an exception basis. A short summary report is provided showing performance against the key constitutional target along with relevant information to demonstrate both drivers and impact of performance. This section is split into A&E, Cancer, RTT, diagnostics, Community and Harm Review.

**Domain reports (Covid recovery)** – this section is included on a temporary basis. No exception reported is included. Data is provided showing the trust performance against the NHSI phase 3 recovery targets.

**Appendix** – this replicates the information provided in the domain summaries, but each metric is supported by a statistical 12 month SCP chart. A description is also provided below each metric.

# Appendix:

## Tables of Metrics

# Appendix:

| Metric  | Target | Latest reporting period | Previous reporting period | Reporting period | MoM mvmt<br>G = Improvement<br>R = Deterioration | RAG    | 12-month trend |
|---|--------|-------------------------|---------------------------|------------------|--|--------|----------------|
| <b>OPERATIONAL PERFORMANCE</b>  |        |                         |                           |                  |  |        |                |
| <b>A&amp;E</b>  |        |                         |                           |                  |  |        |                |
| A&E - 4 hour performance  | 95.0%  | 82.0%                   | 82.6%                     | Apr-21           | ↓  | Red    |                |
| <i>% of patients attending A&amp;E who are admitted, transferred or discharged within 4 hours.</i>      |        |                         |                           |                  |  |        |                |
| A&E - Child under age one - triage in 15 mins   |        | 83.6%                   | 89.4%                     | Apr-21           | ↓  | Grey   |                |
| <i>% of patients under 12m of age attending A&amp;E who are triaged within 15 minutes</i>               |        |                         |                           |                  |  |        |                |
| A&E - Patients over 12 hours in A&E   | 0      | 394                     | 366                       | Apr-21           | ↑  | Red    |                |
| <i># of patients attending A&amp;E who are not admitted, transferred or discharged within 12 hours.</i> |        |                         |                           |                  |  |        |                |
| A&E - Delayed ambulance handovers   | 0      | 48                      | 53                        | Apr-21           | ↓  | Orange |                |
| <i>Ambulance handover of patients taking longer than 15 minutes</i>                                     |        |                         |                           |                  |  |        |                |
| A&E - Patients returning within 72 hours  |        | 4.0%                    | 4.7%                      | Apr-21           | ↓  | Grey   |                |
| <i>% of patients attending A&amp;E who have attended A&amp;E within the last 72 hours.</i>              |        |                         |                           |                  |  |        |                |

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# Appendix:

| Metric   | Target | Latest reporting period | Previous reporting period | Reporting period | MoM mvmt<br>G = Improvement<br>R = Deterioration | RAG | 12-month trend |
|--|--------|-------------------------|---------------------------|------------------|--|-----|----------------|
| <b>RTT</b>   |        |                         |                           |                  |  |     |                |
| RTT - Open Pathway performance   | 92.0%  | 52.6%                   | 52.6%                     | Apr-21           | →  |     |                |
| <i>% of patients commencing treatment within 18 weeks of referral</i>              |        |                         |                           |                  |  |     |                |
| RTT - Number of open pathways  | 31,024 | 35,497                  | 33,911                    | Apr-21           | ↑  |     |                |
| <i># of patients awaiting the commencement of treatment</i>                        |        |                         |                           |                  |  |     |                |
| RTT - Patients open pathways over 52 weeks   | 0      | 6,048                   | 6,678                     | Apr-21           | ↓  |     |                |
| <i># of patients awaiting the commencement of treatment for more than 52 weeks</i> |        |                         |                           |                  |  |     |                |
| RTT - Patients open pathways over 26 weeks   | 0      | 12,017                  | 11,801                    | Mar-21           | ↑  |     |                |
| <i># of patients awaiting the commencement of treatment for more than 26 weeks</i> |        |                         |                           |                  |  |     |                |
| RTT - Diagnostic waits under 6 weeks   | 99.0%  | 59.6%                   | 58.9%                     | Mar-21           | ↑  |     |                |
| <i>% of patients receiving diagnostic within 6 weeks</i>                           |        |                         |                           |                  |  |     |                |

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# Appendix:

| Metric   | Target | Latest reporting period | Previous reporting period | Reporting period | MoM mvmt<br>G = Improvement<br>R = Deterioration | RAG    | 12-month trend |
|--|--------|-------------------------|---------------------------|------------------|--|--------|----------------|
| <b>Cancer</b>  |        |                         |                           |                  |  |        |                |
| Cancer - 2ww - first appt within 2 weeks   | 93.0%  | 99.1%                   | 98.3%                     | Mar-21           | ↑  | Green  |                |
| <i>% of patients referred on an urgent 2 week wait pathway receiving first appointment within 2 weeks</i>                  |        |                         |                           |                  |  |        |                |
| Cancer - 2ww - treatment within 62 days  | 85.0%  | 82.9%                   | 69.6%                     | Mar-21           | ↑  | Orange |                |
| <i>% of patients referred on an urgent 2 week wait pathway commencing treatment within 62 days</i>                         |        |                         |                           |                  |  |        |                |
| Cancer - screening - treatment within 62 days  | 90.0%  | 100.0%                  | 80.0%                     | Mar-21           | ↑  | Green  |                |
| <i>% of patients receiving treatment within 62 days after diagnosis</i>  |        |                         |                           |                  |  |        |                |
| Cancer - 31 days to first treatment  | 100.0% | 98.3%                   | 96.4%                     | Mar-21           | ↑  | Green  |                |
| <i>% of patients referred on an urgent 2 week wait pathway commencing treatment within 31 days of receiving diagnostic</i> |        |                         |                           |                  |  |        |                |
| Cancer - 104 day waits   | 0      | 11                      | 9                         | Mar-21           | ↑  | Red    |                |
| <i># of patients referred on an urgent 2 week wait pathway waiting more than 104 days to commence treatment</i>            |        |                         |                           |                  |  |        |                |

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# Appendix:

| Metric  | Target | Latest reporting period | Previous reporting period | Reporting period | MoM mvmt<br>G = Improvement<br>R = Deterioration | RAG | 12-month trend |
|---|--------|-------------------------|---------------------------|------------------|--|-----|----------------|
| <b>Community</b>  |        |                         |                           |                  |  |     |                |
| Contacts all - Total  |        | 48,822                  | 50,831                    | Apr-21           | ↓  |     |                |
| <i># of total all Community patient contacts</i>  |        |                         |                           |                  |  |     |                |
| Total number of EHCP referrals  |        | 102                     | 110                       | Apr-21           | ↓  |     |                |
| <i># number of Education, Health and Care Plan referrals received by community paediatric team</i>                                      |        |                         |                           |                  |  |     |                |
| % of EHCP completed in 6 weeks  |        | 70.0%                   | 44.1%                     | Mar-21           | ↑  |     |                |
| <i>% of Education, Health and Care Plan assessments competed by community paediatric team with 6 weeks or referral</i>                  |        |                         |                           |                  |  |     |                |
| % of births offered a face to face appointment with a Health Visitor within 14 days   |        | 80.0%                   | 81.1%                     | Apr-21           | ↓  |     |                |
| <i>% of mothers offered a Health Visitor appointment with 14 days of birth</i>  |        |                         |                           |                  |  |     |                |
| % of LAC seen within 20 days (in county)  |        |                         |                           | Feb-21           | →  |     |                |
| <i>% of Looked After Children (In local authority care system) given holistic health assessment within 20 days (in Buckinghamshire)</i> |        |                         |                           |                  |  |     |                |

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# Appendix:

| Metric  | Target | Latest reporting period | Previous reporting period | Reporting period | MoM mvmt<br>G = Improvement<br>R = Deterioration | RAG | 12-month trend |
|---|--------|-------------------------|---------------------------|------------------|--|-----|----------------|
| % of LAC seen within 20 days (out of county)  |        |                         |                           | Feb-21           | →  |     |                |
| <i>% of Looked After Children (In local authority care system) given holistic health assessment within 20 days (outside of Buckinghamshire)</i> |        |                         |                           |                  |  |     |                |
| <b>Harm review</b>  |        |                         |                           |                  |  |     |                |
| Cancer - COVID delays   |        | 15                      | 21                        | Apr-21           | ↓  |     |                |
| <i># of patient treatment delays due to COVID</i>   |        |                         |                           |                  |  |     |                |
| Elective referrals  |        | 19,068                  | 22,391                    | Apr-21           | ↓  |     |                |
| <i># number of elective surgical referrals received</i>   |        |                         |                           |                  |  |     |                |
| Clinical Harm assessment - category P1 waiters  |        | 3                       | 2                         | Apr-21           | ↑  |     |                |
| <b>Missing definition</b>   |        |                         |                           |                  |  |     |                |
| Clinical Harm assessment - category P2 waiters  |        | 305                     | 297                       | Apr-21           | ↑  |     |                |
| <b>Missing definition</b>   |        |                         |                           |                  |  |     |                |

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# Appendix:

| Metric   | Target | Latest reporting period | Previous reporting period | Reporting period | MoM mvmt<br>G = Improvement<br>R = Deterioration | RAG   | 12-month trend |
|--|--------|-------------------------|---------------------------|------------------|--|-------|----------------|
| <b>Other Operational</b>   |        |                         |                           |                  |  |       |                |
| Reablement - median urgent response time (hours)   | 8      | 2                       | 2                         | Apr-21           | ↓  | Green |                |
| <i>Median average hours patients awaiting reablement care</i>  |        |                         |                           |                  |  |       |                |
| District Nursing - median urgent response time (hours)   | 8      | 2                       | 2                         | Apr-21           | →  | Green |                |
| <i>Median average hours patients awaiting urgent district Nursing care</i>   |        |                         |                           |                  |  |       |                |
| Elective operations cancelled on the day   | 20     | 16                      | 16                        | Apr-21           | →  | Green |                |
| <i># of elective cancelled operations cancelled on the say of surgery</i>  |        |                         |                           |                  |  |       |                |
| Outpatient appointment disruption  | 0      | 0                       | 0                         | Apr-21           | ↓  | Green |                |
| <i># of appointments changed, time, date or location</i>   |        |                         |                           |                  |  |       |                |
| Average bed occupancy (G&A)  |        | 91.8%                   | 91.7%                     | Apr-21           | ↑  | Green |                |
| <i>Average occupancy at midnight of all G&amp;A (General and Acute) beds (excludes paediatric, critical care, maternity and community bed stock)</i> |        |                         |                           |                  |  |       |                |

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# Appendix:

| Metric   | Target | Latest reporting period | Previous reporting period | Reporting period | MoM mvmt<br>G = Improvement<br>R = Deterioration | RAG | 12-month trend |
|--|--------|-------------------------|---------------------------|------------------|--|-----|----------------|
| Emergency readmission within 30 days   | 5.0%   | 7.9%                    | 6.6%                      | Mar-21           | ↑  |     |                |
| <i>% of discharged emergency patients readmitted within 30 days of discharge</i>   |        |                         |                           |                  |  |     |                |
| Patients with expected discharge date  |        | 63.2%                   | 57.8%                     | Apr-21           | ↑  |     |                |
| <i>% of inpatients with a recorded estimated discharge date</i>                    |        |                         |                           |                  |  |     |                |
| CAT clinic activity  | 120    | 148                     | 76                        | Apr-21           | ↑  |     |                |
| <i># of Patient contacts at the Community Assessment and Treatment Service</i>     |        |                         |                           |                  |  |     |                |
| GP referrals   | 10,500 | 6,478                   | 7,876                     | Apr-21           | ↓  |     |                |
| <i># of GP referrals received in month</i>   |        |                         |                           |                  |  |     |                |
| Neck of femur fracture to theatre in 36 hours                                      |        | 83.3%                   | 60.0%                     | Apr-21           | ↑  |     |                |
| <i># of patients with fractured neck of femur reaching theatre within 36 hours</i> |        |                         |                           |                  |  |     |                |

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# Appendix:

| Metric  | Target | Latest reporting period | Previous reporting period | Reporting period | MoM mvmt<br>G = Improvement<br>R = Deterioration | RAG | 12-month trend |
|---|--------|-------------------------|---------------------------|------------------|--|-----|----------------|
| % of beds occupied by MFFD  |        |                         |                           | Feb-21           | →  |     |                |
| <i>The monthly average bed occupancy of patients who are recorded as medically fit for discharge.</i>   |        |                         |                           |                  |  |     |                |
| Average length of stay post-MFFD  |        |                         |                           | Feb-21           | →  |     |                |
| <i>For patients discharged in month, the average number of days that they stayed after they were recorded as medically fit for discharge.</i> |        |                         |                           |                  |  |     |                |

[Link to Operational Performance Overview](#)

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# Appendix:

| Metric   | Target | Latest reporting period | Previous reporting period | Reporting period | MoM mvmt<br>G = Improvement<br>R = Deterioration | RAG    | 12-month trend |
|--|--------|-------------------------|---------------------------|------------------|--|--------|----------------|
| <b>QUALITY</b>   |        |                         |                           |                  |  |        |                |
| MRSA   | 0      | 0                       | 0                         | Apr-21           | →  | Green  |                |
| <i>Number of MRSA recorded infections</i>  |        |                         |                           |                  |  |        |                |
| Clostridioides Difficile (C Diff)  | 0      | 6                       | 2                         | Apr-21           | ↑  | Orange |                |
| <i>Number of Clostridioides Difficile recorded infections</i>                                    |        |                         |                           |                  |  |        |                |
| Never Events   | 0      | 0                       | 0                         | Apr-21           | →  | Green  |                |
| <i>Number of never events recorded</i>   |        |                         |                           |                  |  |        |                |
| Falls causing severe harm  | 0      | 0                       | 0                         | Apr-21           | →  | Green  |                |
| <i>Number of inpatient falls causing harm</i>  |        |                         |                           |                  |  |        |                |
| Medication errors causing severe harm  | 0      | 0                       | 0                         | Apr-21           | →  | Green  |                |
| <i>Number of errors in prescribing or delivering medication causing severe harm to a patient</i> |        |                         |                           |                  |  |        |                |

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# Appendix:

| Metric   | Target | Latest reporting period | Previous reporting period | Reporting period | MoM mvmt<br>G = Improvement<br>R = Deterioration | RAG   | 12-month trend |
|--|--------|-------------------------|---------------------------|------------------|--|-------|----------------|
| Line infections  | 0      | 0                       | 2                         | Mar-21           | ↓  | Green |                |
| <i>Number of IV lines resulting in patient infection</i>                                   |        |                         |                           |                  |  |       |                |
| Failures to isolate  |        | 6                       | 11                        | Apr-21           | ↓  | Grey  |                |
| <i># of infected patients not isolated</i>   |        |                         |                           |                  |  |       |                |
| Crude mortality (rolling 12 months)  |        | 1.5%                    | 1.6%                      | Apr-21           | ↓  | Grey  |                |
| <i>% of patients who died in hospital against number of discharges</i>                     |        |                         |                           |                  |  |       |                |
| Hospital Standardised Mortality Ratio (HSMR) (rolling 12 months)                           |        | -                       | -                         | Feb-21           | →  | Grey  |                |
| <i>Healthcare Standard Mortality Ratio</i>   |        |                         |                           |                  |  |       |                |
| Medical Examiner screens selected for further review                                       |        | 14.1%                   | 12.0%                     | Apr-21           | ↑  | Red   |                |
| <i># of cases selected for mortality review</i>  |        |                         |                           |                  |  |       |                |
| Sepsis Compliance - Suspicion to needle time (STNT) within one hour                        | 80.0%  | 88.0%                   | 71.0%                     | Mar-21           | ↑  | Grey  |                |
| <i>% of patients with suspected sepsis receiving intravenous antibiotics within 1 hour</i> |        |                         |                           |                  |  |       |                |

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# Appendix:

| Metric  | Target | Latest reporting period | Previous reporting period | Reporting period | MoM mvmt<br>G = Improvement<br>R = Deterioration | RAG | 12-month trend |
|---|--------|-------------------------|---------------------------|------------------|--|-----|----------------|
| Extended perinatal mortality (per 1000 cases)   |        | 5                       | 5                         | Feb-21           | ↑  |     |                |
| <i># of stillbirths and neonatal deaths</i>   |        |                         |                           |                  |  |     |                |
| Stillborn 24 weeks or later (per 1000 cases)  |        | 4                       | 4                         | Feb-21           | ↓  |     |                |
| <i># of still births after 24 weeks gestation per 1000 births.</i>                    |        |                         |                           |                  |  |     |                |
| Avoidable cardiac arrests   | 0      | 2                       | 1                         | Feb-21           | ↑  |     |                |
| <i>Number of avoidable inpatients cardiac arrests</i>                                 |        |                         |                           |                  |  |     |                |
| VTE assessment  | 95.0%  | 96.7%                   | 95.3%                     | Mar-21           | ↑  |     |                |
| <i>% of admitted inpatients who have received a venous thromboembolism assessment</i> |        |                         |                           |                  |  |     |                |

[Link to Quality & Safety Overview](#)

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# Appendix:

| Metric   | Target | Latest reporting period | Previous reporting period | Reporting period | MoM mvmt<br>G = Improvement<br>R = Deterioration | RAG | 12-month trend |
|--|--------|-------------------------|---------------------------|------------------|--|-----|----------------|
| Pressure ulcers - deep tissue damage                                   |        | 4                       | 3                         | Feb-21           | ↑  |     |                |
| <i>Number of confirmed pressure ulcers relating inpatient stay.</i>    |        |                         |                           |                  |  |     |                |
| Safeguarding training (C&YP Level 2)                                   |        | 83.0%                   | 81.5%                     | Apr-21           | ↑  |     |                |
| <i># of staff overdue Children and Young People Safeguard training</i> |        |                         |                           |                  |  |     |                |
| A&E - median time to triage (minutes)                                  |        | 17                      | 14                        | Apr-21           | ↑  |     |                |
| <i>Average time taken to triage adult (18+) A&amp;E attendances.</i>   |        |                         |                           |                  |  |     |                |

[Link to Quality & Safety Overview](#)

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# Appendix:

| Metric  | Target | Latest reporting period | Previous reporting period | Reporting period | MoM mvmt<br>G = Improvement<br>R = Deterioration | RAG | 12-month trend |
|---|--------|-------------------------|---------------------------|------------------|--|-----|----------------|
| <b>PATIENT EXPERIENCE</b>                                     |        |                         |                           |                  |  |     |                |
| New complaints  |        | 48                      | 47                        | Apr-21           | ↑  |     |                |
| <i># of new complaints received by the Trust</i>              |        |                         |                           |                  |  |     |                |
| Complaints - still outstanding after 90 days                  | 10     | 6                       | 1                         | Apr-21           | ↑  |     |                |
| <i># of complaints unresolved after 90 days</i>               |        |                         |                           |                  |  |     |                |
| Complaints - response within 25 days                          | 85.0%  | ended during            | 69.0%                     | Feb-21           | →  |     |                |
| <i>% of complaints responded to within 25 days of receipt</i> |        |                         |                           |                  |  |     |                |
| Compliments - total received                                  |        | 506                     | 403                       | Mar-21           | ↑  |     |                |
| <i># of compliments received by the Trust.</i>                |        |                         |                           |                  |  |     |                |
| Patients discharged before noon                               |        | 18.0%                   | 19.4%                     | Apr-21           | ↓  |     |                |
| <i>% of daily discharges completed before noon.</i>           |        |                         |                           |                  |  |     |                |

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# Appendix:

| Metric   | Target | Latest reporting period | Previous reporting period | Reporting period | MoM mvmt<br>G = Improvement<br>R = Deterioration | RAG    | 12-month trend |
|--|--------|-------------------------|---------------------------|------------------|--|--------|----------------|
| Outstanding patient safety alerts  | 0      | 0                       | 0                         | Apr-21           | →  | Green  |                |
| <i># of alerts not completed</i>   |        |                         |                           |                  |  |        |                |
| 12 hour trolley waits in A&E   | 0      | 0                       | 0                         | Apr-21           | →  | Green  |                |
| <i># of patients waiting for more than 12 hours on a trolley in A&amp;E</i>    |        |                         |                           |                  |  |        |                |
| Friends & Family - overall response rate                                       |        | 27.0%                   | 39.4%                     | Apr-21           | ↓  | Grey   |                |
| <i>% of all Friends and Family surveys responded to</i>                        |        |                         |                           |                  |  |        |                |
| Friends & Family - Inpatient - positive response                               | 95.0%  | 92.3%                   | 89.2%                     | Apr-21           | ↑  | Orange |                |
| <i>% of all Friends and Family surveys of inpatients responding positively</i> |        |                         |                           |                  |  |        |                |

# Appendix:

| Metric   | Target | Latest reporting period | Previous reporting period | Reporting period | MoM mvmt<br>G = Improvement<br>R = Deterioration | RAG    | 12-month trend |
|--|--------|-------------------------|---------------------------|------------------|--|--------|----------------|
| Friends & Family - A&E - positive response   | 95.0%  | 82.3%                   | 82.3%                     | Apr-21           | ↓  | Orange |                |
| <i>% of all Friends and Family surveys of A&amp;E patients responding positively</i>   |        |                         |                           |                  |  |        |                |
| Friends & Family - Maternity - positive response                                       | 95.0%  | 78.8%                   | 78.8%                     | Apr-21           | ↓  | Red    |                |
| <i>% of all Friends and Family surveys of maternity patients responding positively</i> |        |                         |                           |                  |  |        |                |

[Link to Patient Experience Overview](#)

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# Appendix:

| Metric   | Target | Latest reporting period | Previous reporting period | Reporting period | MoM mvmt<br>G = Improvement<br>R = Deterioration | RAG    | 12-month trend |
|--|--------|-------------------------|---------------------------|------------------|--|--------|----------------|
| <b>WORKFORCE</b>   |        |                         |                           |                  |  |        |                |
| <b>Substantive</b>   |        |                         |                           |                  |  |        |                |
| Staff Turnover   | 12.0%  | 12.3%                   | 12.2%                     | Apr-21           | ↑  | Orange |                |
| <i>% of staff leaving in month calculated on an annualised basis.</i>                            |        |                         |                           |                  |  |        |                |
| Sickness   | 3.5%   | 3.5%                    | 3.8%                      | Apr-21           | ↓  | Green  |                |
| <i>% of staff hours lost to sickness in month</i>  |        |                         |                           |                  |  |        |                |
| Nursing vacancy rate   | 12.0%  | 17.9%                   | 16.5%                     | Apr-21           | ↑  | Red    |                |
| <i>Average nurse vacancy rate in month</i>   |        |                         |                           |                  |  |        |                |
| Wards with 30%+ nursing vacancies  | 0      | 11                      | 8                         | Mar-21           | ↑  | Red    |                |
| <i>Number of inpatient Wards for at least 30% of whole time equivalent Nursing posts vacant.</i> |        |                         |                           |                  |  |        |                |
| Statutory training   | 90.0%  | 86.2%                   | 84.6%                     | Apr-21           | ↑  | Orange |                |
| <i>% compliance with Staff Statutory Training Matrix</i>   |        |                         |                           |                  |  |        |                |

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# Appendix:

| Metric   | Target | Latest reporting period | Previous reporting period | Reporting period | MoM mvmt<br>G = Improvement<br>R = Deterioration | RAG | 12-month trend |
|--|--------|-------------------------|---------------------------|------------------|--|-----|----------------|
| Occupational Health referrals - stress   | 20     | 79                      | 107                       | Apr-21           | ↓  |     |                |
| <i># of staff referrals to Occupational Health for stress related health issues.</i> |        |                         |                           |                  |  |     |                |
| <b>Temporary</b>   |        |                         |                           |                  |  |     |                |
| Temporary staff - % spend  | 10.0%  | 17.5%                   | 14.9%                     | Apr-21           | ↑  |     |                |
| <i>% of total pay spend made up of bank, locum and agency costs</i>                  |        |                         |                           |                  |  |     |                |
| Temporary staff (all nursing) - shifts requested                                     | 6000   | 5552                    | 6857                      | Apr-21           | ↓  |     |                |
| <i>Missing definition</i>  |        |                         |                           |                  |  |     |                |
| Temporary staff (all nursing) - shifts breaching Agency Cap                          | 575    | 52                      | 83                        | Apr-21           | ↓  |     |                |
| <i>Missing definition</i>  |        |                         |                           |                  |  |     |                |
| Nursing - Bank fill rate   |        | 49.7%                   | 51.3%                     | Apr-21           | ↓  |     |                |
| <i>% of Nursing shifts put out to the Nursing bank and confirmed as filled</i>       |        |                         |                           |                  |  |     |                |
| Average time to replace vacancy (days)   | 56     | 53                      | 54                        | Apr-21           | ↓  |     |                |
| <i>Average time from leaving date to replacement start date</i>                      |        |                         |                           |                  |  |     |                |

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# Appendix:

| Metric   | Target | Latest reporting period | Previous reporting period | Reporting period | MoM mvmt<br>G = Improvement<br>R = Deterioration | RAG | 12-month trend |
|--|--------|-------------------------|---------------------------|------------------|--|-----|----------------|
| <b>Equality &amp; Diversity</b>  |        |                         |                           |                  |  |     |                |
| Relative likelihood of White staff being appointed from shortlisting compared to BAME staff  |        | #N/A                    | #N/A                      | #N/A             | ↑↔↘  |     |                |
| <i>Missing definition</i>  |        |                         |                           |                  |  |     |                |
| Relative likelihood of Disabled staff being appointed from Shortlisting compared to non-Disabled staff   |        | #N/A                    | #N/A                      | #N/A             | ↑↔↘  |     |                |
| <p><i>This measure is the ratio of shortlisted non-disabled to disabled candidates being offered positions. A measure of 1 would be an equal chance of being offered a position. A measure of 2 would mean shortlisted non-disabled candidates are twice as likely to be offered positions. This measure is weighted by the number of non-disabled and disabled candidates shortlisted</i></p> |        |                         |                           |                  |  |     |                |

[Link to Workforce Overview](#)

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# Appendix:

| Metric  | Target | Latest reporting period | Previous reporting period | Reporting period | MoM mvmt<br>G = Improvement<br>R = Deterioration | RAG    | 12-month trend |
|---|--------|-------------------------|---------------------------|------------------|--|--------|----------------|
| <b>EFFICIENCY</b>   |        |                         |                           |                  |  |        |                |
| <b>Theatres/Other</b>   |        |                         |                           |                  |  |        |                |
| Theatre utilisation   | 85.0%  | 87.6%                   | 89.5%                     | Mar-21           | ↓  | Green  |                |
| <i>% usage of available theatre capacity</i>  |        |                         |                           |                  |  |        |                |
| Clinical coding within target   | 95.0%  | 97.1%                   | 96.0%                     | Mar-21           | ↑  | Green  |                |
| <i>% of completed coding by working day 10</i>  |        |                         |                           |                  |  |        |                |
| Coding depth - avg no. of diagnosis codes per FCE - Elective  | 5.2    | 3.6                     | 3.5                       | Mar-21           | ↑  | Red    |                |
| <i>Average number of ICD-10 codes recorded per elective FCE</i>   |        |                         |                           |                  |  |        |                |
| Coding depth - avg no. of diagnosis codes per FCE - Non Elective  | 5.4    | 4.2                     | 5.6                       | Mar-21           | ↓  | Red    |                |
| <i>Average number of ICD-10 codes recorded per non elective FCE</i>   |        |                         |                           |                  |  |        |                |
| Coding depth - % of R codes in primary diagnosis (per FCE)  | 0.3    | 0.1                     | 0.1                       | Mar-21           | ↑  | Grey   |                |
| <i>Percentage of R codes recorded as primary diagnosis per FCE</i>  |        |                         |                           |                  |  |        |                |
| Receipts without a purchase order   | 250    | 314                     | 124                       | Apr-21           | ↑  | Orange |                |
| <i>Total number of receipts received without a valid purchase order contrary to the Trusts finance policy</i> |        |                         |                           |                  |  |        |                |

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# Appendix:

| Outpatient appointments - DNAs  | <5%    | 6.7%                    | 6.3%                      | Apr-21           | ↑  |     |                |
|---|--------|-------------------------|---------------------------|------------------|--|-----|----------------|
| <i>% of all outpatient appointments where a patient did not attend without cancellation</i>                     |        |                         |                           |                  |  |     |                |
| Metric  | Target | Latest reporting period | Previous reporting period | Reporting period | MoM mvmt<br>G = Improvement<br>R = Deterioration | RAG | 12-month trend |
| Outpatient appointments - not cashed up   | 2.0%   | 2.7%                    | 2.3%                      | Apr-21           | ↑  |     |                |
| <i>% of all attended outpatient attendances without a completed electronic outcome form.</i>                    |        |                         |                           |                  |  |     |                |
| Outpatient letters to GPs within 14 days  | 90.0%  | 76.5%                   | 83.1%                     | Apr-21           | ↓  |     |                |
| <i>% of all outpatient attendances where the outcome letter has been sent to the patients GP within 14 days</i> |        |                         |                           |                  |  |     |                |
| <b>Flow</b>   |        |                         |                           |                  |  |     |                |
| Stranded patients at 7 days   |        | 258                     | 265                       | Apr-21           | ↓  |     |                |
| <i># of acute inpatients with a length of stay longer than 7 days</i>   |        |                         |                           |                  |  |     |                |
| LoS > 21 days - patients in acute hospitals   | 80     | 52                      | 60                        | Apr-21           | ↓  |     |                |

[Link to Efficiency Overview](#)

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# Appendix:

| Metric  | Target | Latest reporting period | Previous reporting period | Reporting period | MoM mvmt<br>G = Improvement<br>R = Deterioration | RAG | 12-month trend |
|---|--------|-------------------------|---------------------------|------------------|--|-----|----------------|
| SMH - Average medical length of stay (days)   | 6.5    | 7.7                     | 9.0                       | Apr-21           | ↓  |     |                |
| <i>Average length of stay on wards</i>  |        |                         |                           |                  |  |     |                |
| Community Hosps - Average length of stay (days)   | 28     | 24                      | 23                        | Apr-21           | ↑  |     |                |
| <i>Average length of stay from Community Hospital admission to patients discharge or death</i>  |        |                         |                           |                  |  |     |                |
| <b>Investment Case Performance</b>  |        |                         |                           |                  |  |     |                |
| Ageing Well step up activity  |        |                         |                           | Feb-21           | →  |     |                |
| <i>Average monthly activity delivered through the Aging Well setup up initiative. This measure specifically relates to the rapid access to Community support to avoid an admission.</i> |        |                         |                           |                  |  |     |                |
| Aylesbury post code over 75 ED admission rate   |        |                         |                           | Feb-21           | →  |     |                |

# Appendix:

|  |  |  |  |        |   |  |  |
|--|--|--|--|--------|---|--|--|
| Ageing Well step down activity   |  |  |  | Feb-21 | → |  |  |
| <p><i>This measure tracks the average monthly activity delivered by through Aging Well step down service. This measure specifically relates to the rapid access to Community support to step down inpatients from secondary care and to facilitate an earlier discharge.</i></p> |  |  |  |        |   |  |  |
|  |  |  |  |        |   |  |  |

[Link to Efficiency Overview](#)

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# Appendix:

| Metric  | Target         | Latest reporting period | Previous reporting period | Reporting period | MoM mvmt<br>G = Improvement<br>R = Deterioration | RAG   | 12-month trend |
|---|----------------|-------------------------|---------------------------|------------------|--|-------|----------------|
| <b>RECOVERY</b>   |                |                         |                           |                  |  |       |                |
| Activity to pre COVID levels - Outpatients (baseline is 19/20)  | 90.0%          | 99.9%                   | 108.4%                    | Apr-21           | ↓  | Green |                |
| <i>Outpatient appointments delivered as a % of 19/20 activity</i>   |                |                         |                           |                  |  |       |                |
| Activity to pre COVID levels - Elective/Daycase (baseline is 19/20)   | 90.0%          | 74.7%                   | 76.2%                     | Apr-21           | ↓  | Red   |                |
| <i>Elective Surgical daycase and inpatient procedures delivered as a % of 19/20 activity</i>                      |                |                         |                           |                  |  |       |                |
| Waiting list size at pre COVID levels   |                | 115.7%                  | 101.4%                    | Mar-21           | ↑  | Grey  |                |
| <i>Waiting list size as a % of 19/20 levels</i>   |                |                         |                           |                  |  |       |                |
| Transition to virtual appointments  | 30.0%          | 30.0%                   | 33.7%                     | Apr-21           | ↓  | Grey  |                |
| <i>% of outpatient attendances delivered through a non-face to face medium (telemedicine or video conference)</i> |                |                         |                           |                  |  |       |                |
| RTT - Average weeks wait on waiting list  | 20/21<br>19/20 | 26<br>13                | 26<br>11                  | Mar-21           |  | Grey  |                |
| <i>Average wait from referral to treatment compared to pre-COVID levels</i>                                       |                |                         |                           |                  |  |       |                |

[Link to Recovery Overview](#)

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**Meeting:** Trust Board Meeting in Public

**26 May 2021**

|                              |  |  |
|------------------------------|--|--|
| <b>Agenda item</b>           | Operating guidance and recovery - briefing for May   |  |
| <b>Board Lead</b>            | D.H.R. Gibbs – Chief Operating Officer   |  |
| <b>Type name of Author</b>   | Matan Czaczkes and Isobel Day  |  |
| <b>Attachments</b>           | (21-05-07) May Op guidance update EMC briefing v0.2 (MCz)  |  |
| <b>Purpose</b>               | Approval   |  |
| <b>Previously considered</b> | Elective Recovery Meeting – April, 2021<br>Recovery Performance Meeting – 12.05.2021<br>F&BPC – 18.05.2021 |  |

### Executive Summary

The purpose of this paper is to provide the Board an update on, and assurance of, work to deliver the requirements of the operational planning guidance. In particular, the paper focuses on elective recovery progress and the Elective Recovery Fund element of the operating planning guidance.

The 2021/22 Operational Planning guidance has been issued by NHS England. BHT is monitoring compliance against the requirements set out, which are due to be delivered between April 21 and March 22. To date the BHT has completed 54% of actions relating to acute Trusts.

Elective activity recovery is being tracked to provide assurance. All services have now restarted. In April the trust delivered 94% of its 19/20 activity in aggregate.

Clinically urgent patients and patients with long waits for treatment continue to be monitored and prioritised. Plans are set out for continuing to reduce the long wait numbers and to provide assurance around clinical harm management.

Covid pressures continue to remain low in the Trust with only three Covid inpatients at time of writing. The predicted third Covid wave pattern is set out, suggesting a smaller wave peaking approximately in August. Based on this revised NHSE/I Modelling it is now not expected that this should impact on elective recovery in Buckinghamshire.

A £1 billion elective care recovery fund was announced in the 21/22 operational planning guidance. The aim of the fund is to support elective. The fund incentivises increasing the value of activity delivered above 19/20 baseline. Trust activity has been analysed in terms of financial value, in line with the requirements of the Elective Recovery Fund. This analysis suggests that the Trust is on track to exceed the ERF thresholds for the first half of the year. Initial estimates suggest that BHT activity in excess of the ERF threshold will be worth c£2 million to the ICS in April.

Individual service level forward plans to meet and exceed the ERF thresholds have been developed and will be aggregated in the coming weeks. Some plans may involve additional spend over budget. A governance proposal is set out to manage these funding requests. The Board are requested to review and approve this proposed process.

Claiming additional funding on the basis of the elective recovery fund is also dependent on achieving gateway criteria. Though these are assessed at system level, locally the trust has self-assessed to be 67%

compliant, and on track to meeting the requirements.

In order to reflect the requirements of the operating planning guidance, updated governance proposals are set out. It is proposed that the existing recovery and renewal governance structure is superseded by a operational planning board structure. The Board are requested to approve this proposed governance change.

|  |   |  |  |
|--|---|--|--|
| <b>Decision</b>  | The Board are invited to: <ul style="list-style-type: none"> <li>• note progress on operational planning guidance requirements</li> <li>• note progress on elective recovery</li> <li>• approve proposed governance procedures for elective recovery fund additional spend</li> <li>• approve proposed revised governance structures to support the operational planning guidance delivery</li> </ul> |  |  |
| <b>Relevant Strategic Priority</b>                                 |   |  |  |
|  |   |  |  |
| <b>Quality</b> <input checked="" type="checkbox"/>                 | <b>People</b> <input checked="" type="checkbox"/>   | <b>Money</b> <input checked="" type="checkbox"/>   |  |
|  |   |  |  |
| <b>Implications / Impact</b>                                       |   |  |  |
| <b>Patient Safety</b>  |   | Yes - potential impact of delay in treatment is a recognised risk as a consequence of the COVID pandemic. The paper provides recommendations on how the potential risk is prioritised. |  |
| <b>Risk: link to Board Assurance Framework (BAF)/Risk Register</b> |   | 1.2 Developing as a learning organisation  |  |
| <b>Financial</b>   |   | No   |  |
| <b>Compliance CQC Standards Person-centred Care</b>                |   | Yes requirement to ensure that the potential impact of delay does not cause harm to patients.  |  |
| <b>Partnership: consultation / communication</b>                   |   | Yes requirement to engage with our staff and the public in the delivery national recovery programme and the actions taken to mitigate risk   |  |
| <b>Equality</b>  |   | Yes - requirement to ensure health inequalities are identified and addressed   |  |
| <b>Quality Impact Assessment [QIA] completion required?</b>        |   | No   |  |

# Operating guidance and recovery

## Briefing for May

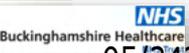
Isobel Day  
Matan Czaczkes  
May 2021

# Providing assurance on the 21/22 Operating Planning Guidance

# 2021/22 Operational Planning Guidance recovery elements

2021/22 Operational Planning guidance has been issued by NHS England. ICSs are expected to work across partner organisations to produce plans that consider alignment between CCGs and providers, and between activity and finances.

Priorities and planning guidance focus on six months 1 April to 30 September 2021 (H1). These are set out in the table below. A BHT logo indicates those for which the trust is responsible.

| Ref | Section of 2021/22 priorities and operational planning guidance  |   |
|-----|--|---|
| A   | Supporting the health and wellbeing of staff and taking action on recruitment and retention  |    |
| B   | Continuing to meet the needs of patients with Covid-19   |    |
| C1  | Maximise elective activity, taking full advantage of the opportunities to transform the delivery of service  |    |
| C2  | Restore full operation of all cancer services  |    |
| C3a | Expand and improve mental health services [incorporated in section A.]   |   |
| C3b | Expand and improve services for people with a learning disability and/or autism  |   |
| C4  | Deliver improvements in maternity care, including responding to the recommendations of the Ockenden review   |    |
| D1  | Restoring and increasing access to primary care services   |   |
| D2  | Implementing population health management and personalised care approaches to improve health outcomes and address health inequalities                            |  |
| E1  | Transforming community services and improve discharge  |  |
| E2  | Ensuring the use of NHS111 as the primary route to access urgent care and the timely admission of patients to hospital who require it from emergency departments |   |
| F   | Working collaboratively across systems to deliver on these priorities  |  |

# Tracking for assurance on progress



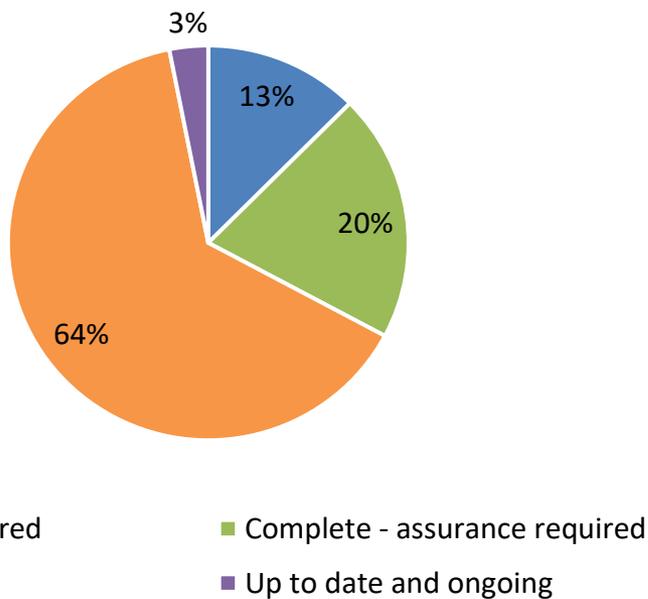
Though compliance with the requirements of the operational planning guidance is determined at system level, locally a system for assurance of compliance place has been implemented.

This assurance will be carried out by the proposed Bucks Operational Planning Board in the same way that the Phase 1-3 recovery requirements were tracked by the Recovery and Renewal Board.

The charts below show current ICP status for compliance with requirements

Operating guidance requirement status

This represents progress across the ICP. For BHT led requirements 54% are complete



|                               |           |
|-------------------------------|-----------|
| Done and assured              | 8         |
| Complete - assurance required | 13        |
| In progress                   | 41        |
| Up to date and ongoing        | 2         |
| <b>Total</b>                  | <b>64</b> |

# Tracking the elective recovery

# Tracking the elective activity recovery

All services have now restarted and are building up activity levels, which are being monitored daily. To give an indication of recovery progress activity is compared to 19/20 month-on-month. An example of this report is set out below for April:

April

| OUTPATIENTS  |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |
|--------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| Day of Month | 1     | 2     | 3     | 4     | 5     | 6     | 7     | 8     | 9     | 10    | 11    | 12    | 13    | 14    | 15    | 16    | 17    | 18    | 19    | 20    | 21    | 22    | 23    | 24    | 25    | 26    | 27    | 28    | 29    | 30    |
| 2019/20      | 1998  | 3766  | 5640  | 7643  | 9195  | 9266  | 9291  | 11078 | 12863 | 14695 | 16503 | 17912 | 19984 | 18025 | 19757 | 21578 | 23310 | 25101 | 25141 | 25224 | 25268 | 25313 | 27091 | 29005 | 30331 | 31909 | 31957 | 31995 | 33897 | 35798 |
| 2021/22      | 1705  | 1919  | 2134  | 2249  | 2301  | 3976  | 5573  | 7191  | 8827  | 9034  | 9078  | 10788 | 12481 | 14121 | 15678 | 17166 | 17316 | 17382 | 19115 | 20965 | 22167 | 23879 | 25416 | 25580 | 25646 | 27423 | 29260 | 30965 | 32545 | 33712 |
| Monitor      | 88.0% | 51.0% | 37.8% | 29.4% | 25.0% | 42.9% | 60.0% | 64.9% | 68.6% | 61.7% | 55.0% | 60.2% | 69.4% | 78.3% | 79.4% | 79.6% | 74.3% | 69.2% | 76.0% | 83.1% | 87.7% | 94.3% | 93.8% | 88.2% | 84.6% | 85.9% | 91.6% | 96.8% | 96.0% | 94.2% |

| ALL ELECTIVE TYPES |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |
|--------------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| Day of Month       | 1     | 2     | 3     | 4     | 5     | 6     | 7     | 8     | 9     | 10    | 11    | 12    | 13    | 14    | 15    | 16    | 17    | 18    | 19    | 20    | 21    | 22    | 23    | 24    | 25    | 26    | 27    | 28    | 29    | 30    |
| 2019/20            | 163   | 399   | 626   | 827   | 1045  | 1106  | 1146  | 1331  | 1534  | 1738  | 1934  | 2144  | 2194  | 2207  | 2385  | 2622  | 2833  | 3017  | 3038  | 3068  | 3081  | 3092  | 3302  | 3544  | 3690  | 3886  | 3943  | 3980  | 4191  | 4428  |
| 2021/22            | 143   | 162   | 175   | 188   | 192   | 327   | 498   | 618   | 768   | 805   | 810   | 942   | 1095  | 1256  | 1382  | 1549  | 1574  | 1594  | 1721  | 1879  | 1997  | 2134  | 2295  | 2322  | 2336  | 2496  | 2684  | 2855  | 3047  | 3217  |
| Monitor            | 87.7% | 40.6% | 28.0% | 22.7% | 18.4% | 29.6% | 43.5% | 46.4% | 50.1% | 46.3% | 41.9% | 43.9% | 49.9% | 56.9% | 57.9% | 59.1% | 55.6% | 52.8% | 56.6% | 61.2% | 64.8% | 69.0% | 69.5% | 65.5% | 63.3% | 64.2% | 68.1% | 71.7% | 72.7% | 72.7% |

| DAYCASE      |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |
|--------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| Day of Month | 1     | 2     | 3     | 4     | 5     | 6     | 7     | 8     | 9     | 10    | 11    | 12    | 13    | 14    | 15    | 16    | 17    | 18    | 19    | 20    | 21    | 22    | 23    | 24    | 25    | 26    | 27    | 28    | 29    | 30    |
| 2019/20      | 148   | 364   | 570   | 750   | 938   | 980   | 1014  | 1188  | 1381  | 1562  | 1743  | 1939  | 1967  | 1973  | 2138  | 2363  | 2556  | 2716  | 2723  | 2743  | 2749  | 2756  | 2961  | 3191  | 3306  | 3484  | 3523  | 3558  | 3762  | 3981  |
| 2021/22      | 131   | 142   | 149   | 159   | 160   | 291   | 452   | 561   | 701   | 723   | 724   | 851   | 999   | 1151  | 1270  | 1411  | 1421  | 1438  | 1558  | 1706  | 1812  | 1940  | 2080  | 2094  | 2100  | 2254  | 2434  | 2589  | 2746  | 2905  |
| Monitor      | 88.5% | 39.0% | 26.1% | 21.2% | 17.1% | 29.7% | 44.6% | 47.2% | 50.8% | 46.3% | 41.5% | 43.9% | 50.8% | 58.3% | 59.4% | 59.7% | 55.6% | 52.9% | 57.2% | 62.2% | 65.9% | 70.4% | 70.2% | 65.6% | 63.5% | 64.7% | 69.1% | 72.8% | 73.0% | 73.0% |

| ELECTIVE     |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |       |
|--------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| Day of Month | 1     | 2     | 3     | 4     | 5     | 6     | 7     | 8     | 9     | 10    | 11    | 12    | 13    | 14    | 15    | 16    | 17    | 18    | 19    | 20    | 21    | 22    | 23    | 24    | 25    | 26    | 27    | 28    | 29    | 30    |
| 2019/20      | 15    | 35    | 56    | 77    | 107   | 126   | 132   | 143   | 153   | 176   | 191   | 205   | 227   | 234   | 247   | 259   | 277   | 301   | 315   | 325   | 332   | 336   | 341   | 353   | 384   | 402   | 420   | 422   | 429   | 447   |
| 2021/22      | 12    | 20    | 26    | 29    | 32    | 36    | 46    | 57    | 67    | 82    | 86    | 91    | 96    | 105   | 112   | 138   | 153   | 156   | 163   | 173   | 185   | 194   | 215   | 228   | 236   | 242   | 250   | 266   | 301   | 312   |
| Monitor      | 80.0% | 57.1% | 46.4% | 37.7% | 29.9% | 28.6% | 34.8% | 39.9% | 43.8% | 46.6% | 45.0% | 44.4% | 42.3% | 44.9% | 45.3% | 53.3% | 55.2% | 51.8% | 51.7% | 53.2% | 55.7% | 57.7% | 63.0% | 64.6% | 61.5% | 60.2% | 59.5% | 63.0% | 70.2% | 69.8% |

| OUTPATIENTS  |       |
|--------------|-------|
| Day of Month | 30    |
| 2019/20      | 35798 |
| 2021/22      | 33712 |
| Monitor      | 94.2% |

| DAYCASE      |       |
|--------------|-------|
| Day of Month | 30    |
| 2019/20      | 3981  |
| 2021/22      | 2905  |
| Monitor      | 73.0% |

| ELECTIVE     |       |
|--------------|-------|
| Day of Month | 30    |
| 2019/20      | 447   |
| 2021/22      | 312   |
| Monitor      | 69.8% |

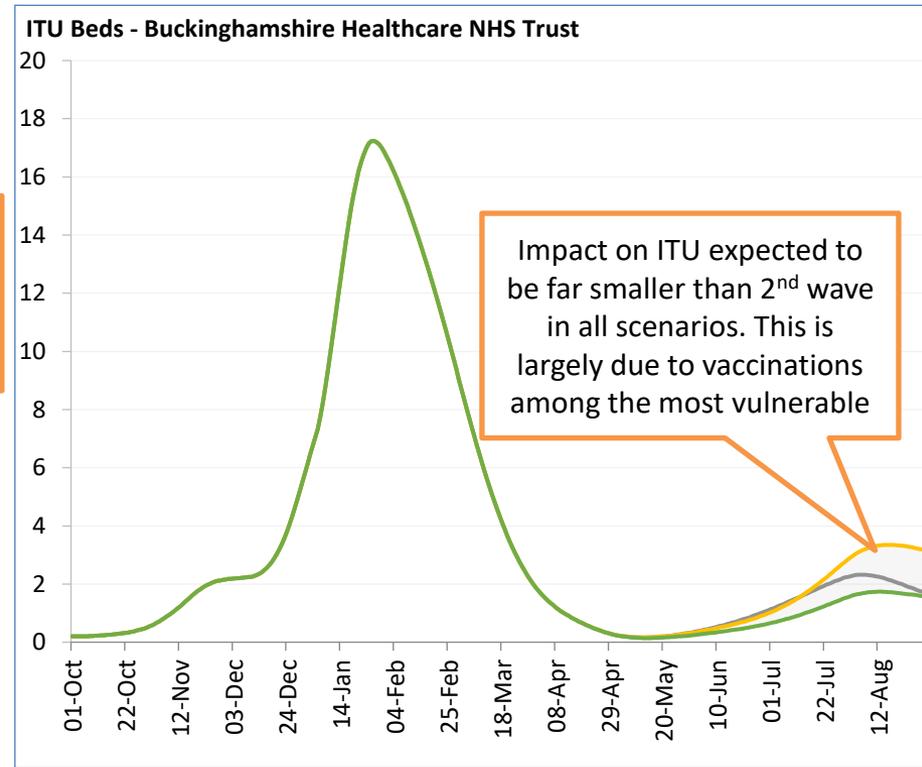
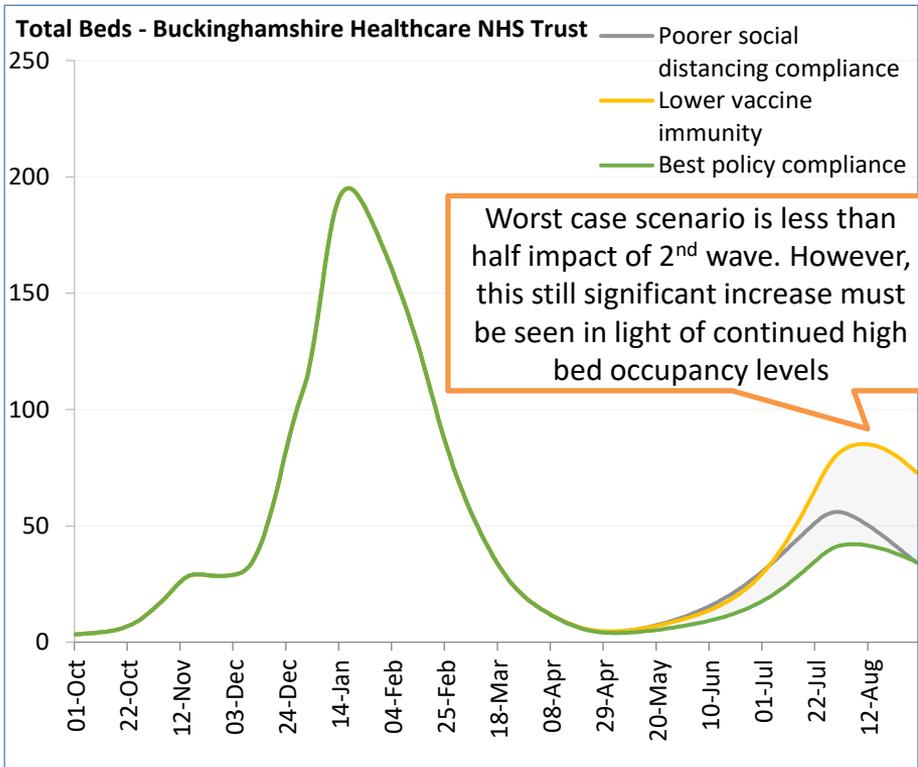
The above shows day on day cumulative performance compared to same day last year. As such, for complete months is it is the final day that is most relevant – presented right. Overall the Trust delivered 94% of it's April 19/20 activity.

The current report looks at actual performance. A report is being worked up to give a forward view of performance based on theatre lists and OPD bookings.

Planned activity trajectories, activity financial values and relationship to ERF targets are discussed in the ERF section.

# Planning for winter and the third wave

A potential third wave of Covid, as well as the expected winter pressures for both adults and children cannot be allowed to impact the current positive recovery trajectory. The charts below show the latest expected impact of the third wave in Bucks on both general & acute beds and ICU beds. These demonstrate that elective activity should be able to continue as planned.



The surge plans currently being formed should take into account the need to continue to delivering elective care to manage clinical harm and long waits.

## Managing clinically urgent patients

A key performance metric for a safe recovery is ensuring patients with the highest clinical needs are booked in priority order. P2 patients should have their procedure within 4 weeks of decision to admit. The number who are unbooked are tracked weekly at APMG. The table below sets out the number of unbooked 'P2's by division.

### P2 unbooked over 4 weeks from decision to operate

| Weeks        | 4  | 5 | 6  | 7 | 8 | 9 | 10 | 11 | 12 | 14 | 15 | 16 | 17 | 18 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 28 | 31 | 32 | 35 | 37 | 38 | 44 | Total |
|--------------|----|---|----|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|-------|
| <b>Total</b> | 15 | 6 | 11 | 4 | 3 | 1 | 6  | 2  | 2  | 2  | 1  | 2  | 1  | 1  | 1  | 2  | 5  | 1  | 1  | 2  | 1  | 2  | 1  | 2  | 2  | 1  | 1  | 14 | 93    |

### P2 unbooked over 4 weeks by service

| Service                 | Weeks |
|-------------------------|-------|
| Dermatology             | 1     |
| ENT                     | 2     |
| General Surgery         | 3     |
| Gynaecological Oncology | 2     |
| Gynaecology             | 14    |
| Ophthalmology           | 2     |
| Pain Management         | 2     |
| Plastic Surgery         | 20    |
| Trauma & Orthopaedics   | 35    |
| Urology                 | 11    |
| Vascular Surgery        | 1     |
| <b>Grand Total</b>      | 93    |

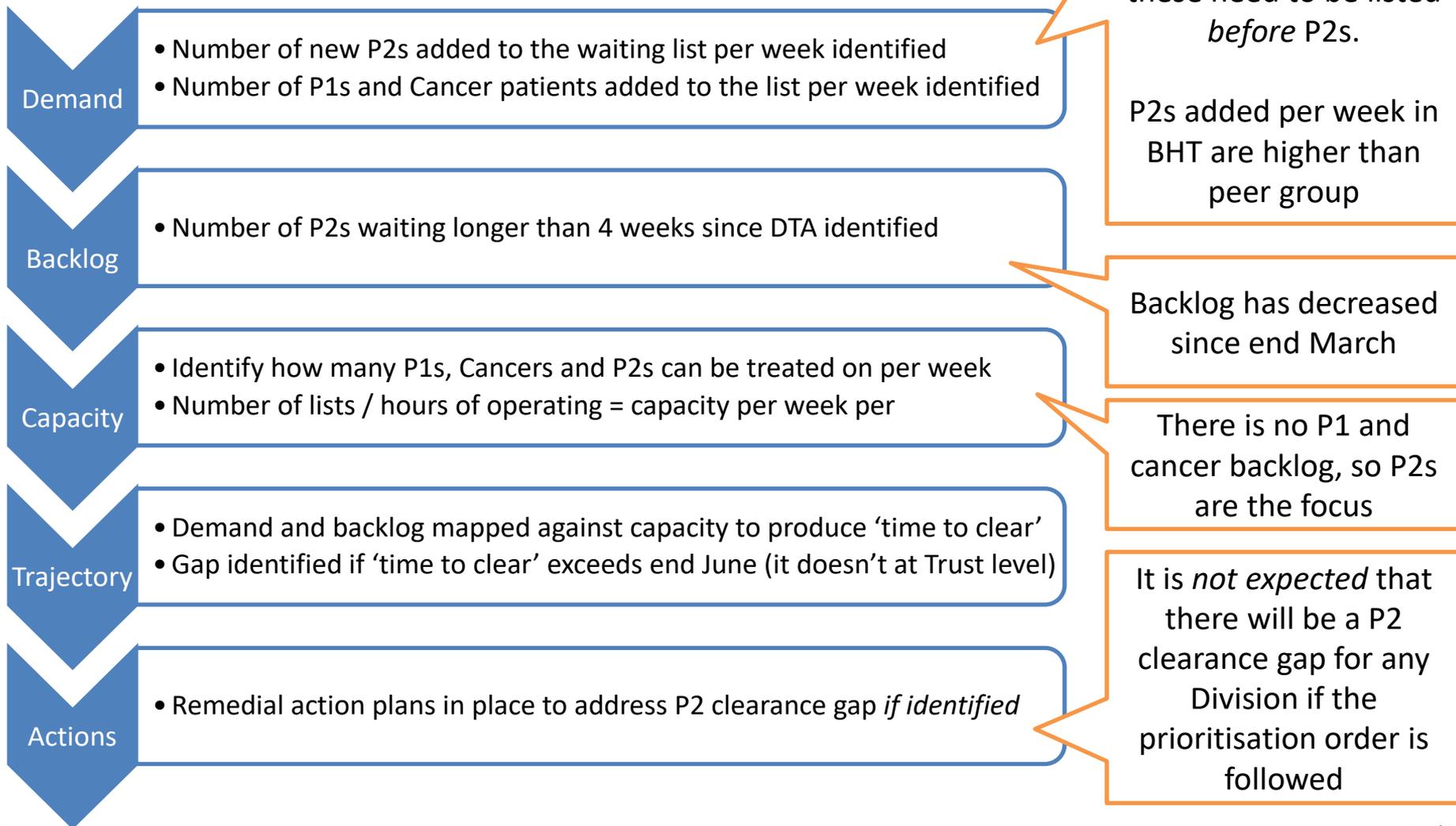
### An improving picture

The reported number for end April has dropped significantly compared to end of March. Last month we reported a total of 160 patients unbooked over 4 weeks from DTA, compared to 93 currently. Moreover, the profile of the wait has improved with the longest waiters in March being at week 86, compared to week 44 now.

Services continue to plan to clear all unbooked patients waiting more than 4 weeks, and to do so by the end of June. The steps of this clearance plan are set out overleaf.

# Booking according to clinical need

The process below sets out the logic by which P2 backlog and clearance trajectories are calculated



# Managing risk for patients with long waits

The tables below sets out the number of patients waiting over 52 weeks by division, as well as the number of weeks they have been waiting. Patients who have requested a postponement (P5 & P6) are excluded

## 52+ week waits

|       |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |     |     |     |     |
|-------|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|-----|-----|-----|-----|
| Weeks | 52 | 53 | 54 | 55 | 56 | 57 | 58 | 59 | 60 | 61 | 62 | 63 | 64 | 65 | 66 | 67 | 68 | 69 | 70 | 71 | 72 | 73 | 74 | 75 | 76 | 77 | 78 | 79 | 80 | 81 | 82 | 83 | 84 | 85 | 86 | 87 | 88 | 89 | 90 | 91 | 92 | 93 | 94 | 95 | 96 | 97 | 98 | 99 | 100 | 101 | 102 | 103 |
| Total | 18 | 18 | 14 | 11 | 10 | 22 | 34 | 47 | 70 | 89 | 79 | 87 | 67 | 72 | 83 | 92 | 85 | 65 | 32 | 29 | 53 | 65 | 78 | 72 | 64 | 55 | 52 | 44 | 50 | 46 | 37 | 46 | 34 | 27 | 30 | 21 | 29 | 28 | 22 | 21 | 19 | 17 | 14 | 27 | 8  | 14 | 8  | 8  | 14  | 4   | 3   | 7   |

## 104 week waits

|       |     |     |     |     |     |
|-------|-----|-----|-----|-----|-----|
| Weeks | 104 | 105 | 106 | 108 | 113 |
| Total | 4   | 6   | 1   | 1   | 1   |

There are 32 patients who have waited over 104 from decision to admit. Of these, 21 have ask that treatment be postponed (category P5 or 6). Due to temporary patient access rules they cannot be removed from the list at this point. The remaining will be booked in ASAP and no later then the end of May

With one year having passed since services were paused to manage the Covid surge the increasing numbers reflect the fact that BHT remained open for referrals throughout the pandemic. The total long waiter number has fallen by 202 since end of Feb.

## Long waits by specialty

| Weeks                      |             |
|----------------------------|-------------|
| ENT                        | 81          |
| General Surgery            | 142         |
| Gynaecology                | 113         |
| Interventional Radiology   | 3           |
| Ophthalmology              | 496         |
| Oral Surgery               | 43          |
| Orthodontics               | 5           |
| Paediatric Ophth           | 23          |
| Paediatric Plastic Surgery | 1           |
| Pain Management            | 4           |
| Plastic Surgery            | 311         |
| Spinal Injuries            | 2           |
| Trauma & Orthopaedic       | 681         |
| Urology                    | 110         |
| Vascular Surgery           | 39          |
| <b>Grand Total</b>         | <b>2054</b> |

# Reviewing patients to manage clinical harm

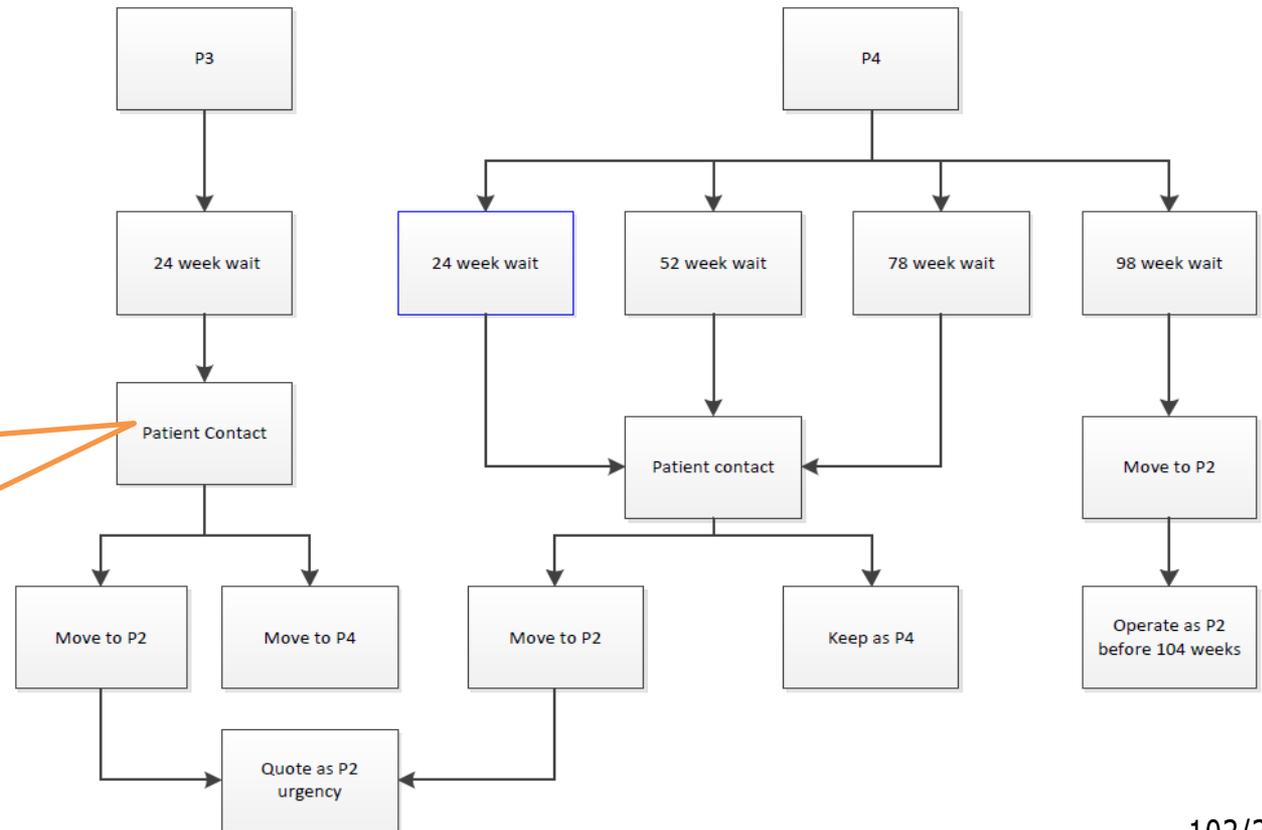
All patients on the admitted waiting list are assigned a priority (P) category in accordance with the clinical risk associated with waiting for treatment.

To manage the potential clinical harm for patients while waiting, the Clinical Chair for surgical division has worked with colleagues to set out a proposed the review protocol below:

By following this process clinical teams hope to ensure that patients are safe to wait while priority is given for treating the most urgent.

Patients are not automatically reclassified to more urgent P category based on length of wait. Reclassification is dependent on clinical

## Surgery & Critical Care Admitted Patients



# Achieving the Elective Recovery Fund

# Elective Recovery Fund - basic rules

A £1 billion elective care recovery fund was announced in the 21/22 operational planning guidance. The aim of the fund is to support elective. The fund incentivises increasing the value of activity delivered above 19/20 baselines

## Activity above a moving threshold

Payments will only be available when activity related income is above a certain proportion of 19/20;

| April | May | June | July to April 22 |
|-------|-----|------|------------------|
| 70%   | 75% | 80%  | 85%              |

## Gateway criteria

Access to the ERF will be subject to meeting a number of gateway criteria including:

- addressing health inequalities
- transformation of outpatient services
- implementing system led elective working
- tackling the longest waits
- supporting staff

Detailed analysis of these is given later

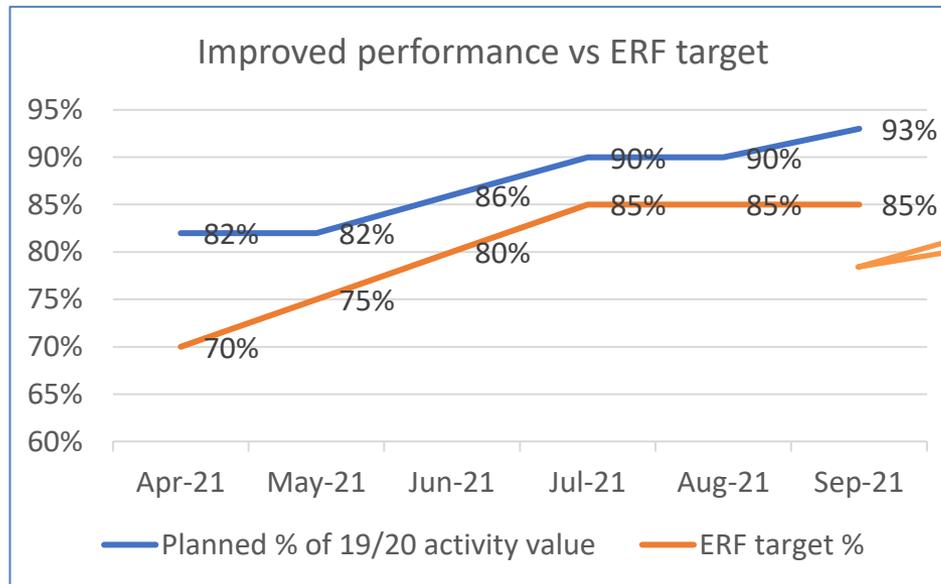
## ICS incentives

ERF targets relate to ICS performance, not individual trust or ICP performance. This means that any financial decision to invest to meet ERF levels should relate to BOB performance as a whole

It is not clear how any funds accessed through the ERF would be distributed by the ICS.

# Delivering the ERF targets

The ERF is calculated based on financial activity value, rather than activity numbers. The chart below sets out the initial submission to the ICS in accordance with the operating planning guidance. The final submission is due in June.



Delivering this trajectory has been forecast to attract £5.6m of additional funding

As well as meeting the operating planning guidance, the Trust now has an opportunity to leverage the ERF funding in order to help drive up activity and clear the backlog – reducing clinical risk.

To take advantage of this opportunity, operational divisions have plans to further exceed the ERF thresholds where possible.

Some of the service plans are seeking funding for additional activity, which is hoped to be clawed back through expected ERF funding. However, as ERF funding is allocated at ICS level there is a small risk if the ICS does not meet these levels.



## Achieving the ERF targets to date

The financial value of Trust activity in April has exceeded the 70% ERF threshold. If the Trust maintains this level of activity, then all the ERF targets for the first half of the year should be achieved.

The table below sets out April activity and associated activity value. This position is subject to change as the allocation of ERF will be based on SUS data, the final position of which is not available until six weeks after month-end

| Year       | Activity value | Financial value |
|------------|----------------|-----------------|
| 2019       | 45,586         | £10,806,215     |
| 2021       | 42,808         | £9,483,314      |
| % of 19/20 | 94%            | 88%             |

Activity over 70% driven by high outpatient volumes

Activity value in excess of the threshold should attract a payment of 120% of tariff. Early estimates of the value of this over-delivery in April amount to £2.3 million.

However, It is expected that this value will shrink month-on-month as the ERF threshold ramps up. It is also contingent on ICS-wide achievement of the thresholds and gateway criteria.

# Achieving the gateway criteria

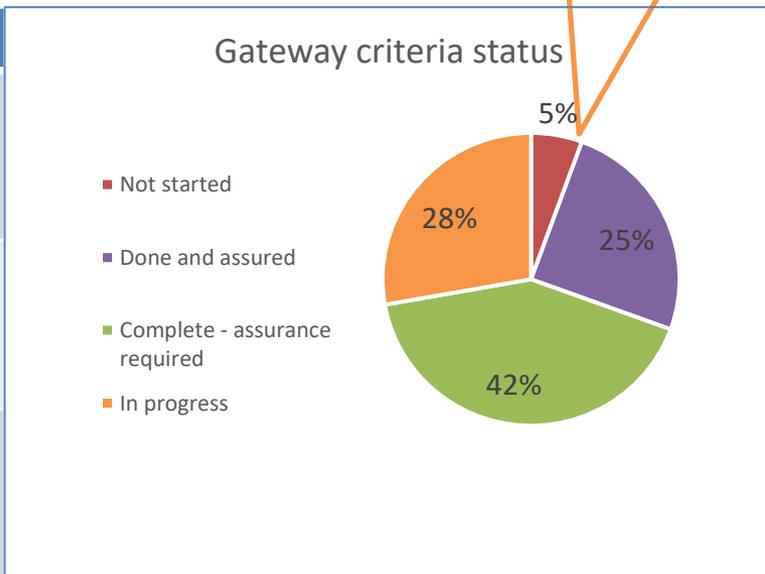
Detailed guidance regarding the measures for success for each of the gateway criteria was issued by NHSE on 21 April 2021. In addition to delivery of the financial value, all five criteria need to have been achieved before ERF funding is released. The gateways criteria are considered as ICS level.

Assessment of compliance will take place monthly by the NHSE/I regional team.

The criteria are not an explicit list of “must do’s”. Rather, they should be seen as guidance for the direction of travel which the regional team is expected to assure against. Given this, BHT is on track for achieving the criteria.

The two 'not started' elements relate to evidencing addressing health inequalities via analysis of the PTL

| Gateway criteria                                | Current status  |
|---|---|
| <b>Addressing health inequalities</b>           | Work has been commissioned around this criteria locally but application of insights has not begun           |
| <b>Transformation of outpatient services</b>    | Trust currently meets criteria for virtual outpatients and A&G, with solid plans to meet PIFU requirements  |
| <b>Implementing system led elective working</b> | Early discussion in ACW and project Initiation commenced (note: this is the responsibility of the ICS team) |
| <b>Tackling the longest waits</b>               | Plan to tackle the longest waits has been written and begun. Now seeing positive direction of travel.       |
| <b>Supporting staff</b>                         | 'Project thrive' is underway with clear plan of action  |



|                               |    |
|-------------------------------|----|
| Not started                   | 2  |
| Done and assured              | 9  |
| Complete - assurance required | 15 |
| In progress                   | 10 |

# Planning to exceed ERF thresholds

To maximise the opportunity presented by the ERF services have produced plans to increase activity within the first half of the year. Individual service plans for the majority of acute services have been submitted. The table below sets out the high-level status of these plans in relation to exceeding the ERF. Analysis is in terms of whether activity values, rather than financial values, are exceeded.

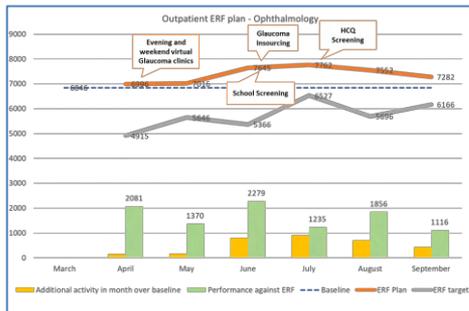
The next step is for activity plans to be calculated as a financial value. Analysis of the additional costs associated with delivery will be compared to expected additional income from ERF. Confirmation of investment proposals will be provided through an agreed governance process.

| SDU              | Outpatients |     |      |      |        |      | DC/IP |     |      |      |        |      | Proposed Costs |
|------------------|-------------|-----|------|------|--------|------|-------|-----|------|------|--------|------|----------------|
|                  | April       | May | June | July | August | Sept | April | May | June | July | August | Sept |                |
| Respiratory      |             |     |      |      |        |      |       |     |      |      |        |      |                |
| Plastics         |             |     |      |      |        |      |       |     |      |      |        |      | £ 120,000      |
| Rheumatology     |             |     |      |      |        |      |       |     |      |      |        |      | £ 72,000       |
| Gastroenterology |             |     |      |      |        |      |       |     |      |      |        |      |                |
| Neurology        |             |     |      |      |        |      |       |     |      |      |        |      |                |
| Diabetes         |             |     |      |      |        |      |       |     |      |      |        |      | £ 31,500       |
| Endocrinology    |             |     |      |      |        |      |       |     |      |      |        |      |                |
| Spinal           |             |     |      |      |        |      |       |     |      |      |        |      | £ 10,500       |
| Cardiology       |             |     |      |      |        |      |       |     |      |      |        |      | £ 100,000      |
| ENT              |             |     |      |      |        |      |       |     |      |      |        |      | £ 329,000      |
| T&O              |             |     |      |      |        |      |       |     |      |      |        |      | £ 130,500      |
| Urology          |             |     |      |      |        |      |       |     |      |      |        |      | £ 99,600       |
| General Surgery  |             |     |      |      |        |      |       |     |      |      |        |      |                |
| Paediatrics      |             |     |      |      |        |      |       |     |      |      |        |      |                |
| Paed Dermatology |             |     |      |      |        |      |       |     |      |      |        |      |                |
| Paed Allergy     |             |     |      |      |        |      |       |     |      |      |        |      | £ 10,000       |
| OMFS             |             |     |      |      |        |      |       |     |      |      |        |      | £ 72,300       |
| Ophthalmology    |             |     |      |      |        |      |       |     |      |      |        |      | £ 386,000      |
| Pain             |             |     |      |      |        |      |       |     |      |      |        |      |                |
| Gynaecology      |             |     |      |      |        |      |       |     |      |      |        |      | £ 180,000      |
| Total Cost       |             |     |      |      |        |      |       |     |      |      |        |      | £ 1,541,400    |

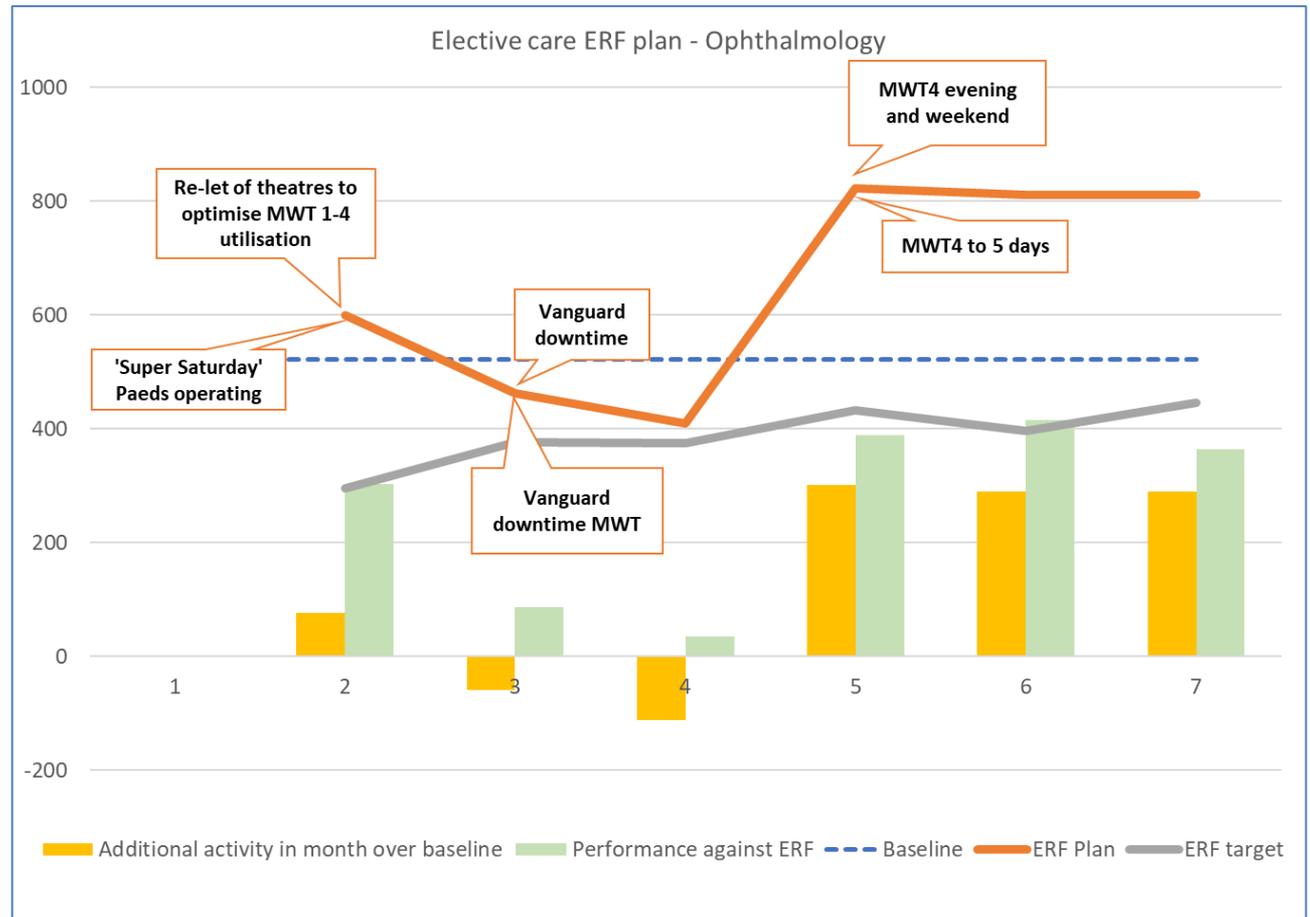
# Example of service level ERF plan

The charts below show the ophthalmology plan as an example of Trust wide ERF planning. All services listed previously have produced such a plan. Using this methodology the Trust is able to both track performance against plan and support decision making with regards individual funding requests.

Separate analysis is given for elective and outpatient plans



The outpatient plan is also analysed in terms of face-to-face & non-face-to-face in order to track against this metric



Individual service plans are available on request. Work is also currently underway to give a divisional and trust wide position, as well as to provide a forward view in terms of financial value.



**Meeting:** Trust Board Meeting in Public

**26 May 2021**

|                              |   |  |
|------------------------------|---|--|
| <b>Agenda item</b>           | Infection Prevention & Control  |  |
| <b>Board Lead</b>            | Karen Bonner, Chief Nurse   |  |
| <b>Type name of Author</b>   | Infection Prevention & Control Head of Nursing,<br>Hannah Bysouth                               |  |
| <b>Attachments</b>           | Infection Prevention and Control Monthly Report March 2021 and Board Assurance Framework update |  |
| <b>Purpose</b>               | Approval  |  |
| <b>Previously considered</b> | Executive Management Committee 27 April 2021 Quality Committee 11 May 2021                      |  |

## Executive Summary

### Introduction

This report outlines the healthcare associated infection (HCAI) data for March 2021. It is a mandatory requirement that the following HCAI are reported to the Trust, CCG and Public Health:

1. *Clostridioides difficile*
2. MRSA Bacteraemia
3. MSSA Bacteraemia
4. Gram Negative Blood Stream Infections (GNBSI)

The Report also covers;

- Bacteraemia Line Infections
- COVID-19
- COVID-19 Nosocomial Infection and outbreaks
- Hand Hygiene/Personal Protective Equipment Audits
- Cleaning Monitoring Scores

### Summary

#### COVID-19

COVID-19 admissions continued to decrease in March. Outbreaks continued to be monitored in 7 areas, these outbreaks caused 721 bed days lost in total. The Infection Prevention and Control (IPC) multidisciplinary team (MDT) continued to chair weekly outbreak meetings with clinical MDTs. In March, the IPC team discontinued the weekend service as outbreaks decreased.

#### MRSA bacteraemia 0

#### MSSA bacteraemia 2

Documentation of cannula insertion, VIP scoring on CVAD & peripheral charts not being done, cannulas missing (issues attributed to all wards involved).

#### *Clostridioides difficile*

2 hospital onset healthcare associated (HOHA), 1 case to be re-scheduled, the case discussed concluded the samples were inappropriately requested (patient having formed stool). Good antimicrobial stewardship highlighted. 2 cases discussed from February at March MDT, both unavoidable although noted compliance with hand hygiene audit and mandatory training highlighted.

#### Cleaning Monitoring Scores

Monitoring scores across the risk categories are within overall compliance (above 95%). Estates team included in outbreak meetings. Estates report areas performing less than 95% complete audit again until compliance with national standard achieved.

#### Board Assurance Framework (BAF) update

The BAF is continuously reviewed and updated by the Head of Nursing for Infection Prevention and Control and Director of Infection Prevention and Control. The BAF accompanies the IPC report, to summarise:

- Plans to build aerosol generating procedure (AGP) area in the Resuscitation of the Emergency Department are underway
- Ventilation remains a key concern in some areas of the organisation. The IPC Team are advising to increase bed spacing, and reduce beds in these areas to improve social distancing during peaks of the pandemic
- Data systems in the Trust are manual (Medway) patients not alerted for infection risk in real time, risk to communication and collection of data including contact tracing
- Manual data systems for everyday IPC work take time from IPC clinical work
- Lateral flow testing compliance is poor in some areas and staff groups, this has been highlighted in outbreak investigations
- Requested to make PPE e-learning mandatory
- Patient compliance with wearing masks during admissions is low, raised in outbreak meetings and Silver
- IPC continue to work with Patient Liaison and Communications to improve information for patients – focus on hand hygiene, space and face masks

**Decision** The Board is requested to discuss and approve

**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**

Infection Prevention and Control

**Financial**

Impact LOS and increased use of resources

**Compliance** Select an item. Select CQC standard from list.

Safety and CQC standards

**Partnership: consultation / communication**

CCG

**Equality**

Patients who pose a known or potential infection risk are equally entitled to treatment. IPC measures to support their safe management should be in place to support this.  
COVID-19 has been found to disproportionately impact individuals from BAME communities, men and people over 50

**Quality Impact Assessment [QIA] completion required?**

No

## IPC at BHT: How do we compare?

NHS England regional data team has shared how BHT nosocomial infection rates compare with other organisations in Berkshire, Oxfordshire and Buckinghamshire. The table below summarises their findings by organism.

| E.coli  | MRSA                                    | MSSA                                 | C difficile                                 | COVID-19  |
|---|---|--------------------------------------|---|---|
| Lower than national median, stable trend but not falling in line with peers | Lower rates, data quality to be checked | Higher than peer and national median | Lower than national median and stable trend | Higher than the rest of South East region earlier in 2021 but now in line with region |

IPC BHT Team response:

- Review data – check processes within the organisation to ensure quality of the data
- Build into annual plan – include back to basics approach to address learning from RCAs and outbreak meetings
- Analyse information and learning from audit processes
- Embed into teaching and strategy for IPC in the Trust

## IPC at BHT: Key points from the BAF

The Board Assurance Framework (BAF) accompanies this report. Here is a brief summary of key points to raise:

- Plans to build aerosol generating procedure (AGP) area in the Resuscitation of the Emergency Department are underway
- Ventilation remains a key concern in some areas of the organisation. The IPC Team are advising to increase bed spacing, and reduce beds in these areas to improve social distancing during peaks of the pandemic
- Data systems in the Trust are manual (Medway) patients not alerted for infection risk in real time, risk to communication and collection of data including contact tracing
- Manual data systems for everyday IPC work take time from IPC clinical work
- Lateral flow testing compliance is poor in some areas and staff groups, this has been highlighted in outbreak investigations
- Requested to make PPE e-learning mandatory
- Patient compliance with wearing masks during admissions is low, raised in outbreak meetings and Silver
- IPC continue to work with Patient Liaison and Communications to improve information for patients – focus on hand hygiene, space and face masks.

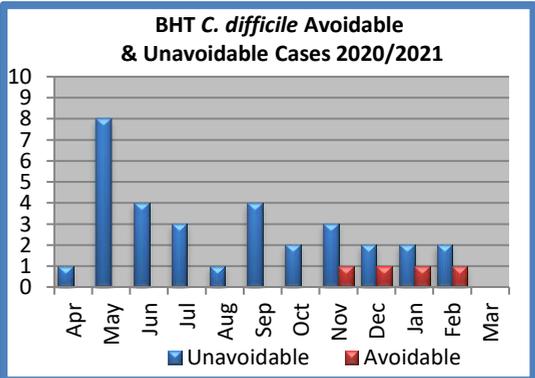
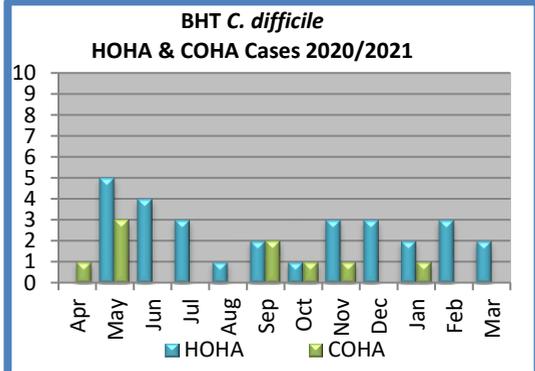
**BHT Objectives set by Public Health England for 2020/2021 – As yet there has been no official confirmation from PHE for 2020/2021 targets.**

|   | Limits set by PHE  | Trust Total from April 2020 | Integrated Medicine | Integrated Elderly & Community Care | Surgery & Critical Care | Women, Children & Sexual Health | Specialist Services |
|---|--------------------|-----------------------------|---------------------|-------------------------------------|-------------------------|---------------------------------|---------------------|
| <i>Clostridioides difficile</i> - HOHA (Hospital onset healthcare associated)   | Yet to be assigned | 29                          | 2                   | 0                                   | 0                       | 0                               | 0                   |
| <i>Clostridioides difficile</i> – COHA (Community onset healthcare associated) (Note – RCA is only completed when requested by CCG) |                    | 9                           | 0                   | 0                                   | 0                       | 0                               | 0                   |
| MRSA Bacteraemia  | 0                  | 1                           | 0                   | 0                                   | 0                       | 0                               | 0                   |
| MSSA Bacteraemia (BHT associated (post 48 hours))   | n/a                | 23                          | 1                   | 0                                   | 1                       | 0                               | 0                   |
| Hand Hygiene Observational Audit Overall Compliance % by Division   | n/a                | n/a                         | 99%                 | 99%                                 | 100%                    | 99%                             | 100%                |

## *Clostridioides difficile*

Total of 2 cases were identified in March 21  
 HOHA = 2 cases  
 COHA = 0 cases

A BHT / CCG MDT Meeting is held monthly to discuss the cases. Hand hygiene and compliance with mandatory training highlighted  
 Totals for 2020/21 =  
 4 Avoidable  
 32 Unavoidable  
 2/8 Yet to be determined



## Hand Hygiene Observational Audits

In-patient areas of non-compliance / areas of concern (Compliance = 95%)  
**All areas that completed the audit are compliant.**  
 Number of Inpatient areas per division that did not complete the audit are:  
 Integrated Medicine = 6  
 Integrated Elderly & Community Care = 3  
 Surgery & Critical Care = 7  
 Women Children & Sexual Health Services = 0  
 Specialist Services = 2  
**Actions** – IPC Nurses supporting divisions with non-compliant areas. Concerns raised at Divisional meetings and actions sit with the division

## Gram Negative Blood Stream Infections (GNBSI)

This work has been paused regionally due to the complexity of understanding what focused actions should be taken to respond to this challenge. We will continue to report crude numbers.  
**For March E.coli = 4, Klebsiella = 3 and Pseudomonas = 0.**

## Personal Protective Equipment Audit

Ward areas of non-compliance/areas of concern  
 48 Audits were completed across 35 areas in March.  
**8 areas achieved 100% compliance.**  
**24 areas achieved over 90% compliance.**  
**15 areas improved from February audit.**  
**2 areas of non-compliance.**  
**Audit questions of lower scores are:**  

- Are staff observed walking in the clinical area wearing PPE inappropriately?
- Are staff wearing the correct PPE for the task?

**Both these questions achieved an improved % score this month.**  
 Actions – non-compliant practice is brought to the individuals attention at the time of the audit. Full audit results are fed back in real time. Weekly audits on all inpatient areas.

## Meticillin Resistant / Sensitive Staphylococcus aureus (MRSA/MSSA) Bacteraemia

**MRSA 0 case identified in March 2021**  
**MSSA 2 cases identified in March 2021**  
 Key learning for MRSA bacteraemia includes monitoring of invasive devices, MRSA screening, antimicrobial stewardship and isolation of patients with infection.

## Delays in Isolation and Outbreaks

| Delay In Isolation of Patients with infections By Division  | Total | Integrated Medicine | Integrated Elderly & Community Care | Surgery & Critical Care | Women, Children & Sexual Health Services | Specialist Services |      |  |
|---|-------|---------------------|-------------------------------------|-------------------------|--|---------------------|------|--|
|   | 11    | 8                   | 1                                   | 2                       | 0  | 0                   |      |  |
| Delay In Isolation of Patients with infections By Infection | Total | COVID-19            | Loose Stool                         | MRSA                    | ESBL / Amp C                             | VRE                 | MRAB | Others including Influenza, GAS Campylobacter etc. |
|   | 11    | 3                   | 0                                   | 8                       | 0  | 0                   | 0    | 0  |

| Outbreaks by Division                    | Infection | Number of outbreaks                                 | Positive Patients (probable or definite HOHA) | Positive staff |
|--|-----------|---|---|----------------|
| Integrated Medicine                      | COVID     | 3 (10, 17, 18)                                      | 41  | 13             |
| Integrated Elderly & Community Care      | COVID     | 3 (Waterside, Buckingham Community Hospital, SMH 8) | 6   | 2              |
| Surgery & Critical Care                  | COVID     | 1 (16A)   | 23  | 11             |
| Women, Children & Sexual Health Services | None      |   |   |                |
| Specialist Services                      | None      |   |   |                |

No new outbreaks declared however outbreak meetings continued for wards 16A, Waterside, SMH 8, 18, 17 and 10. The information above reflects these outbreaks which began before March, the figures for ward 16A reflect cases from January. Compliance with lateral flow testing has been highlighted as low in outbreaks, this was highlighted at Silver to the organisation. Delays in isolation continued in Integrated Medicine where most of the cases occurred. Issues with equipment on 16A, 17 and 18.

## COVID-19

| Month      | Total No. of Specimens taken from any source | Total No. of Negatives from Specimens taken from any source | Total No. of Specimens not tested | Total No. of Positives from Specimens taken from any source |
|------------|--|---|-----------------------------------|---|
| Apr        | 1825   | 1254  | 68                                | 503   |
| May        | 3724   | 3450  | 55                                | 219   |
| Jun        | 5317   | 5171  | 56                                | 90  |
| Jul        | 5110   | 5054  | 11                                | 45  |
| Aug        | 5622   | 5571  | 31                                | 20  |
| Sep        | 7096   | 6998  | 59                                | 39  |
| Oct        | 7354   | 7194  | 68                                | 92  |
| Nov        | 9151   | 8789  | 87                                | 275   |
| Dec        | 9158   | 7892  | 291                               | 975   |
| Jan        | 8469   | 7116  | 338                               | 1015  |
| Feb        | 7826   | 7239  | 232                               | 355   |
| <b>Mar</b> | <b>7673</b>                                  | <b>7318</b>   | <b>244</b>                        | <b>111</b>  |

| Month      | No. of Specimens from Inpatients (including A&E, CSRU, PDU) | No. of Positives from Inpatients (excluding A&E, CSRU, PDU) | No. of positives from Specimens as PHE definitions:<br>Community = <= 2 days after admission<br>Indeterminate = 3-7 days after admission<br>Probable = 8-14 days after admission<br>Definite = 15 or more days after admission | No. of Inpatient Deaths from patients with positive swabs after 8 days of admission | Total No. of Deaths of inpatients with positive swab taken at anytime (includes previous column no.) |
|------------|---|---|--|---|--|
| Apr        | 1071  | 161   | 124, 18, 17, 27  | 5   | 51   |
| May        | 2618  | 48  | 43, 6, 9, 8  | 1   | 20   |
| Jun        | 2762  | 17  | 21, 2, 3, 4  | 0   | 5  |
| Jul        | 3017  | 12  | 11, 1, 3, 1  | 3   | 6  |
| Aug        | 3118  | 10  | 1, 0, 0, 0   | 0   | 3  |
| Sep        | 3178  | 3   | 9, 0, 0, 1   | 0   | 1  |
| Oct        | 3327  | 6   | 43, 0, 1, 0  | 0   | 1  |
| Nov        | 4217  | 54  | 86, 12, 8, 15  | 4   | 19   |
| Dec        | 4806  | 270   | 213, 31, 22, 42  | 12  | 64   |
| Jan        | 3941  | 314   | 402, 52, 48, 51  | 19  | 115  |
| Feb        | 3482  | 228   | 140, 30, 42, 18  | 11  | 45   |
| <b>Mar</b> | <b>3630</b>   | <b>69</b>   | <b>25, 9, 1, 18</b>  | <b>1</b>  | <b>4</b>   |

## COVID-19 Nosocomial Infection

The criteria for Nosocomial Infection has been issued by PHE: Note the first day of admission counts as day one.

**Community-Onset** – First positive specimen date <=2 days after admission to trust

Hospital-Onset **Indeterminate** Healthcare-Associated – First positive specimen date 3-7 days after admission to trust

Hospital-Onset **Probable** Healthcare-Associated – First positive specimen date 8-14 days after admission to trust

Hospital –Onset **Definite** Healthcare-Associated – first positive specimen date 15 or more days after admission to trust

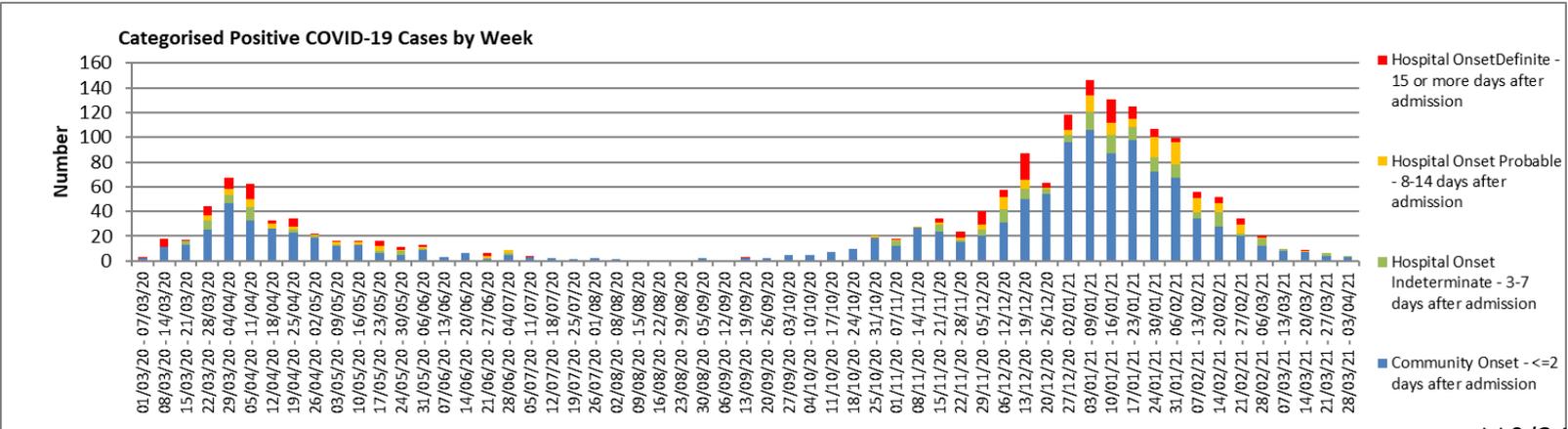
| Nosocomial Infections - No. of positives from Specimens as PHE definitions (above) |           |               |          |          |
|--|-----------|---------------|----------|----------|
| Month  | Community | Indeterminate | Probable | Definite |
| Mar  | 67        | 13            | 6        | 20       |
| Apr  | 124       | 18            | 17       | 27       |
| May  | 43        | 6             | 9        | 8        |
| Jun  | 21        | 2             | 3        | 4        |
| Jul  | 11        | 1             | 3        | 1        |
| Aug  | 1         | 0             | 0        | 0        |
| Sep  | 9         | 0             | 0        | 1        |
| Oct  | 43        | 0             | 1        | 0        |
| Nov  | 86        | 12            | 8        | 15       |
| Dec  | 213       | 31            | 22       | 42       |
| Jan  | 402       | 52            | 48       | 51       |
| Feb  | 140       | 30            | 42       | 18       |
| Mar  | 25        | 9             | 1        | 2        |

The chart below shows the number of COVID-19 positive cases from patients by week as per the definitions above. The Trust saw an increase in admissions of patients who test positive for COVID-19 in line with national trends, this is starting to fall. In February, there is a decrease in both community onset admissions of patients with COVID-19 and healthcare associated cases. Outbreaks were detected in wards 16A, 17, 18, 1 and 2 at Stoke Mandeville, Buckingham Community Hospital, Wycombe Wards 8, 9 and 2A, Amersham Waterside.

Learning from outbreaks continued to include staff compliance with lateral flow testing, hand hygiene compliance and patient placement. It is noted that the Trust had significant capacity pressures during this period.

Within the Trust we continue to:

1. Investigate probable and definite hospital onset COVID-19 infections, new RCA process established
2. Weekly multidisciplinary outbreak meetings for areas under surveillance due to healthcare associated cases
3. Monitor infection prevention practices such as hand hygiene, PPE compliance and cleaning
4. Support the Trust with specialist advice, including the creation of an interim weekend service to assist the organisation with management of patients with infection risk
5. Share learning from outbreaks and healthcare associated infections with clinical areas and at Site and Silver meetings



From 1st July, we are reporting all COVID-19 HOHA cases which were acquired >8 days after admission to BHT – i.e. probable and definite HOHA COVID-19 cases.  
 Prior to July 1st 2020, we have only reported all DEFINITE HOHA COVID-19 cases.

## Bacteraemia Line Infections

### Aims & Ambitions

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

### Definitions to determine Avoidable / Unavoidable

#### Avoidable

- Lapse/lapses in care identified that has/have directly contributed or there is reasonable correlation with the patient acquiring this episode of line infection at Buckinghamshire Healthcare NHS Trust
- For example, if there are gaps or no documentation with respect to line care by the clinical teams.

#### Unavoidable

- No lapses in care have been identified that could have directly contributed to the patient acquiring this episode of line infection at Buckinghamshire Healthcare NHS Trust
- In some cases, some learning can be identified and followed through, but this does not reasonably correlate to the patient obtaining the episode of line infection under review.

### Line Infections Meeting on 8<sup>th</sup> April 21

One discussed - Deemed Not line infection.

### Outcome monitoring notes from meeting:

This was not deemed to be line related although the patient did have a line in situ. The care of the line was managed in line with Trust protocols and good practice around care of the device, timely blood cultures and management of a blocked line were shared.

|                            |                           | Year Totals   | Current Month (March) |
|----------------------------|---------------------------|---------------|-----------------------|
| Central Line               | Avoidable                 | 4             | 0                     |
|                            | Unavoidable               | 30            | 0                     |
|                            | Yet to be discussed       | N/A           | 0                     |
| Peripheral Line Infections |                           | 3 (AVOIDABLE) | 0                     |
| <b>Totals</b>              |                           | <b>37</b>     | <b>0</b>              |
|                            | Deemed not line infection | <b>3</b>      | <b>1</b>              |

### Yearly Comparison Table

|                 |             | 17-18     | 18-19     | 19-20     |
|-----------------|-------------|-----------|-----------|-----------|
| Central Line    | Avoidable   | 5         | 3         | 2         |
|                 | Unavoidable | 24        | 24        | 7         |
| Peripheral Line |             | 3         | 4         | 1         |
| <b>Totals</b>   |             | <b>32</b> | <b>31</b> | <b>10</b> |

## Cleaning Scores Summary

### Cleaning Score Summary - March 2021

| Very High Risk Category |           | NSC    |        |        |
|-------------------------|-----------|--------|--------|--------|
| Hospitals               | Benchmark | Jan-21 | Feb-21 | Mar-21 |
| Stoke Mandeville (SMH)  | 98.0%     | 98.3%  | 98.2%  | 98.2%  |
| High Wycombe (HW)       | 98.0%     | 98.4%  | 98.4%  | 98.3%  |

at SMH, the overall average cleaning score has improved and is above the current benchmark

at HW, all cleaning scores are recorded maintaining the benchmark

| High Risk Category     |           | NSC    |        |        |
|------------------------|-----------|--------|--------|--------|
| Hospitals              | Benchmark | Jan-21 | Feb-21 | Mar-21 |
| Stoke Mandeville (SMH) | 95.0%     | 96.7%  | 97.0%  | 97.3%  |
| Amersham               | 95.0%     | 97.3%  | 97.1%  | 97.7%  |
| High Wycombe (HW)      | 95.0%     | 97.6%  | 97.7%  | 97.1%  |

at SMH, the overall average cleaning score is recorded maintaining above the benchmark

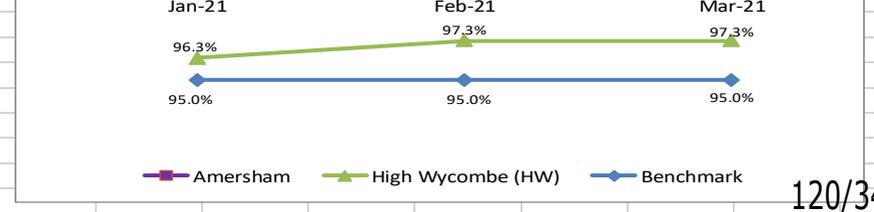
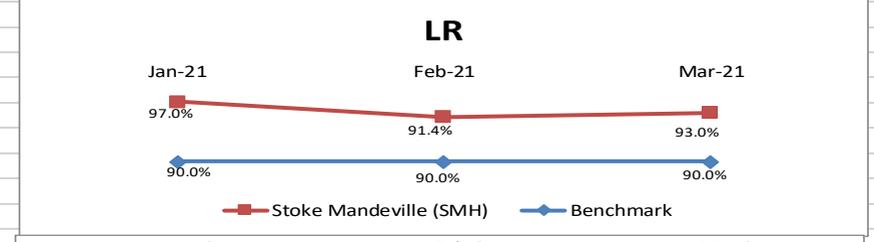
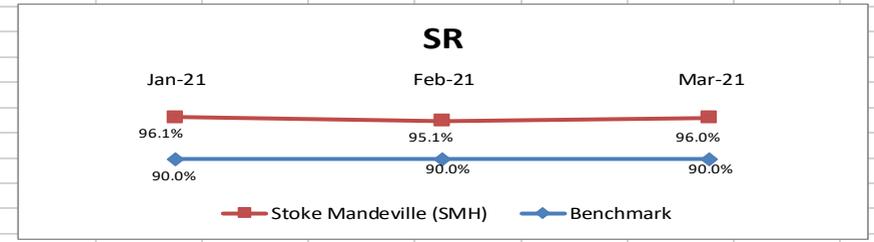
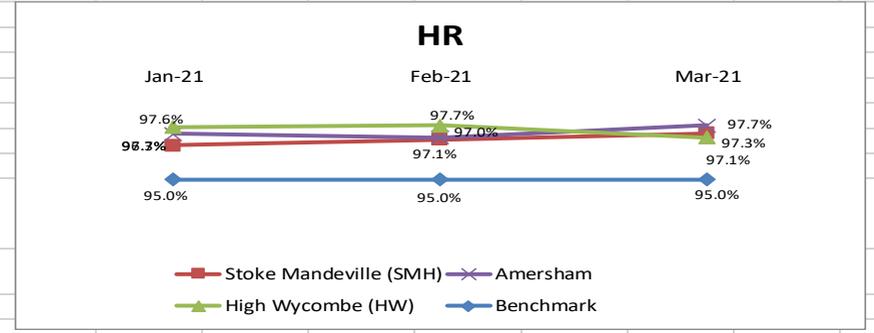
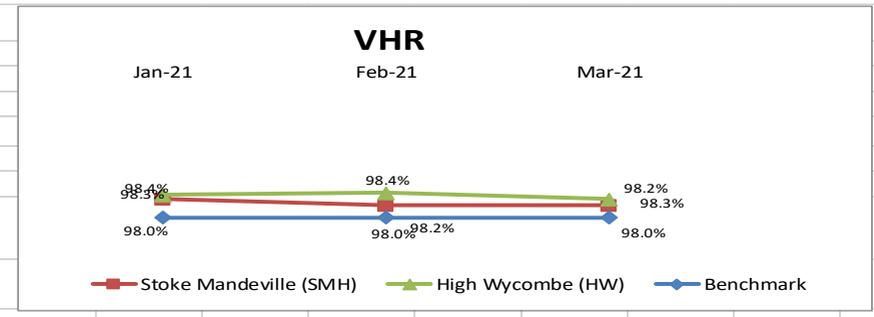
at HW, the overall average cleaning score is recorded attaining the benchmark

| Significant Risk Category |           | NSC    |        |        |
|---------------------------|-----------|--------|--------|--------|
| Hospitals                 | Benchmark | Jan-21 | Feb-21 | Mar-21 |
| Stoke Mandeville (SMH)    | 90.0%     | 96.1%  | 95.1%  | 96.0%  |

The overall cleaning score is recorded maintaining above the benchmark

| Low Risk Category      |           | NSC      |          |          |
|------------------------|-----------|----------|----------|----------|
| Hospitals              | Benchmark | Jan-21   | Feb-21   | Mar-21   |
| Stoke Mandeville (SMH) | 90.0%     | 97.0%    | 91.4%    | 93.0%    |
| Amersham               | 95.0%     | No Audit | No Audit | No Audit |
| High Wycombe (HW)      | 95.0%     | 96.3%    | 97.3%    | 97.3%    |

The overall cleaning score is recorded maintaining above the benchmark level.



**Reassurance from Property Services Department**  
 “The domestic service managers confirmed that the failures have been rectified and the standards have been restored. The Property Services Monitoring Officer will carry out audits of the areas to verify the cleaning standards.”

## IPC Training Figures

| Statutory training as at 31/03/21     |                              | Corporate                          |                                |              | Integrated Medicine                |                                |              | Surgery & Critical Care            |                                |              | Specialist Services                |                                |              | Integrated Elderly Care            |                                |              | Women, Children & Sexual Health Service |                                |              | Total                              |                                |               |
|---------------------------------------|------------------------------|------------------------------------|--------------------------------|--------------|------------------------------------|--------------------------------|--------------|------------------------------------|--------------------------------|--------------|------------------------------------|--------------------------------|--------------|------------------------------------|--------------------------------|--------------|---|--------------------------------|--------------|------------------------------------|--------------------------------|---------------|
| Training Method                       |                              | Number of staff required to attend | No. of staff who have attended | Attendance % | Number of staff required to attend | No. of staff who have attended | Attendance % | Number of staff required to attend | No. of staff who have attended | Attendance % | Number of staff required to attend | No. of staff who have attended | Attendance % | Number of staff required to attend | No. of staff who have attended | Attendance % | Number of staff required to attend      | No. of staff who have attended | Attendance % | Number of staff required to attend | No. of staff who have attended | Attendance %  |
| IPC (No direct patient contact)       | E-learning                   | 560                                | 474                            | 85%          | 160                                | 116                            | 73%          | 240                                | 220                            | 92%          | 174                                | 151                            | 87%          | 100                                | 84                             | 84%          | 117                                     | 109                            | 93%          | 1351                               | 1154                           | 85% (Feb 84%) |
|                                       | IPC (Direct patient contact) | 142                                | 111                            | 78%          | 822                                | 619                            | 75%          | 1031                               | 780                            | 76%          | 744                                | 610                            | 82%          | 727                                | 566                            | 78%          | 819                                     | 690                            | 84%          | 4285                               | 3376                           | 79% (Feb 77%) |
| Hand Hygiene (Direct patient contact) | E-learning                   | 699                                | 629                            | 90%          | 834                                | 681                            | 82%          | 1034                               | 849                            | 82%          | 772                                | 687                            | 89%          | 732                                | 618                            | 84%          | 820                                     | 738                            | 90%          | 4891                               | 4202                           | 86% (Feb 84%) |

Compliance with IPC mandatory training is flagged to divisional leadership at divisional governance meetings and during root cause analysis investigations to senior staff. Divisions are accountable for their training record, IPC Team have now flagged this in the Board Assurance Framework for the Trust to address as an organisation.

**Meeting:** Trust Board Meeting in Public

**26 May 2021**

**Report from Chair of Quality and Clinical Governance Committee**

**Date of Committee: 11 May 2021**

**Key agenda items considered:**

| Item  | Committee assured | Further work   | Referral elsewhere for further work | Recommendation to Board           |
|---|-------------------|--|-------------------------------------|-----------------------------------|
| Safest Staffing   | Yes               | Yes<br>Actions for follow-up with reports to this Committee in next 6 months, to include.<br>-Community Staffing and Ageing well<br>-Safe Staffing Community Tool<br>-Concerns around Children's and Community Health Visiting staffing review | Community Team                      | Assurance and Continued oversight |
| Patient Harm, Safety Surveillance and, Safeguarding/vulnerable patients (Monthly), SI Report and Action Tracker | Yes               | Yes<br>-On-going monitoring and vigilance and identification of Covid-related harm<br>- Downward trend on overdue incidents and on falls and pressure ulcers noted   |                                     | Assurance and Continued oversight |
| Patient Experience  | Yes               | Yes<br>Identify persistently low performing areas.   |                                     | Assurance and Continued oversight |

|                                   |     | Define purpose of the Patient Experience Report  |                |  |
|-----------------------------------|-----|--|----------------|--|
| Patient Story                     | Yes | No   |                | Assurance and Congratulations to the Community Immunisations team – only team in the country to continue childhood immunisations throughout the pandemic. The benefits of this should not be underestimated. |
| IPC Monthly report and IPC BAF    | Yes | Yes<br>-C.Difficile<br>-Addressing challenges presented by our estates and systems<br>-Hand Hygiene training<br>Compliance | IPC Team       | Assurance and Continued oversight  |
| Maternity Quarterly Safety Report | Yes | Yes<br>Wycombe Birth Centra<br>Perinatal Mortality rates<br>Improvement plans  | Maternity Team | Assurance and Continued oversight  |
| CQC Action Plan Update            | Yes | Yes<br>Ensure future reports to Committee and Board include the “Should Do” actions  |                | Assurance and Continued oversight  |
| Quality Accounts                  | Yes | Yes<br>Timelines noted   |                | Assurance and Continued oversight  |
| Corporate Risk Register           | Yes | Yes<br>-Ensuring adequate oversight and holistic triangulation of risks<br>-Inclusion of medicines risks in the register.  |                | Assurance and Continued oversight  |

**Meeting:** Trust Board Meeting in Public

**26 May 2021**

|                              |  |  |
|------------------------------|--|--|
| <b>Agenda item</b>           | Managing the risk of harm occurring to our patients who are waiting for elective surgery at Buckinghamshire Healthcare NHS Trust |  |
| <b>Board Lead</b>            | Chief Medical Officer  |  |
| <b>Type name of author</b>   | Mike Tyler, Divisional Co-Chair for Surgery  |  |
| <b>Attachments</b>           | Appendices attached  |  |
| <b>Purpose</b>               | Assurance  |  |
| <b>Previously considered</b> | EMC  |  |

**Executive Summary**

Managing the clinical harm which occurs whilst a patient is awaiting elective surgery has changed because of the huge increase in numbers of people waiting for surgery since the COVID-19 pandemic started. Those waiting over 52 weeks has risen from zero (March 2020) to 2284 patients (January 2021). Cancer waiting times have been less affected.

The risk of clinical harm to our patients waiting for surgery on our admitted waiting list is based on a priority rating given to each patient when their surgery is booked – in line with the national directive. This enables us to order our admitted waiting lists in a manner which tackles harm in an effective manner.

The traditional measurement of RTT performance (18 weeks and 52 weeks) for non-cancer patients is no longer reasonable and will probably remain inappropriate for up to two years. 21/22 priorities will be based on managing the P2 patients in a timely manner and cancer targets.

Decisions on using limited theatre resource for acute and urgent conditions is relatively simple. Integrating the less urgent conditions into the risk matrix is more difficult but needs to be articulated, otherwise these patients will always be “bumped” by more urgent cases. There is combated by argument that it simply becomes unreasonable for some patients to wait any longer, even if their condition is stable and that equates to a form of clinical urgency used to access theatre time. The definition of “unreasonable” will change and needs to be set in a wider context of the regional and national picture.

A three-step process of interim key targets for our performance in managing the risk of harm in returning to pre pandemic targets is suggested at the conclusion.

|                                    |   |                |  |
|------------------------------------|---|----------------|--|
| <b>Decision</b>                    | The Board is requested to review the paper and challenge any areas of concern |                |  |
| <b>Relevant strategic priority</b> |   |                |  |
|                                    |   |                |  |
| <b>Quality</b> ☒                   | <b>People</b> ☒   | <b>Money</b> ☒ |  |
|                                    |   |                |  |
| <b>Implications / Impact</b>       |   |                |  |

|  |   |
|--|---|
| <b>Patient Safety</b>  | There is a risk that patient will suffer clinical harm if they wait too long for their elective surgery   |
| <b>Risk: link to Board Assurance Framework (BAF)/Risk Register</b>             | BAF 1.2 Develop as a Learning Organisation  |
| <b>Financial</b>   | There is a potential financial impact as additional capacity will need to be provided to treat the backlog of surgical patients   |
| <b>Compliance NHS Regulation</b> <small>Select CQC standard from list.</small> | 18-week Referral to Treatment constitutional standard   |
| <b>Partnership: consultation / communication</b>                               | CCG, ICS  |
| <b>Equality</b>  | <p>There is a potential inequality impact to patients who may not be able to access elective services for a variety of reasons</p> <p>There is a risk that patients from deprived communities will not be pulled equally from the waiting list – which will need close monitoring</p> |
| <b>Quality Impact Assessment [QIA] completion required?</b>                    | To be completed   |

# Managing the risk of harm occurring to our patients who are waiting for elective surgery at Buckinghamshire Healthcare NHS Trust

## Summary:

Managing the harm which occurs whilst a patient is awaiting elective surgery has changed because of the huge increase in numbers of people waiting for surgery since the pandemic started. Those waiting over 52 weeks has risen from zero (March 2020) to 2284 patients (January 2021). Cancer waiting times have been less affected.

The evolution of our harm review process carried out by BHT is described. The traditional measurements of RTT performance (18 weeks and 52 weeks) for non-cancer patients is no longer valid and will probably remain inappropriate for up to two years.

A three-step process of interim key targets for our performance in managing risk of harm in returning to pre pandemic targets is suggested at the conclusion.

## Introduction:

Once the need for a patient to have elective surgery at Buckinghamshire Healthcare NHS Trust (BHT) is made, the patient is placed onto the admitted waiting list. The disease process continues whilst the patients awaits their surgery and this decay in health status is different from condition to condition and patient to patient. Keeping this decay and hence harm, to a minimum, relies on two key strategies:

- Time
  - Adjusting the time spent on the list is the primary tool for managing the harm which occurs whilst someone is on the DTA list. The aim is to identify which conditions have the greatest rate of decay and operate on them in a first and accept that those conditions with a slower rate of decay can afford, from a healthcare intervention perspective, to wait longer.
- The ability to respond to changes in healthcare status:
  - BHT lies within an integrated healthcare system and therefore responds to changes in healthcare primarily through the GP and other Allied Health Professionals. The ability to identify and respond to changes in health Access to this and thus move people up of down the list is a key part of ensuring this process keeps harm to a minimum. Access to this ability and may wis an area where healthcare inequalities could be magnified.

This describes how the BHT has identified, measured and managed this risk of harm over the past year.

## Evolution of BHT management of the burden of risk of harm on the admitted waiting list

We stopped elective surgery on 24 March 2020 with just over 7500 cases on the waiting list and we conducted a harm review of all of those patients on our DTA list so the burden of risk was quantifiable from that moment forward.

How did we initially quantify the risk to harm on the BHT list?

We asked our clinicians to ask two key questions for each person on their waiting list<sup>1</sup>.

- What will happen to the patient if we do not operate?
- How quickly will that harm happen?

The system went live on 18 March. This system was bespoke to BHT<sup>1</sup> and has been at the core of our harm management since then. A small group of clinicians from each surgical Specialty Delivery Unit (SDU) coordinated this process. It was called the Back to Work Group and every patient was assessed and given a harm rating. The process was live, updated and subsequently used to manage the changing theatre resource available. The key principles which we used were in line with the subsequently produced document from the Thames Valley region<sup>2</sup> looking at the ethics of this. We engaged part of that panel in the surgical 'Back to Work Group' and discussed and got approval with this approach from the Trusts ethics panel.

The Royal College of Surgeons (RCS) Clinical Prioritisation System<sup>3</sup>.

In April 2020 the Royal College of Surgeons<sup>3</sup> published its harm review process, in conjunction with other national clinical bodies and the NHS. This differed from our original process because it was based on the type of operation. The assumption being that types of operation have an association with certain health conditions and hence with rate of health decay. It was the RCS belief that it was the type of operation that was associated with harm caused by delay to surgery.

Table 1 The RCS priority levels 2020

| Priority level | Timing of operation | Example                   |
|----------------|---------------------|---------------------------|
| P1a            | Under 24 hours      | Emergency laparotomy      |
| P1b            | Under 72 hours      | Fixing a fractured tibia  |
| P2             | Under 1 month       | Aggressive cancers        |
| P3             | Under 3 months      | Some sight saving surgery |
| P4             | Over 3 months       | Most joint replacements   |

## Third Phase of NHS Response to COVID-19 - Clinical Prioritisation & Validation of Elective Waiting Lists

In September 2020 we were charged with validating our entire waiting list and submitting data to the NHS in line with the RCS system. We therefore converted our whole list from the

BHT bespoke system to be in line with the national system using the RCS prioritisation categories outlined above. The current breakdown of the admitted waiting list with these categories is shown in appendix 4.

## What are the main measurements of performance?

### Performance measurement one: Time

There are many performance measures within surgery but the main two measurements we have for time divides patients into two groups:

- Cancer patients
- Non cancer patients.

#### Cancer Patients:

The cancer patients are rated within the P system but also have their own time measurement and we are measured by two key time points:

- 62 days
- 104 days

These cancer specific data sets are measured and can be viewed:

<V:\Cancer Performance\Cancer Reporting\DAILY 10 DAY ACTION LIST\Cancer PTL as at 04.02.21.xlsx>

Table 2 The number of surgical cancer patients as of 04/02/2021

|              |               |
|--------------|---------------|
| 0-39 weeks   | 1235 patients |
| 40-61 weeks  | 282 patients  |
| 62-80 weeks  | 133 patients  |
| 81-103 weeks | 51 patients   |
| 104+ weeks   | 43 patients   |

Our cancer performance is monitored with weekly meetings with the cancer performance managers and reports widely.

#### Non-Cancer Patients:

These are measured simply by time on the Patient Tracking List (PTL) and prior to this pandemic there were two key measurements our performance:

- Number of patients treated within **18 weeks** (*expected number was 92%*)
- Number of patients waiting longer than **52 weeks** (*expected number was zero*)

How has this altered?

In February 2021 we have **2284** patients who have waited more than 52 weeks.

## Performance measurement two: Ability to respond to changes in healthcare status

The second key feature of this performance measurement is the ability to respond to changes once on the PTL, especially as some elective waits are now up to two years. There are three elements to this to achieve a consensual priority rating.

1/. List validation.

- All patients are given clinical priority by clinicians
- Patients are informed of this choice and given the opportunity to discuss and alter if needed
- Response to
  - a. Patient initiated change
  - b. Healthcare professional initiated change.

In our opinion, the ability to access this change in healthcare status is recognised as a potential for health inequality to be magnified. In addition, the Thames Valley prioritisation document recognised two additional elements relevant here:

- Non-clinical harms
- Need and ability

### What have we done so far?

The process for list validation was described as part of the phase three response set out by the NHS in September<sup>5,6</sup>.

We have validated our elective surgical lists with the following assumptions.

- P1a, P2b, and P2 – these patients will not receive waiting list validation because it is assumed, due to their urgency, they will receive treatment before any reasonable delay between initial assessment and revalidation is appropriate.
- P3 – validation awaited
- P4 - completed in the following manner.
  1. A letter<sup>7</sup> was sent to all our P4 patients 3635 sent October and a further 2257 was sent in December. The process was split into two waves
  2. First wave – Patients were sent the letter via their mobile phone to access it electronically. If the letter was not accessed via their mobile phone – or no mobile number was available - then they were included in the second wave (which also included patients added to the list from October) and a paper copy of the letter was sent to them via Royal Mail.
  3. About 70 patients phoned the telephone service in the challenges in the first wave and about 150 in the second.

## What are our proposals for be the new time measurements?

It is accepted that the cancer targets will remain but clearly the non-cancer targets will initially be inappropriate. We therefore propose that we will work to achieve the pre pandemic level in a realistic timeframe (two years?) with achievable milestones.

A suggested programme might look like:

### Phase 1:

- 100% patients to have a P rating (currently have 428 patients who have not got a priority rating)
- No 104 **cancer day waits**
- No 104 **non cancer week waits**
- All P2 categories dated within three weeks of DTA (being added to the PTL?)
- Process of the waiting list validation in place to accommodate any health inequalities which may arise.

### Phase 2

- List validation process set up and ongoing
- No 64 **cancer day waits**
- No 78 **non cancer week waits**
- All P2 categories dated within two weeks of DTA

### Phase 3

- List validation concentrating on health inequalities only
- Cancer targets pre pandemic levels
- Non cancer targets pre pandemic levels

Realistic modelling to achieve these target points has not been done, as the time points to start are not clear, the theatre resource and wider implications of BOB/national involvement also are key factors in this modelling and as yet, not defined.

## Conclusion

The risk of harm to our patients waiting for surgery on our admitted waiting list is based on a priority rating given to each patient when their surgery is booked. This enables us to order our elective waiting lists in a manner which tackles harm in an effective manner.

Decisions on using limited theatre resource for acute and urgent conditions is relatively simple. Integrating the less urgent conditions into the risk matrix is more difficult but needs to be articulated, otherwise these patients will always be “bumped” by more urgent cases. This is combated by argument that it simply becomes unreasonable for some patients to wait any longer, even if their condition is stable and that equates to a form of clinical urgency used to access theatre time. The definition of “unreasonable” will change and

needs to be set in a wider context of the regional and national picture.

An excellent digital system is in place at BHT which has been engineered to be very user friendly and gives clinical and operational managers easy sight of the PTL. This provides good visibility and oversight to manage the waiting list with priorities set out by the trust and wider.

There are certain cultural and behavioural elements which we need to complete to ensure this prioritisation mindset becomes second nature to ensure that the harm accrued from patient waiting for surgery is kept as low as possible. A considerable amount of that task has already been achieved, and it remains for us to crack on and get the surgery completed!

## Appendices

1/.



BACK TO WORK-  
questions.docx

2/.



Covid-19 System  
Recovery\_Principles fc

3/.



C0221\_Specialty  
Guide\_ Surgical priori

4/.

5/ Current PTL provision 01/02/2021

| Count of Clinical P Category | Column Labels |    |     |     |       |             |
|------------------------------|---------------|----|-----|-----|-------|-------------|
| Row Labels                   | P1            | P2 | P3  | P4  | Blank | Grand Total |
| Breast Surgery               |               | 4  | 2   | 2   | 29    | 37          |
| Clinical Oncology            |               |    | 1   |     | 6     | 7           |
| Dermatology                  |               | 1  |     |     | 2     | 3           |
| ENT                          |               | 4  | 11  | 160 | 5     | 180         |
| General Surgery              |               | 21 | 164 | 369 | 80    | 634         |
| Gynaecological Oncology      |               | 5  | 1   | 1   |       | 7           |
| Gynaecology                  | 2             | 74 | 79  | 293 | 6     | 454         |
| Interventional Radiology     |               |    |     | 1   | 4     | 5           |

|                            |   |     |      |      |     |      |
|----------------------------|---|-----|------|------|-----|------|
| Ophthalmology              |   | 36  | 198  | 1280 |     | 1514 |
| Oral Surgery               |   | 11  | 37   | 91   |     | 139  |
| Orthodontics               |   |     | 1    | 7    |     | 8    |
| Orthoptics                 |   |     |      | 1    | 1   | 2    |
| Paediatric Ophthalmology   |   |     | 21   | 21   | 1   | 43   |
| Paediatric Plastic Surgery |   |     | 2    |      |     | 2    |
| Pain Management            |   |     | 1    | 387  | 30  | 418  |
| Plastic Surgery            |   | 160 | 194  | 361  | 48  | 763  |
| Trauma & Orthopaedics      | 3 | 34  | 366  | 1031 | 138 | 1572 |
| Urology                    |   | 64  | 104  | 190  | 37  | 395  |
| Vascular Surgery           |   | 2   | 4    | 79   | 4   | 89   |
| Grand Total                | 5 | 416 | 1186 | 4274 | 412 | 6293 |

5/.



C0753 Clinical  
Prioritisation of Electiv

6/.



National Clinical  
Validation Program

7/.



P4 informing letter  
final.docx

**Meeting:** Public Trust Board

26 May 2021

|                              |   |
|------------------------------|---|
| <b>Agenda item</b>           | Nursing 'Safest Staffing' Assurance: March 2021                               |
| <b>Board Lead</b>            | Karen Bonner, Chief Nurse   |
| <b>Type name of authors</b>  | Karen Gollop, Lead Nurse, Workforce Engagement and Retention                  |
| <b>Attachments</b>           | Appendices 1 & 2: Planned v actual reports                                    |
| <b>Purpose</b>               | Assurance   |
| <b>Previously considered</b> | Executive Management Committee 27 April 2021<br>Quality Committee 11 May 2021 |

**Executive Summary**

This report covers the reporting period of March 2021 and triangulates information to demonstrate achieving effective staff deployment and meets the needs of the Well-Led Framework for NHSi and CQC.

This report should be reviewed in the context of the pandemic, resulting in ever changing activity requiring an immediate and flexible response from the nursing workforce to ensure safest staffing levels.

The current understanding of the word safe in the NHS did not match the challenging situation the Trust was in. Therefore, in recognition of this change, the Trust utilised the word 'safest', taking into consideration the risks that needed to be reviewed.

The report contains the following workforce parameters:

- The workforce bureau is repatriating redeployed staff.
- Sickness levels whilst remaining higher than normal continues to reduce.
- High vacancy level of 14.8% registered nurses, against an expected norm of 10%.
- Agency and bank fill, both registered and non-registered has reduced. This is not reflected in spend as a number of shifts have been paid in March that had been worked earlier in the year.
- Escalation units opened with no pre-allocated staffing. Two of the four escalation areas have now closed.

Monitoring has continued for all inpatient wards both acute and community, with escalation plans to mitigate any new pressures. There were occasions, which were escalated, where the organisational demand outstripped supply.

Senior leadership continues to provide visible and accessible focus and support to colleagues.

Whilst safety has been maintained with deployment of staff, it is noted that ward/unit areas do not have their full complement of staff on a regular basis. This has a potential impact on staff morale.

|                                    |   |
|------------------------------------|---|
| <b>Decision</b>                    | The Board / Committee are requested to take assurance from the report and seek clarification if required. |
| <b>Relevant strategic priority</b> |   |
|                                    |   |

| Quality ☒  | People ☒  | Money ☒ |
|--|---|---------|
| <b>Implications / Impact</b>                                       |   |         |
| <b>Patient Safety</b>  | Patient harm is a risk factor that is being actively monitored, as is our staff experience in challenging circumstances.  |         |
| <b>Risk: link to Board Assurance Framework (BAF)/Risk Register</b> | Where risks are identified, mitigations are being put in place and monitored.   |         |
| <b>Financial</b>   | Robust systems are used to capture and report on costs relating to Covid-19 ensure the Trust is reimbursed accordingly, which contributes to the Trust's ability to support and manage the Financial Plan.  |         |
| <b>Compliance CQC Standards Staffing</b>                           | Regulations of the Health & Social Care Act:<br>Safe Care and Treatment (12)<br>Environment and Equipment (15)<br>Good Governance (17)<br>Staffing (18)(1)  |         |
| <b>Partnership: consultation / communication</b>                   | N/A   |         |
| <b>Equality</b>  | The Workforce Race Equality Standard (WRES) collecting data on race inequality revealed the disparities that exist for black and minority ethnic staff compared to their white colleagues. The has shown that our black and minority ethnic staff members are less well represented at senior levels, have measurably worse day to day experiences of life in NHS organisations, and have more obstacles to progressing in their careers. The persistence of outcomes like these is unacceptable and the Trust is working to improve through the BHT people plan. |         |
| <b>Quality Impact Assessment [QIA] completion required?</b>        | No  |         |

## 1. Introduction

This document outlines our organisation's nursing workforce approach to utilise effective staff deployment and the key measures taken to ensure the safest staffing levels during the month of March 2021.

## 2. Staff vacancies

| Vacancy rate           | Q1 2020 | Q2 2020 | Q3 2020 | Q4 Jan 21 | Q4 Feb 21 | Q4 Mar 21 |
|------------------------|---------|---------|---------|-----------|-----------|-----------|
| Registered nursing     | 15.5%   | 15.3%   | 14.1%   | 14.9%     | 15%       | 14.8%     |
| Non-registered nursing | 14.8%   | 11.4%   | 2.8%    | 5.7%      | 6%        | 5.5%      |

It is to be noted that this data fluctuates due to instability of wards opening, and staff being moved, during peaks in activity due to Covid.

### 3. Turnover

| 12 Month Rolling Turnover | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan 21 | Feb 21 | Mar 21 |
|---------------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|
| Registered nursing        | 13.2%  | 14.0%  | 13.9%  | 13.6%  | 13.6%  | 13.0%  | 12.5%  | 13.4%  | 12.9%  | 13.5%  | 13.4%  | 13.8%  |
| Non-registered nursing    | 14.7%  | 14.1%  | 13.5%  | 12.9%  | 12.4%  | 13.2%  | 12.7%  | 12.7%  | 12.4%  | 12.4%  | 11.4%  | 10.6%  |

Turnover for Registered Nurses has slightly increased and Nonregistered nurses have seen a 0.8% improvement.

### 4. Bank and Agency usage

March saw a small decrease in bank and agency usage and demand. There continues to be an increase in availability of temporary staffing, potentially due to neighbouring Trusts who have been able to reduce their reliance on agency staff.

Now we have a full year picture, this has shows a significant increase in agency and bank spend from 19/20 which is to be expected with the demand that has been placed on services and the additional services that have been created throughout the year i.e. PPE buddies, vaccination centre, swabbing teams etc.

|                          | Jun 2020 Q1  | Sep 2020 Q2  | Dec 2020 Q3  | Jan 2021 Q4  | Feb 2021 Q4 | Mar 2021 Q4 | Q4 Combined |
|--------------------------|--------------|--------------|--------------|--------------|-------------|-------------|-------------|
| Agency Nursing           | £1,407,536   | £1,194,581   | £1,808,827   | £1,093,797   | £1,359,343  | £1,212,417  | £3,665,557  |
| Bank nursing qualified + | (£2,018,924) | (£2,308,177) | (£2,701,086) | (£1,214,990) | (£931,571)  | £2,325,233  | £4,471,794  |
| Bank nursing unqualified | (£832,291)   | (£940,286)   | (£1,017,661) | (£393,303)   | (£287,821)  | £622,877    | £1,304,001  |
| Total (BANK)             | £2,914,215   | £3,248,463   | £3,718,747   | £1,608,293   | £1,219,392  | £2,948,110  | £5,775,795  |
| Absolute total           | £4,321,751   | £4,443,044   | £5,527,574   | £2,702,090   | £2,578,735  | £4,160,527  | £9,441,352  |

### 5. Workforce Bureau

A workforce bureau was re-established in early January to redeploy staff as their services closed, to areas of increased need. As Covid 19 activity has continued to reduce during March, the staff repatriations process which commenced in February has seen most of our redeployed staff returned to their substantive posts. The Workforce Bureau has commenced plans to be dis-established and will carry out a reflective process in order to prepare in the event of a third wave.

### 6. Student nurses (excluding midwifery)

The Nursing and Midwifery Council initiative to enable final year students to opt into a paid extended clinical placement has continued throughout March. 59 third year students from Bucks New University (BNU) and the University of Bedfordshire (UoB) are supporting clinical areas and have been very gratefully received. For some of these students this has been the second time they would have been deployed to help support the healthcare provision within the Trust. These clinical placements are due to close on April 25<sup>th</sup>, 2021.

### 7. Planned v actual care

In line with the National Quality Board (NQB) standards all trusts are required to publish a national dataset their staff position in terms of planned vs unplanned actual levels for both registered, non-registered, nursing associates and nursing assistant practitioners.

- Planned: the number of planned nursing hours (based upon the agreed baseline Covid-safe daily staffing numbers for each ward)  
**and**
- Actual nursing hours, (the total number of nursing hours used each day) for each inpatient ward area is submitted to the national dataset.

With the return of repatriated staff to their substantive posts, achieving optimum ratio has presented challenges that areas were experiencing pre-covid. Cross divisional flexibility to utilise all available resources is required to ensure safest staffing and has increased the reliance on temporary staffing.

In many instances the Trust has achieved the ratios advised for all areas. The decrease overall in staff absence, particularly related to Covid sickness and self- isolation has supported these ratios, despite the increase in CEV shielding.

Attached as Appendix 1 is the position in March 2021 highlighting wards reporting less than 90% actual fill against optimum levels, Appendix 2 gives background explanation to the data. Explanation of RAG rating:

| <b>RATING</b> | <b>Description</b>  | <b>Exception</b>   |
|---------------|---|--|
| <b>RED</b>    | ITU both sites were staffed for an integrated bed base of 25; however, recent status update shows a gradual decrease strongly in alignment with the national picture. | Non ITU red rated wards indicate the ward was closed for considerable periods or completely e.g. 12A and B at WGH and staff were redeployed. |
| <b>AMBER</b>  | Were either partially or fully closed during parts of the month, therefore staff usage was not fully required   |  |
| <b>GREEN</b>  | The staffing was fully met  |  |

## **8. Monitoring of all adult and paediatric in-patient areas, excluding maternity**

### **8.1 E-Rostering**

E-Rostering and SafeCare remains invaluable during Covid to enable us to monitor available staffing, essential skills, Covid related absences, and Covid related expenditure. In March 2021 rosters have been amended to reflect the repatriation of staff back to substantive posts and the reopening of rosters that had previously been suspended or amalgamated with other rosters where services were closed or reduced. E-Rostering are now undertaking the adjustments to accommodate annual leave that has been approved to be carried forward for the 2021/22 leave year.

### **8.2 SafeCare and Safety Huddles**

SafeCare across all in patient areas enables the real time visibility of staffing levels across the Trust. The collection of the data highlights and supports decision making relating to the deployment of staff to support safest staffing.

The Divisional Matrons are encouraged to manage staffing deficits with the expectation that solutions are found within the division in the first instance. Now that our redeployed staff have been repatriated back to their departments, the pre-covid staffing escalation process is to be followed, discussed at the safety huddle for cross divisional support if required.

### **8.3 Datix**

The month of March has seen a slight increase in the number of the reporting of incidences relating to safe staffing levels via the clinical management system (Datix). The SafeCare Matron undertakes investigation in partnership with the ward sister and matron of that area.

| Month    | Number of Datix | Themes / Outcome  |
|----------|-----------------|---|
| December | 15              | None recorded harm to patients. 11 were de-escalated  |
| January  | 21              | 2 non-nursing, none recorded harm to patients. 4 de-escalated   |
| February | 6               | None recorded harm to patients, and all were de-escalated. No areas were unsafe due to staffing issues.                                   |
| March    | 8               | None recorded harm to patients, and all were de-escalated. 5 reports related to a CAMH's patient where all appropriate actions were taken |

#### 8.4 Red flags

Nursing red flags are events that may have an impact on the way care is delivered to patients and can be raised at any point during the shift. All red flags require a prompt response by the nurse in charge to mitigate patient safety concerns.

| Month    | Number of Red Flags | Themes / Outcome  |
|----------|---------------------|---|
| January  | 8                   | Red flags raised for less than two registered nurses on shift. Five were incorrectly raised and three were resolved within minutes of shift commencing. Two of the red flags were raised for missed intentional rounding, both were resolved and there were no lapses in care.  |
| February | 2                   | Red flags were raised for less than two registered nurses on shift. On investigation one was raised in error and the other was to highlight the late arrival of a registered nurse which was resolved within 20 minutes.  |
| March    | 4                   | Red flags were raised for less than two registered nurses on shift. One was raised in error, one resolved immediately with temporary staff and one had only one RN on shift supported by two CSW. The ward only had 5 patients and the adjacent ward supported as required.<br>One red flag was raised as unplanned omission in providing medication which was raised in error. |

Whilst acknowledging optimum levels of staffing on some occasions may not have been met, safe staffing levels have been achieved. At the time of reporting no harm has been identified by triangulating the data, however it must be acknowledged that harm may not be identified until some months to come.

#### 9. Staff sickness, newly identified clinically extremely vulnerable

Below shows the non-availability of nursing staff (registered and non-registered), in hours, due to sickness lost between October 2020 to March 2021, on all inpatient wards, Emergency Department and ICU. There has been a significant overall decrease in absence due to Covid 19, from February to March except for Covid 19 shielding which has seen an increase of approximately 2000 hours in the month resulting from the newly identified clinically extremely vulnerable.

|            | COVID-19 Symptomatic | COVID-19 Self Isolation/ Test+Trace | COVID-19 - Shielding | COVID-19 - Other Absence | All other Sickness | Grand Total | Equivalent - 11.5-hour shifts |
|------------|----------------------|-------------------------------------|----------------------|--------------------------|--------------------|-------------|-------------------------------|
| Oct-Dec 20 | 8989.17              | 7824.13                             | 5064.07              | 1838.75                  | 33944.05           | 57660.17    | 5013.93                       |
| Jan 21     | 11265.08             | 4955.98                             | 2353.50              | 1313.50                  | 11661.90           | 31549.97    | 2743.48                       |
| Feb 21     | 5509.13              | 868                                 | 2576.3               | 1803.12                  | 11251              | 22007.55    | 1913.7                        |
| Mar 21     | 2268.47              | 210                                 | 4534.0               | 888.9                    | 12901.2            | 20802.57    | 1808.91                       |

## **10. Escalation Wards**

The reduction in Covid 19 prevalence and admission has allowed the staff repatriation process to match the operational reconfiguration of ward areas. The escalation Ward 9 and St George has remained open throughout the month of March. St Joseph remained open as medical escalation until 28<sup>th</sup> March. From the 29<sup>th</sup> March St Joseph transferred to IECC to become a new 12 bedded Short Stay Frailty Unit (SSFU) and Discharge Lounge. Winter ward (12a) closed on 5 March.

Chartridge ward the system Covid 19 positive facility, closed on the 8<sup>th</sup> March and reopened on 10<sup>th</sup> March as a community rehabilitation ward to 12 patients. The agency and bank staff continue as long lines to ensure consistency for both nursing and patient care.

## **11. Adult Community Healthcare Teams (ACHT)**

ACHT remains an area of significant concern due to existing vacancies, staff shielding and sickness. Whilst some staff have now returned from shielding, others have been advised that they must continue to shield. Certain localities prove difficult to recruit to (Marlow, Thame, Wycombe) these localities are being supported by agency nurses on long lines. The recruitment action plan which focuses on attraction and retention of staff is ongoing.

A twice daily safety huddle is now in place across the ACHT localities to discuss staffing and dependencies and how the teams can support each other. This has received positive feedback from staff. The internal escalation reporting tool pilot which monitors daily staffing v total dependency for each locality, is then RAG rated, reviewed by locality managers to allow for patients who are on bordering localities to be redeployed.

## **12. Intensive Care Unit (ICU / Critical Care CCU) (update below)**

As March progressed, redeployed staff returned to their substantive roles in line with the reduction in COVID activity on both Critical Care Units. The final member of redeployed staff was repatriated on 4 April.

The Department of Health (DoH) also advised staff who were shielding that shielding was to be paused on 31 March. Risk assessments were carried out for all staff to ensure a safe and smooth return to the clinical workplace by 1 April. Despite adjustments to make the critical care environment safer for this group of staff, all 9 WTE remained in the high-risk category. Those staff are therefore unable to return to patient-facing duties as per advice issued by the Occupational Health and Wellbeing (OHW) department. Alternative roles are being reviewed to match staff knowledge and skills where appropriate.

Whilst the number of COVID+ patients on either unit has reduced considerably, the Critical Care Units maintained the escalation areas due to the need to segregate patient pathways on admission. This has been managed safely despite the repatriations, due to lower patient numbers.

To prepare for a potential third covid 19 wave, and supported by the Chief Nurse, the Temporary Staffing Manager will work closely with the Critical Care Matron to agree additional staffing requirements to fill the gap created by the return of redeployed staff. This will support the need to provide escalation beds (Wycombe ICU has 8 beds open instead of 6) and the non-return of previous shielders. Work has also begun on building a Critical Care "reservist workforce" comprised of previously redeployed staff who have expressed a desire to maintain their newly acquired skills through regular, scheduled shifts on Critical Care.

Critical Care staff continue to access the Wellbeing team throughout the week. There are a few cases of senior Critical Care staff who are receiving psychological support for PTSD and anxiety. Following on from the resignation of some of their colleagues in February, senior Band 5 CCNs want clear role definition between newer recruits (Band 5) to Critical Care and those with a specialist qualification in Critical Care. Meetings to identify and to map developmental pathways for Critical Care nurses have been scheduled with the Divisional

Director for Surgery and Critical Care. This should pave the way for Critical Care to build a robust and sustainable workforce that is able to respond dynamically to peak surges in the future.

### **13. Paediatrics**

Paediatric bed capacity was reduced from 26 to 22 in line with Covid social distancing between beds. Safe staffing levels and competencies during March have been maintained. A low vacancy rate of a 0.2 WTE registered nurse has enabled the paediatric nurses to be redeployed to support colleagues in Emergency Department (adult), Neonates, St Francis and the Vaccination hub whilst paediatric activity remains below normal levels.

There has been an increase in Emergency Department attendances in March and paediatric admissions to ward 3, although these remain below normal seasonal attendances. The increase in the number of attendances for children and young people with mental health concerns has continued, particularly those with pre-existing mental health needs and those with neurodevelopmental disorders such as autism and attention deficit hyperactivity disorders and young adolescents (12-16) with complex eating disorders.

The unit continues to work collaboratively with colleagues in CAMHS and Social Care to ensure that these young people are cared for appropriately and were provided with 1:1 supervision when required. There has been a noted reduction in CAMHS beds in the system and an increased wait for transfer leading to increased length of stay on ward 3. Staff are being supported in caring for these complex young people through regular supervision sessions and increased access to mental health training.

### **14. Children and Young People Community Services**

This service continues to find recruitment a challenge in Health Visitors and School Nursing services. It is recognised that there is a national shortage for both health visitors and school nurses. Vacancies have remained at 12% compounded by the higher than usual maternity absence. The department is proactive and supports the training of students, but retention post qualifying is a continued challenge with a number of staff opting to return closer to home post qualification.

The child health drop ins that have been replaced by an appointment system, are still receiving high levels of phone calls to the aligned Health Visiting team. In January 2021, the Health Visiting teams reinstated their Getting to Know Your Baby groups virtually. They are now in the process of repeating this with the introduction to Solid Workshops. The appointment only clinics to follow up jaundiced baby clinics, faltering growth and vulnerable families continue.

The school nursing service are currently planning to reinstate the vision screening for Year 1 children as these were the children who should have been screened last year.

To mitigate shortages, caseloads are reviewed and distributed accordingly, and staff deployed to ensure safe staffing levels.

The wellbeing of the teams continues to be paramount and managers have set up lunch calls with teams and the direct line manager as well as increasing one-to-ones.

### **15. Conclusion**

The Trust continues to closely monitor nurse staffing levels. Covid 19 presented challenges which are slowly beginning to reduce. However, with the repatriations of staff almost complete the work is underway to address the pre-covid challenges of vacancies and the continued reliance on temporary staffing. Examples of the work being undertaken are International recruitment, of which 17 nurses arrived in March. Dedicated workstreams have been established in conjunction with recruitment and human resources to support this process which will also include domestic recruitment and a 'grow your own strategy', to retain staff. The

robust escalation and mitigation processes remain in place ensuring oversight of the staffing arrangements and allow safest staffing to be prioritised.

Daily assurance is gained through a variety of mechanisms: The Safety Huddles, the use of the real time data of acuity and activity released through SafeCare, the cross-Divisional working, and email updates on staffing levels.

**16. Action required from the Board/Committee**

The Committee / Board is requested to take assurance from this report.

**Appendix 1**

| Ward/Area             | Division | Actual V planned Hours | Monthly Day and Night hours for registered and unregistered staff |              |
|-----------------------|----------|------------------------|---|--------------|
|                       |          |                        | Total Planned   | Total Actual |
| Mar-21                |          | % summary              |   |              |
| Buckingham            | IECC     | 98.43%                 | 2511.98   | 2472.48      |
| Florence Nightingale  | IECC     | 85.07%                 | 2800.5  | 2382.5       |
| SM Ward 8             | IECC     | 92.45%                 | 5646.5  | 5220.1       |
| Bucks Neuro Rehab     | IECC     | 91.24%                 | 3905.25   | 3563.31      |
| Waterside             | IECC     | 82.63%                 | 5440  | 4495.25      |
| SM MDU                | IECC     | 145.58%                | 2512.5  | 3657.75      |
| SM Ward 18            | IM       | 86.97%                 | 5721.5  | 4975.75      |
| SM Ward 4 Respiratory | IM       | 59.58%                 | 10308   | 6141.5       |
| SM Ward 7 Respiratory | IM       | 63.44%                 | 7948.5  | 5042.83      |
| SM Ward 10 SSW        | IM       | 91.55%                 | 6954.5  | 6367         |
| SM Ward 17 Gastro     | IM       | 92.05%                 | 5236  | 4819.5       |
| WH CCU 2A             | IM       | 79.50%                 | 4490.5  | 3569.75      |
| SM Ward 6 Diabetes    | IM       | 86.42%                 | 6390  | 5522.5       |
| WH Ward 8             | IM       | 87.35%                 | 5300  | 4629.5       |
| WH Ward 9             | IM       | 90.67%                 | 4949.5  | 4487.5       |
| SM ITU                | SCC      | 65.23%                 | 17879.61  | 11662.66     |
| WH ITU                | SCC      | 62.48%                 | 8781.25   | 5486.75      |
| SM Ward 1             | SCC      | 83.71%                 | 5961.33   | 4990.33      |
| SM Burns Unit         | SCC      | 76.57%                 | 2188.5  | 1675.66      |
| SM Ward 16a           | SCC      | 90.10%                 | 6579  | 5927.75      |
| SM Ward 2             | SCC      | 93.75%                 | 4736  | 4440         |
| SM St Andrew          | SSD      | 83.94%                 | 6841  | 5742.25      |
| SM St David           | SSD      | 87.66%                 | 4595  | 4028         |
| SM St Francis         | SSD      | 91.00%                 | 2166.5  | 1971.5       |
| SM St George          | SSD      | 91.41%                 | 5442.75   | 4975         |
| SM St Patrick         | SSD      | 81.60%                 | 6333  | 5167.5       |
| SM Ward 5             | SSD      | 83.35%                 | 3582.5  | 2986         |
| SM Ward 3             | W&C      | 78.96%                 | 5652.45   | 4463.25      |

## Appendix 2

### Exception report for wards below 90%

Mar-21

These are all areas under 90%

| Ward name             | Planned  | Actual   | Percentage | Narrative  |
|-----------------------|----------|----------|------------|--|
| Florence Nightingale  | 2800.5   | 2382.5   | 85.07%     | Reduced patient numbers fluctuating between 5 and 10 patients. Staffing requirements adjusted and staff redeployed to other areas. Bed capacity 12       |
| Waterside             | 5440     | 4495.25  | 82.63      | Reduced patient numbers between 16 and 20. Staff redeployed to other areas. Bed capacity 21  |
| SM Ward 18            | 5721.5   | 4975.75  | 86.97%     | Patient numbers fluctuated between 19 and 21. Staffing requirements adjusted as required. Bed capacity 21.   |
| SM Ward 4 Respiratory | 10308    | 6141.5   | 59.58%     | Up to 4 closed beds due to life style works being carried out. Staff redeployed to other areas within IM. Bed capacity 23.                               |
| SM Ward 7 Respiratory | 7948.5   | 5042.83  | 63.44%     | Reduced patient numbers between 12 and 17 patients as covid cases have fallen as ward is covid area. Staff redeployed as required. Bed capacity 9.       |
| WH CCU 2A             | 4490.5   | 3569.75  | 79.50%     | Reduced patient numbers between 10 and 17. Staff redeployed, as necessary. Bed capacity 22.  |
| SM Ward 6 Diabetes    | 6390     | 5522.5   | 86.42%     | Reduced patient numbers between 22 and 24. Staff redeployed as required. Bed capacity 24.  |
| WH Ward 8             | 5300     | 4629.5   | 87.35%     | Reduced patient numbers between 19 and 21. Staff redeployed as required. Bed capacity 21.  |
| SM ITU                | 17879.61 | 11662.66 | 65.23%     | Planned hours based on capacity. Patient numbers fluctuated between 15 and 7. Staff redeployed, or agency nurses cancelled. Bed capacity 17.             |
| WH ITU                | 8781.25  | 5486.75  | 62.48%     | Planned based on capacity. Capacity of 9 beds. Patient numbers fluctuated between 7 and 4 patients. Staff redeployed to support other areas as required. |
| SM Ward 1             | 5961.33  | 4990.33  | 83.71%     | Patient numbers fluctuated between 19 and 23. Staff redeployed as required. Bed capacity 22.   |
| SM Burns Unit         | 2188.5   | 1675.66  | 76.57%     | Patient numbers reduced between 0 and 4. staff redeployed to support other areas as required. Bed capacity 6.  |
| SM St Andrew          | 6841     | 5742.25  | 83.94%     | Reduced patient capacity to 18 for the Month of March. Patient numbers between 12 and 15. Ward capacity 23 when fully open.                              |
| SM St David           | 4595     | 4028     | 87.66%     | Reduced patient capacity to 18 beds. Ward capacity usually 23 patients. Patient numbers between 16 and 18.   |
| SM St Patrick         | 6333     | 5167.5   | 81.60%     | Patient numbers fluctuated between 14 and 27. Staff redeployed as required. Normal bed capacity 24.  |
| SM Ward 5             | 3582.5   | 2986     | 83.35%     | Patients numbers fluctuated between 3 and 14. Staff redeployed as required to other areas. Bed capacity 14.  |
| SM Ward 3             | 5652.45  | 4463.25  | 78.96%     | No change in bed capacity but fewer admissions for the month of March. Staff redeployed to other paediatric areas as required.                           |

These are areas over 115%

| Ward name | Planned | Actual  | Percentage | Narrative  |
|-----------|---------|---------|------------|--|
| SM MDU    | 2512.5  | 3657.75 | 145.58%    | The discharge lounge has reopened and required extra staffing to accommodate this. |

Meeting: Trust Board Meeting in Public

26 May 2021

|                              |  |
|------------------------------|--|
| <b>Agenda item</b>           | 2021/22 Month 1 Finance Report               |
| <b>Board Lead</b>            | Barry Jenkins, Chief Financial Officer       |
| <b>Type name of Author</b>   | Aneel Pattni, Deputy Chief Financial Officer |
| <b>Attachments</b>           | Month 1 Finance Committee Report             |
| <b>Purpose</b>               | Assurance                                    |
| <b>Previously considered</b> | EMC 11/05/2021 – FBPC 18/05/2021             |

### Executive Summary

- 2021/22 I&E month 1 year to date (YTD) headline position of break even** in line with the provisional annual budget agreed by Board in April 2021. This is supported by £3.3m of non-recurrent Block top-up income funding, this income has been accrued based on the latest guidance from NHSE/I. This income is subject to their review and approval.
- Position includes £0.8m of Covid-19 related incremental expenditure and income**, resulting in a neutral impact to the year to date position. There are ongoing discussions with Bucks CCG and BOB ICS which may result in a reduction to the total income assumed in the H1 Plan. Further details will be covered in a separate update on the H1 Plan.
- Full year forecast of £22.0m deficit in line with plan.** This plan is based on a number of key assumptions and an assessment of risk undertaken in April 2021. Due to the level of uncertainty and additional risk created by the Covid-19 pandemic, this is a draft plan and it remains subject to final review and approval by the Board.
- The Trust is continuing to develop the CIP efficiencies plan.** This may result in a final plan and forecast that is materially different to the current plan.
- Capital, Balance Sheet and Cash Flow** analysis will be provided from Month 2.

**Decision** The Board is requested to APPROVE the paper.

### Relevant Strategic Priority

**Quality**  **People**  **Money**

### Implications / Impact

|  |  |
|--|--|
| <b>Patient Safety</b>  | Any impacts on patient safety are identified and addressed as part of the Trust and divisional integrated performance review process   |
| <b>Risk: link to Board Assurance Framework (BAF)/Risk Register</b> | BAF 4.1a Failure to deliver the annual financial plan  |
| <b>Financial</b>   | See Executive Summary in paper   |
| <b>Compliance NHS Regulation Good Governance</b>                   | Monthly reporting is provided to the committee to provide assurance. The financial position is reported to NHSE/I on a monthly basis as part of the regulatory oversight process |
| <b>Partnership: consultation / communication</b>                   | This report is shared with partners across the ICP, ICS and regulators, as required.   |

|   |   |
|---|---|
| <b>Equality</b>   | Any material equality impacts of expenditure are identified and addressed as part of the budget setting process |
| <b>Quality Impact Assessment [QIA] completion required?</b> | N/A   |

Safe & compassionate care,  
every time

Finance Report Month 1 - 30th April, 2021

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## Financial performance

**Table 1 - Income and expenditure summary**

| (£m)  | In Mth Plan   | In Mth Actuals | In Mth Variance | YTD Mth Plan  | YTD Actuals   | YTD Variance | Annual Plan    | Forecast       |
|---|---------------|----------------|-----------------|---------------|---------------|--------------|----------------|----------------|
| Contract Income                               | 40.8          | 40.8           | 0.0             | 40.8          | 40.8          | 0.0          | 467.3          | 467.3          |
| Other income                                  | 2.3           | 2.4            | 0.1             | 2.3           | 2.4           | 0.1          | 27.9           | 27.9           |
| <b>Total income</b>                           | <b>43.1</b>   | <b>43.2</b>    | <b>0.1</b>      | <b>43.1</b>   | <b>43.2</b>   | <b>0.1</b>   | <b>495.3</b>   | <b>495.3</b>   |
| Pay   | (24.7)        | (26.3)         | (1.6)           | (24.7)        | (26.3)        | (1.6)        | (296.4)        | (296.4)        |
| Non-pay                                       | (15.0)        | (13.7)         | 1.3             | (15.0)        | (13.7)        | 1.3          | (179.9)        | (179.9)        |
| <b>Total operating expenditure</b>            | <b>(39.7)</b> | <b>(40.0)</b>  | <b>(0.3)</b>    | <b>(39.7)</b> | <b>(40.0)</b> | <b>(0.3)</b> | <b>(476.3)</b> | <b>(476.3)</b> |
| <b>EBITDA</b>                                 | <b>3.4</b>    | <b>3.2</b>     | <b>(0.2)</b>    | <b>3.4</b>    | <b>3.2</b>    | <b>(0.2)</b> | <b>19.0</b>    | <b>19.0</b>    |
| Non Operating Expenditure                     | (3.4)         | (3.2)          | 0.3             | (3.4)         | (3.2)         | 0.3          | (41.3)         | (41.3)         |
| <b>Retained Surplus / (Deficit)</b>           | <b>0.0</b>    | <b>0.0</b>     | <b>0.0</b>      | <b>0.0</b>    | <b>0.0</b>    | <b>0.0</b>   | <b>(22.3)</b>  | <b>(22.3)</b>  |
| Non Recurrent I&E                             | (3.3)         | (3.3)          | 0.0             | (3.3)         | (3.3)         | 0.0          | (19.7)         | (19.7)         |
| <b>Normalised I&amp;E Surplus / (Deficit)</b> | <b>(3.3)</b>  | <b>(3.3)</b>   | <b>0.0</b>      | <b>(3.3)</b>  | <b>(3.3)</b>  | <b>0.0</b>   | <b>(42.0)</b>  | <b>(42.0)</b>  |

### Executive Summary

- The Trust reports a break-even position for month 1 in line with plan.

- The plan used in this report is based on NHSE/I planning guidance issued at the end of March 2021 which covers guidance for the first six months of the year (referred to as H1). NHSE/I has issued providers with pre-populated plans for H1 based on a continuation of the emergency financial regime. In calculating the Trust's income and expenditure, NHSE/I has applied a simple high level methodology of Q3 (2020/21) multiplied by 2. NHSE/I's expectation is that this funding settlement will allow the ICS, commissioners and providers to deliver break even for this period. The plan for the second half of the year currently (referred to as H2) indicates a £22.3m deficit. The H2 plan is subject to final approval by the Trust Board and agreement with BOB ICS and NHSE/I.

- The plan assumes a £16m efficiency plan will be delivered. This plan is phased equally throughout the year at £1.3m per month.

- Covid-19 expenditure totals £0.8m YTD and is reported within the overall expenditure position for this financial year. Income to cover covid-19 expenditure is assumed to be within the block values received, reported within contract income in the table opposite.

- Pay costs in month total £26.3m, £1.6m adverse to plan. Key drivers of this adverse position include medical staffing spend and shortfalls in CIP delivery due to the plan being phased equally across the year. The pay position continues to include year end provisions held for the Flowers legal case, working time directive payments, annual leave and BHT Thrive pay expenditure. Further details are provided on page 5.

- Non-pay costs total £13.7m for the month, £1.3m favourable to plan. Key drivers of this underspend include drugs and clinical supply expenditure being lower than plan. Further details are provided on page 6.

- The non-recurrent I&E adjustment removes the benefit of H1 Block income top-up funding receivable from NHSE/I and Bucks CCG. This would result in an underlying normalised deficit of £42m for the full year.

## Key Highlights: Income

### NHS Income and Activity

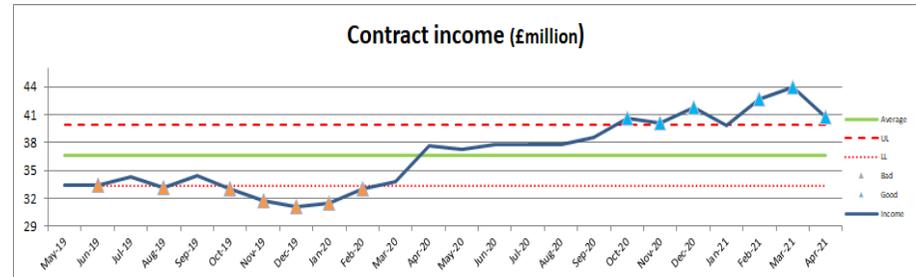
- Contract Income (Table 2) is in line with plan at month 1 totalling £40.8m.
- The Contract Income plan used in this report is based on NHSE/I planning guidance issued at the end of March 2021 which covers guidance for the first six months of the year (referred to as H1). NHSE/I has issued providers with pre-populated plans for H1 based on a continuation of the emergency financial regime. In calculating the trust's income, NHSE/I has applied a simple high level methodology of Q3 (2020/21) multiplied by 2. Further work is being undertaken with BOB ICS and CCGs to agree the final level of Block income for H1.
- The contract income position includes the NHSE/I top-up funding settlement which provides £32.3m of top-up income for H1. This non recurrent top-up income totals £5.4m per month and is given with the expectation that the Trust will breakeven in H1.
- The Statistical Process Control Chart (Graph 1) for Contract Income shows income is above the mean average throughout the 2020-21 financial year and month 1 for the new financial year. The reduction in contract income from October through to December 2019 relates to the agreed return of ICS Risk Allocation funding to Bucks CCG (£1.5m per month) and in January 2020 relates to the provision for bad debts including Spinal delayed discharges. The increase in December 2020 income relates to the one off benefit to the position following the settlement of the 2019-20 contracts position. The February 2021 position includes £2.6m additional monies received from NHSE/I relating to funding support for lost income during the Covid-19 pandemic and the March 2021 position includes further income receive to cover income lost during the Covid-19 pandemic totalling £2.8m.

### Other Income

**Table 2 - Breakdown of other income**

| Category (£m)                   | Annual Budget | YTD Budget | YTD Actuals | YTD Variance |
|---------------------------------|---------------|------------|-------------|--------------|
| Research                        | 1.2           | 0.1        | 0.1         | (0.0)        |
| Education And Training          | 9.4           | 0.8        | 1.3         | 0.5          |
| Non-NHS PPS & Overseas Visitors | 2.7           | 0.2        | 0.1         | (0.2)        |
| Injury cost recovery scheme     | 1.2           | 0.1        | (0.1)       | (0.2)        |
| Donated Asset Income            | 0.7           | 0.1        | 0.0         | (0.1)        |
| Other Income                    | 12.7          | 1.0        | 1.0         | (0.0)        |
| <b>Total</b>                    | <b>27.9</b>   | <b>2.3</b> | <b>2.4</b>  | <b>0.1</b>   |

**Graph 1 - Contract Income Statistical Process Control (SPC) Charts**



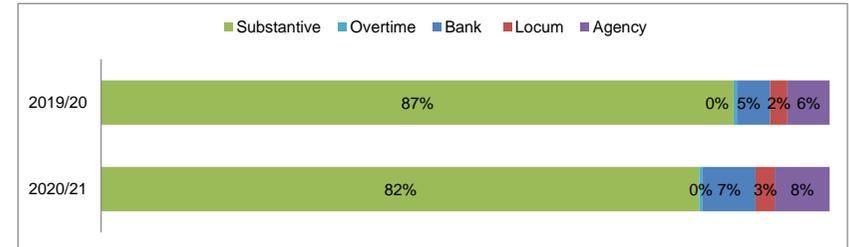
- Other Income (Table 3) is £0.1m favourable to plan YTD.
- Private Patient and Overseas work reports a £0.2m adverse variance against plan.
- Donated Asset Income reports a £0.1m adverse variance. This variance however is removed when calculating the bottom line financial position as the full impact of donated asset income and depreciation is removed when calculating the final position.

## Key Highlights: Expenditure (Pay & Workforce)

**Table 3 - YTD pay position**

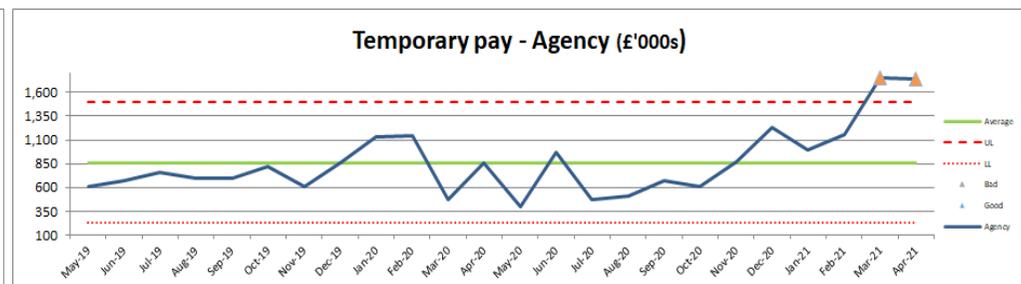
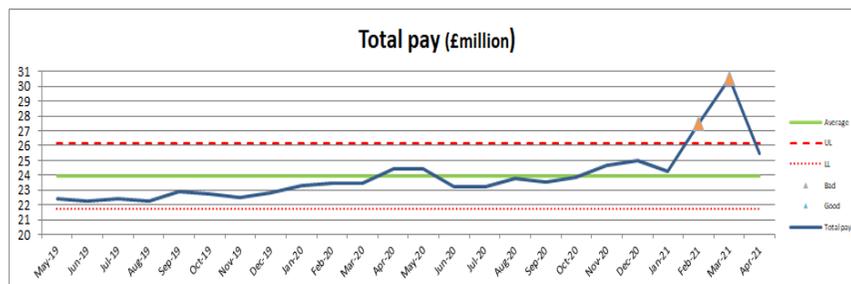
| Pay category (£m) | YTD Spend * | % of Total Pay Bill | Last Year YTD Spend | Last Year % of Total Pay Bill |
|-------------------|-------------|---------------------|---------------------|-------------------------------|
| Substantive       | 21.6        | 82%                 | 22.4                | 87%                           |
| Overtime          | 0.1         | 0%                  | 0.1                 | 0%                            |
| Bank              | 1.9         | 7%                  | 1.2                 | 5%                            |
| Locum             | 0.7         | 3%                  | 0.6                 | 2%                            |
| Agency            | 2.0         | 8%                  | 1.5                 | 6%                            |
| <b>Total</b>      | <b>26.3</b> | <b>100%</b>         | <b>25.8</b>         | <b>100%</b>                   |

**Graph 2 - YTD pay position**



- Pay expenditure totals £26.3m year to date (YTD), £1.6m adverse to plan.
- The pay position includes £0.8m expenditure associated with managing Covid-19.
- Temporary staffing expenditure (Bank, Agency & locum) totals £4.6m, a large proportion of which is offset by underspends against substantive budgets totalling £3.5m. Agency expenditure totals £2.0m YTD with key usage areas including Emergency Medicine, IT, Radiology, Medicine for Older People, Acute Medical wards and managing Covid-19. The vacancy control panel (VCP) will undertake analysis and support divisions with deep dives during May 2021 to review areas of agency spend.
- The pay efficiency target totals £0.7m YTD. This target will be applied to individual budget lines once final plans are identified and processed.
- Year end provisions for the Flowers Legal Case, working time directive payments, annual leave not taken in 2020-21 and BHT Thrive associated expenditure continue to be held in the position and will be released to match spend as and when this comes through.
- The Pay Statistical Process Control Charts are detailed below (Graph 4). Key highlights include:
  - The increase in total pay in September 2019 relates to the Medical Staff Pay Award.
  - The increase in total pay spend in April 2020 relates to the 2020-21 Agenda for change pay award (£0.7m) and CEA award payments to medical staff (£0.5m).
  - The increase in total pay costs in February 2021, relate to provisions for the Flowers Legal case, unsocial hours claims and payment of consultant CEA awards.
  - The increase in total pay costs in March 2021 includes payment of the bank winter incentive payments and pay related provisions as noted above.
  - The reduction in agency costs in March 2020 relate to the capitalisation of IT agency costs relating to the HSLI Capital IT project.
  - The reduction in agency costs in July 2020 relate to a number of backdated agency shifts being identified as relating to the Covid-19 pandemic.
  - The increase in agency costs from November to December 2020 relates to sickness cover and Christmas holiday cover.

**Graph 3 - Pay Statistical Process Control (SPC) Charts**



## Key Highlights: Expenditure (Non Pay)

**Table 4 - YTD non-pay position**

| Non-Pay category (£m)    | Annual Budget | YTD Budget  | YTD Actuals | YTD Variance |
|--------------------------|---------------|-------------|-------------|--------------|
| Drugs                    | 48.7          | 4.1         | 3.4         | 0.7          |
| Clinical supplies        | 36.6          | 3.1         | 2.5         | 0.6          |
| Other non-pay            | 94.6          | 7.9         | 7.9         | 0.0          |
| <b>Total Expenditure</b> | <b>179.9</b>  | <b>15.0</b> | <b>13.7</b> | <b>1.3</b>   |

• Non-pay expenditure totals £13.7m year to date (YTD), £1.3m favourable to plan.

• Although increasing, activity levels being below normal following the covid-19 pandemic is the key driver in this underspend with expenditure on clinical supplies reporting a £0.6m favourable variance against plan and drugs a £0.7m favourable variance against plan.

• The non pay efficiency target totals £0.5m YTD. This target will be applied to individual budget lines once final plans are identified and processed.

**Table 5 - YTD drugs position**

| Drug Categories (£m)     | Annual Budget | YTD Budget | YTD Actuals | YTD Variance |
|--------------------------|---------------|------------|-------------|--------------|
| PBR Drugs                | 9.7           | 0.8        | 0.8         | 0.0          |
| PBR excluded Drugs       | 37.3          | 3.1        | 2.5         | 0.6          |
| Other Drug Items         | 1.8           | 0.1        | 0.1         | 0.1          |
| <b>Total expenditure</b> | <b>48.7</b>   | <b>4.1</b> | <b>3.4</b>  | <b>0.7</b>   |

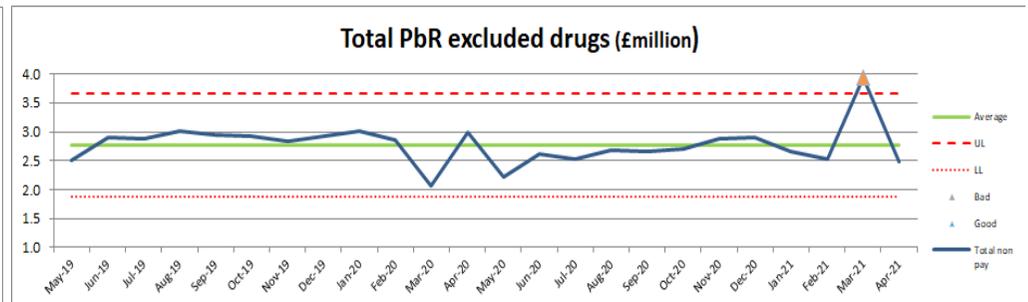
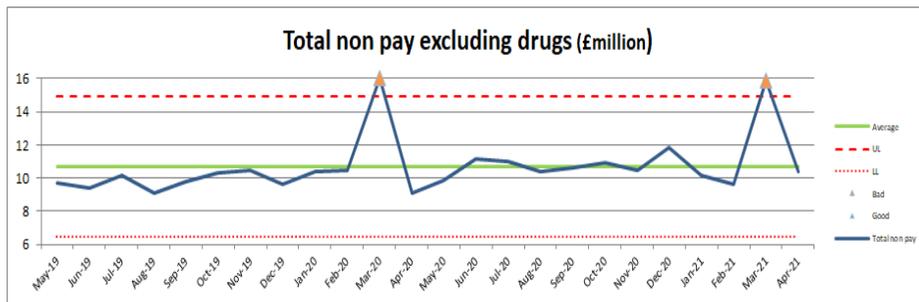
• Drugs expenditure totals £3.4m YTD, a £0.7m favourable variance to plan. PBR drugs are in line with plan YTD and PBR excluded drugs, £0.6m favourable to plan.

• Statistical Process Control charts (SPC) for non pay and PBR Excluded drugs expenditure are detailed below (Graph 4). Key highlights show:

- Total non pay expenditure is below the mean average in April and May 2020 primarily due to reduced elective activity levels. Non pay spend was back above the mean average from July to September 2020 as activity levels increased however this has gone back below the mean average in January and February 2021 as the second covid-19 wave hit and activity levels have reduced again. February 2021 costs have also reduced due to February being a short month which sees a reduction in working days and therefore associated costs including the PFI contracts.

- March 2020 and March 2021 costs includes the impact of non recurrent year end balance sheet adjustments.

**Graph 4 - Non Pay Statistical Process Control (SPC) Charts**



## Divisional Position

### Breakdown of financial position by division

**Table 6 - Divisional income and expenditure**

| Division / (£m)                     | YTD Variance against Plan | Outturn Plan   | Total for Domain (Finance) | Finance YTD Sector Rating | Current Month Run Rate |               |               |
|-------------------------------------|---------------------------|----------------|----------------------------|---------------------------|------------------------|---------------|---------------|
|                                     |                           |                |                            |                           | M11                    | M12           | M01           |
| Integrated Medicine                 | (0.0)                     | (85.9)         | 2                          | 1                         | (6.7)                  | (8.2)         | (7.2)         |
| Integrated Elderly Care             | (0.1)                     | (41.1)         | 4                          | 1                         | (3.0)                  | (3.0)         | (3.5)         |
| Surgery And Critical Care           | 0.3                       | (101.1)        | 2                          | 1                         | (8.0)                  | (8.7)         | (8.1)         |
| Women and Children                  | (0.0)                     | (44.7)         | 2                          | 1                         | (4.2)                  | (3.8)         | (3.7)         |
| Specialist Services                 | 0.3                       | (78.0)         | 2                          | 1                         | (6.1)                  | (7.2)         | (6.2)         |
| <b>Total Clinical Divisions</b>     | <b>0.5</b>                | <b>(350.8)</b> |                            |                           | <b>(28.0)</b>          | <b>(30.8)</b> | <b>(28.7)</b> |
| Chief Executive                     | 0.1                       | (3.8)          | 2                          | 1                         | (0.3)                  | 0.2           | (0.2)         |
| Chief Operating Off-Management      | (0.1)                     | (4.1)          | 4                          | 1                         | (0.3)                  | (0.5)         | (0.4)         |
| Corporate Services                  | (0.1)                     | 1.2            | N/A                        | N/A                       | (2.4)                  | 4.6           | (0.1)         |
| Commercial Director Mgmt            | (0.1)                     | 1.0            | 4                          | 1                         | (0.1)                  | (0.0)         | (0.0)         |
| Finance Dept.                       | (0.1)                     | (6.8)          | 4                          | 1                         | (0.4)                  | (0.4)         | (0.7)         |
| Information Technology              | (0.3)                     | (10.1)         | 4                          | 1                         | (1.1)                  | (4.5)         | (1.1)         |
| Performance and Delivery            | 0.0                       | (4.1)          | 2                          | 1                         | (0.6)                  | (0.3)         | (0.3)         |
| Property Services                   | (0.2)                     | (55.6)         | 4                          | 1                         | (4.1)                  | (6.1)         | (4.8)         |
| Human Resources                     | 0.2                       | 4.0            | 2                          | 1                         | 0.1                    | 0.3           | 0.5           |
| Medical Director                    | 0.0                       | (0.5)          | 2                          | 1                         | 0.0                    | (0.1)         | (0.0)         |
| Nursing Director                    | 0.1                       | (17.4)         | 2                          | 1                         | (1.3)                  | (1.3)         | (1.4)         |
| PDC And Depreciation                | 0.0                       | (32.3)         | N/A                        | N/A                       | (1.8)                  | 0.1           | (2.7)         |
| Covid-19 Division                   | (0.8)                     | 0.0            | N/A                        | N/A                       | (2.6)                  | (4.5)         | (0.8)         |
| Strategy And Business Dev.          | 0.0                       | (0.2)          | 2                          | 1                         | 0.0                    | (0.0)         | (0.0)         |
| <b>Total Corporate</b>              | <b>(1.4)</b>              | <b>(128.7)</b> |                            |                           | <b>(14.8)</b>          | <b>(12.5)</b> | <b>(12.2)</b> |
| Contract Income                     | 0.0                       | 467.3          |                            |                           | 42.7                   | 43.9          | 40.8          |
| Provisions                          | 0.8                       | (10.1)         |                            |                           | 0.0                    | 0.0           | 0.0           |
| Donated Asset Reporting Adj         | 0.2                       | 0.0            |                            |                           | 0.1                    | (0.8)         | 0.2           |
| <b>Retained Surplus / (Deficit)</b> | <b>0.0</b>                | <b>(22.3)</b>  |                            |                           | <b>0.1</b>             | <b>(0.2)</b>  | <b>0.0</b>    |

Key reasons for YTD divisional variances are as follows:

**Integrated Medicine (In line with plan YTD).**

• Expenditure is in line with plan YTD with underspends on the new modular build being offset with temporary staffing pay pressures in Emergency Medicine, Respiratory and the Site Team. From April, 2021 the budget for ward 9 has moved from Integrated Elderly Care Division to Integrated Medicine. Further work is required across the two divisions to enable the costs of this ward to be separately identifiable from Ward 8 therefore ensuring they are coded to the correct division. This could result in some costs currently reported in Elderly Care transferring to Integrated Medicine.

**Surgery and Critical Care (£0.3m underspend YTD).**

• The key drivers behind this underspend relates to expenditure on Theatre clinical supplies being lower than plan (£0.4m) which is linked to lower than normal activity levels following the Covid-19 pandemic.

**Specialist Services (£0.3m underspend YTD).**

• Reductions in managed service contract expenditure and Stem Cell income being above plan are the key drivers in the £0.3m YTD reported underspend.

**Information Technology (£0.3m overspend YTD)**

• This overspend relates to temporary staffing costs and consultancy expenditure.

**Property Services (£0.2m overspend YTD).**

Key drivers of this overspend include shortfalls in other operating income against plan for car parking, residences and PFI associated income.

**Covid-19 Division (£0.8m adverse YTD).**

• The Covid-19 Division is where all incremental costs associated with managing the Covid-19 pandemic are recorded. YTD expenditure total £0.8m, the majority of which relates to pay including £0.2m agency costs.

## Glossary and Definitions

|              |  |
|--------------|--|
| A&E          | Accident and Emergency                       |
| BHT          | Buckinghamshire Healthcare NHS Trust         |
| BOB          | Buckinghamshire, Oxfordshire, Berkshire West |
| BPPC         | Better Payment Practice Code                 |
| CCG          | Clinical Commissioning Group                 |
| CEA          | Clinical Excellence Awards                   |
| CRL          | Capital Resource Limit                       |
| DH           | Department of Health                         |
| EIS          | Elective Incentive Scheme                    |
| HEE          | Health Education England                     |
| HMRC         | Her Majesty's Revenue and Customs            |
| HSLI         | Health System Led Investment                 |
| ICS          | Integrated Care System                       |
| NHS          | National Health Service                      |
| NHSE         | NHS England                                  |
| NHSE/I       | NHS England & Improvement                    |
| NHSI         | NHS Improvement                              |
| NHSLA        | NHS Litigation Authority                     |
| OUH          | Oxford University Hospital                   |
| PBR          | Payment by results                           |
| PBR excluded | Items not covered under the PBR tariff       |
| PDC          | Public Dividend Capital                      |
| PFI          | Private Finance Initiative                   |
| PP           | Private Patients                             |
| WTE          | Whole Time Equivalent                        |
| YTD          | Year to Date                                 |

**Meeting:** Trust Board Meeting in Public

**26 May 2021**

**Report from Chair of FBP Committee**

**Date of Committee: 20 April 2021**

**Key agenda items considered:**

| Item                           | Committee assured | Further work  | Referral elsewhere for further work  | Recommendation to Board   |
|--------------------------------|-------------------|---|--|---|
| Monthly Finance Report M12     | Yes               | n/a   | Impairment of capital for 2020/21 statutory accounts to be reviewed and updated at Audit Committee | Approve and recommend to Board  |
| Capital Programme/ 5 year view | Yes               | Continuation of negotiations with BOB for emergency capital funding – bid for £24m submitted to date and seek additional funds eg Digital as available  | n/a  | Approve and recommend to Board the £16.5m capital plan for 2021/22, being the minimum capital programme for the year. |
| 21/22 Finance Plan update      | Yes               | Further detail of the H1 plan following receipt of financial envelope. Further discussions regarding H1 assumptions r top up/ covid finding etc. work to continue on development of H2 re no further Covid funding expected; future transformations needed; analysis of the underlying productivity of the business | n/a  | Approve and recommend to Board the H1 plan for submission to ICS  |

|                                      |     |   |     |  |
|--------------------------------------|-----|---|-----|--|
| IPR – March 2021                     | Yes | Enhance exception reporting   | n/a |  |
| Recovery Plan                        | Yes | Develop Recovery Dashboard for future reporting to FBP. Prioritise risks to be managed through recovery – eg meeting ERF thresholds; UEC transformation; reduction of P2 waiters.   | n/a | Assured and agree with the proposed priorities as set out in the Revery plan   |
| Transformation and Efficiency update | Yes | Revision of Transformation reporting to future FBP. Focus on accelerating financial plan savings by portfolio to address key risks emerging from the plans. Deep dives in significant portfolios to be considered by FBP at milestone dates through year.   | n/a | Noted the CIP performance for 2020/221. Noted 2021/22 Transformation/ efficiency plans and development of £16m financial plans to support these. |
| BHPL Social Enterprise               | Yes | Further consideration and explanation to be presented regarding the reasons to become a Social Enterprise; conformation of the strategic direction regarding incorporation as a Social Enterprise; further consider whether better to include details as policies rather than within the Articles | n/a | Endorse the changes in principle, but Board should receive additional background information to support the changes.                             |

**Other risks noted by the committee for the Board to be aware of:**

Annual Capital Plan – risk of not gaining further capital from BOB will limit the delivery and implementation of critical IT, digital, estates, clinical and other projects Trust wide

Achievement of operational trajectories for receipt of ERF – further modelling of activity plans to be complete to assess ERF available; availability of capacity through independent sector and overall impact on capacity to deliver.

**Meeting:** Trust Board Meeting in Public

**26 May 2021**

**Report from Chair of Strategic Workforce Committee**

**Date of Committee:** 10/05/21

**Key agenda items considered:**

| Item                          | Committee assured | Further work   | Referral elsewhere for further work   | Recommendation to Board  |
|-------------------------------|-------------------|--|---|--|
| Chief People officer report   | yes               | no   | Share NHS Just culture one pager  | A request to continue with report for future SWC   |
| IPR (people section)          | yes               | Continue to work with up and coming retirees, how can we keep their vast knowledge and experience in BHT                 |   |  |
| International recruitment     | yes               | Great work completed in this area, how can we 'make heroes' of the people who leave their home countries to work with us | How can the comms team help here  | Continue to support, be vocal in encouraging everyone to celebrate the outstanding contribution  |
| Thrive                        | yes               | At least a 2 year programme as research has shown issues can take a t least a year to surface                            | Encourage all BHT people to sign up and participate in the programme particularly 'React' |  |
| Nurses & Midwifery conference | yes               |  |   | Look to see what we can learn from such a successful event and consider where else we can re use |

| Item  | Committee assured    | Further work   | Referral elsewhere for further work  | Recommendation to Board |
|---|----------------------|--|--|-------------------------|
| Security  | Partial but approved | Great to see a security strategy. Consider how it can be improved further with clear next steps and dependencies             | When work on the finances are complete share present paper to FB&P – however keep SWC actively involved specifically with car parking as this is so important to our colleagues. |                         |
| Operating plan                                  | Yes                  | Suggest people view appendix five as this has recently been added.   |  |                         |
| People transformation programme – temp staffing |                      | Early days – but a great initiative<br>Keep learning from other successful Trusts  |  |                         |
| Freedom to Speak up Guardian                    | Yes                  | The four newly recruited Outreach FTSUGs” (part time colleagues = 1FTE) need to be trained and registered – planned by 15/07 | A communications piece is planned to introduce the new team to the organisation.   |                         |

Other risks noted by the committee for the Board to be aware of:

- The greatest challenge and therefore risk is related to the enormous cultural change we are facing as we adapt post covid. Exacerbated by the change to our workforce following the success of the international recruitment initiative.
- Impact of unpredictability of covid and potential impact on our international nurse’s recruitment programme
- Even though covid in the UK is currently decreasing it still has a massive impact on our people – this committee must remain focused on this
- Security of our people – we must continue to provide a safe place for our patients and for our colleagues to thrive

**Meeting:** Trust Board Meeting in Public

**26 May 2021**

**Report from Chair of Audit Committee**

**Date of Committee: 6 May 2021**

**Key agenda items considered:**

| Item  | Committee assured | Further work   | Referral elsewhere for further work   | Recommendation to Board   |
|---|-------------------|--|---|---|
| Draft Annual Report                         | Yes               | Subject to further review following audit                  | Will return to Audit Committee  | For noting  |
| Draft Annual governance statement           | Yes               | Subject to further review                                  | Will return to Audit Committee  | For noting  |
| Self-Certification for NHS Provider Licence | Yes               | None   | Meeting with NHSE/I on 5 May agreed the basis for certification as compliant on financial governance subject to formal ratification | Recommend approval  |
| Governance Manual                           | Yes               | Yes requires further amendments following committee review | Will be presented to board subject to agreed changes  | Recommend approval subject to changes made through committee review |
| Internal Audit General Review/Update        | Yes               | Yes - ongoing  | Will be reported on at each meeting   | For noting  |

|   |                             |   |  |                        |
|---|-----------------------------|---|--|------------------------|
| Internal Audit Paediatrics Health and Care Plan | Partial Assurance Report    | Yes - Requires completion of management actions                                   | N/A  | For noting             |
| Internal Audit PFI Implementation of Sirion     | Reasonable Assurance Report | Yes - Requires completion of management actions                                   | N/A  | For noting             |
| Draft Head of Internal Audit Opinion            | Yes                         | Yes final version to be prepared following completion of audits                   | Will be reported at next audit committee meeting                                       | For noting Amber/Green |
| Local Counter Fraud Specialist Annual Report    | Yes                         | Yes – requires self-certification uploading by DoF and Chair of audit             | Will be reported at next audit committee – ratings have been changed from red to amber | For noting             |
| Clinical Audit                                  | Yes                         | Yes – reporting format to be agreed by Chairs of audit and Quality Committees     | To be reported at next Audit Committee   | For noting             |
| Single Tender Waivers                           | Yes                         | Yes – further review of process and form of reporting for assurance to take place | Board Seminar to be rescheduled and further discussions                                | For noting             |

|                             |     |    |     |            |
|-----------------------------|-----|----|-----|------------|
| Losses and Special Payments | Yes | No | N/A | For noting |
| Minutes of SWC/QCGC/F&BP    | Yes | No | N/A | For noting |

Other risks noted by the committee for the Board to be aware of:

Timing of Final Accounts – Trust has opted for extended date

**Meeting:** Trust Board Meeting in Public

**26 May 2021**

|                              |   |
|------------------------------|---|
| <b>Agenda item</b>           | Compliance with Legislation                               |
| <b>Board Lead</b>            | Chief Nurse, transferred from the Director for Governance |
| <b>Type name of Author</b>   | Sandie Knight, Governance Manager                         |
| <b>Attachments</b>           | None  |
| <b>Purpose</b>               | Assurance   |
| <b>Previously considered</b> | EMC 01/12/20 EMC 19/01/2021 Quality Committee 21/04/2021  |

**Executive Summary**

The Compliance with Legislation process is carried out within the Trust on an annual basis to review and monitor progress against the requirements laid out by regulatory and legislative bodies, and to provide the Trust Board with assurance of the robustness of this compliance.

The managing leads identified any gaps in compliance and the actions required to mitigate or resolve them, along with details of how compliance is monitored, evidenced and therefore managed within the Trust. Each completed review was approved and signed off by the executive lead. The reviews were then challenged by other executive leads and brought together with any comments or feedback to a peer challenge session held on 01/12/2020.

An action plan based on the gaps was reviewed at the Quality and Clinical Governance Committee on 21<sup>st</sup> April 2021 and will subsequently be reviewed quarterly at the Executive Management Committee.

The outcome of the review has identified 3 new areas with compliance gaps, 3 existing areas with compliance gaps from 2019, and 3 areas where compliance gaps in 2019 have now been closed.

A proposed schedule for next year’s process has been included in the report.

|                 |   |
|-----------------|---|
| <b>Decision</b> | The Board is requested to take assurance from the process described and note The Trust’s current position |
|-----------------|---|

|  |   |  |
|--|---|--|
| <b>Relevant Strategic Priority</b>                 |   |  |
|  |   |  |
| <b>Quality</b> <input checked="" type="checkbox"/> | <b>People</b> <input checked="" type="checkbox"/> | <b>Money</b> <input checked="" type="checkbox"/> |

|  |  |
|--|--|
| <b>Implications / Impact</b>                                       |  |
| <b>Patient Safety</b>  | Failure to manage and monitor compliance can increase patient safety risks                                   |
| <b>Risk: link to Board Assurance Framework (BAF)/Risk Register</b> | Key risks identified have been placed on the corporate risk register as appropriate                          |
| <b>Financial</b>   | There can be legal costs and fines if the Trust is found to be non-compliant with legislation or regulations |

|  |   |
|--|---|
| <b>Compliance</b> Select an item. Select CQC standard from list. | Relevant legislation and regulations were listed in the detailed action plan received by the Quality and Clinical Governance Committee. |
| <b>Partnership: consultation / communication</b>                 | Not required  |
| <b>Equality</b>  | Equality legislation has been considered and if any gaps have been identified these are listed in the legislation templates for action. |
| <b>Quality Impact Assessment [QIA] completion required?</b>      | Not required  |

## 1. Compliance with Legislation December 2020:

The Compliance with Legislation process is carried out within the Trust on an annual basis to review and monitor progress against the requirements laid out by regulatory and legislative bodies, and to provide the Trust Board with assurance of the robustness of this compliance.

## 2. The process

The 2020 Compliance with Legislation process commenced in early September with the distribution of templates providing key information regarding the regulations /legislations to the Executive Team who nominated managing leads to complete each individual review. The templates had been revised following feedback from previous exercises to allow the leads to identify gaps in compliance and list specific actions against each gap with target dates allocated for achievement of each action.

The managing leads identified any gaps in compliance and the actions required to mitigate or resolve them, along with details of how compliance is monitored, evidenced and therefore managed within the Trust. Each completed review was approved and signed off by the executive lead and returned to the Governance Manager for collation. The reviews were then challenged by other executive leads and brought together with any comments or feedback to a peer challenge session held on 01/12/2020 and attended by:

- Director for Governance
- Deputy Chief Nurse
- Medical Director
- Director for Finance
- Chief People Director
- Chief Operations Officer
- Director of Strategy
- Commercial Director
- Governance Manager

The gaps and subsequent actions were copied directly from the approved review forms to produce an action plan. The plan will be presented quarterly to the Executive Management Committee for information and review and has been assured through the Quality and Clinical Governance Committee.

### 3. The Outcome of the 2020 Review

The outcome of the review is provided in the summary comparison in table 1. There are 3 new areas with gaps in compliance (See table 2), 3 existing areas with gaps in compliance from 2019 that have not been resolved in year (See table 3), and 3 areas identified with gaps in compliance in 2019 which are now assured as compliant. (See table 4)

**Table 1. Summary comparison 2019/2020**

| 2020 | Comparison                                   | 2019 |
|------|--|------|
| 79   | Number of legislations/ regulations reviewed | 79   |
| 73   | Number Compliant                             | 73   |
| 6    | Number with gaps in compliance               | 6    |

**Table 2.**

| Areas identified with new compliance gaps in 2020                               |   |
|---|---|
| Regulatory Reform (Fire Safety) Order 2005 (CQC Regulation 15)                  | Challenges with universal compartmentalisation across all buildings given the age of the estate. Mitigation plans in place along with a 5-year rectification programme. Fire alarm systems upgraded at Wycombe Hospital.          |
| Criminal Justice and Immigration Act 2008 s119 s120 s121(1) (CQC Regulation 15) | Compliance training was previously provided with NHS Protect which ceased operation in 2019 with no provision to support the Local Security Management Specialist Role. An internal training programme is being developed         |
| Gas Safety (Installation and Use) regulations 1998                              | Gaps in assurance were identified through safety certificates not being produced in a timely manner and other contractor documentation being incomplete. A new contractor was appointed, and all assurance received by March 2021 |

**Table 3.**

| Areas identified with compliance gaps in 2019 where the gaps remain in 2020 |
|---|
|---|

|  |  |
|--|--|
| HTM 02 01 NHS Estates Guidance for Medical Gas Pipeline Systems (CQC Regulation 5) | Issues with ageing pipework – significant, multi-million pound and multi-year infrastructure issue. Work plan underway - new feedback systems have been installed; servicing programme in place; vacuum systems replaced; new VIE (Oxygen) arriving quarter 2 2021/22. |
| HTM 04 Safe Water in Healthcare Premises   | Water storage tanks and pipework require replacement to meet regulatory standards – multi-year programme. Compliance with testing and procedure standards -some tank and pipe replacements completed this year.  |
| Electricity at Work Regulations (CQC Regulation 15)                                | Insufficient high voltage supply and infrastructure – multi-year programme. Major HV/LV programme to be completed Q2 2021/22 at Stoke Mandeville, as well as upgrades to infrastructure in Wycombe planned for 2021/23.  |

**Table 4.**

| <b>Areas identified with compliance gaps in 2019 which are now compliant in 2020</b> |  |
|--|--|
| Copyright, Designs and Patents Act 1988 (the CDPA)                                   | The Trust had met the requirements of the application for relevant licenses but had not completed the annual media survey. This has now been undertaken and scheduled to repeat annually.  |
| Freedom of Information Act 2000  | Response times to Freedom of Information requests have been brought into line with regulatory requirements.  |
| Local Government and Public Involvement in Health Act 2007                           | Public involvement had not been sought with reference to the transfer of a service from one Trust site to another. Awareness of the requirement for public involvement has been raised and training given to ensure this issue does not recur. |

#### **4. The Process for 2021**

The executive team agreed that whilst still evolving, the process had become more robust, building on work previously undertaken and allowing the teams to see and monitor progress in compliance.

The templates for 2021 will include an additional **Yes/No** box for the managing leads to identify whether or not the Trust is deemed compliant and this will provide clarity in cases where ongoing actions are required but do not render the Trust non-compliant with the regulation/ legislation.

#### **5. Proposed Schedule for 2021:**

- **1<sup>st</sup> September:**  
Data gathering exercise to commence for 4 weeks. In that time the templates should be reviewed by the managing leads and signed off by the executive lead
- **30<sup>th</sup> September:**  
Deadline for return to the Governance Manager to collate and check for any incomplete/ missing information
- **October 18<sup>th</sup> to 29<sup>th</sup>:**  
Peer Challenge Buddy Review - 2 weeks to complete: Executive Leads will be allocated another person to 'buddy' with and each will review the other's returned documents raising any challenges or comments for feedback
- **November 4<sup>th</sup>:**  
Peer Challenge feedback – the executive team will meet to discuss the peer challenge and any changes they may wish to make to the process ongoing
- **December 14<sup>th</sup>**  
Presentation to EMC – the overall findings will be reported to EMC including any feedback for approval prior to presentation at the Trust Board
- **January 2022:**  
Presentation to the Trust Board

The Governance Manager will update the existing action plan and continue to circulate on a quarterly basis.

#### **6. Action required from the Committee**

The Committee is requested to:

- a) Take assurance from the process described and undertaken
- b) Note the action plan which will be monitored and reported to the Executive Management Committee for information on a quarterly basis.

**Meeting:** Trust Board Meeting in Public

**26 May 2021**

|                              |  |
|------------------------------|--|
| <b>Agenda item</b>           | Annual Governance Statement                    |
| <b>Board Lead</b>            | Neil Macdonald, Chief Executive                |
| <b>Type name of author</b>   | Chloe Powell, CEO Business Manager             |
| <b>Attachments</b>           | Annual Governance Statement                    |
| <b>Purpose</b>               | Approval                                       |
| <b>Previously considered</b> | EMC 27 April 2021; Audit Committee 06 May 2021 |

### Executive Summary

The Trust Annual Governance Statement (AGS) forms part of the Trust Annual Report & Accounts.

This version of the 2020/21 AGS has been drafted in accordance with guidance issued by NHS England & Improvement (NHSE/I). Some of the content is dictated by the guidance.

The AGS will be considered by the Trust internal and external auditors and must be submitted as part of the Trust's Annual Report & Accounts by 29 June 2021.

Following correspondence from NHSE/I, a meeting took place on 05 May 2021 at which NHSE/I agreed to recommend the Trust's 'undertakings' to be removed. The formal certification of this cannot be confirmed by the regulator until a scheduled meeting of the Regional Support Group (RSG) in early June, after the 31 May 2021 deadline for self-certification (the self-certification is a critical part of the AGS). NHSE/I has agreed that verbal assurance given at the meeting on 05 May 2021 is sufficient for the Trust to certify compliance accordingly.

Comments from Audit Committee members have been addressed in the attached version.

|                 |   |
|-----------------|---|
| <b>Decision</b> | The Board is requested to approve this draft for inclusion in the Annual Report, subject to external audit. |
|-----------------|---|

### Relevant strategic priority

|                  |                 |                |
|------------------|-----------------|----------------|
| <b>Quality</b> ☒ | <b>People</b> ☒ | <b>Money</b> ☒ |
|------------------|-----------------|----------------|

### Implications / Impact

|  |  |
|--|--|
| <b>Patient Safety</b>  | Governance regrading clinical and patient safety is described in the AGS.        |
| <b>Risk: link to Board Assurance Framework (BAF)/Risk Register</b> | The Trust risk management process is referred to in the attached document        |
| <b>Financial</b>   | The Trust financial process are referred to in the attached document             |
| <b>Compliance CQC Standards Good Governance</b>                    | The attached document meets the Trusts statutory requirements                    |
| <b>Partnership: consultation / communication</b>                   | Internal and External Auditors will be asked to comment on the attached document |
| <b>Equality</b>  | Equality issues are highlighted in the report                                    |
| <b>Quality Impact Assessment [QIA] completion required?</b>        | Not required   |

## Annual Governance Statement

### Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Trust Accountable Officer Memorandum*.

I report to the Chair of the Trust and ensure appropriate systems exist to support the work of the Trust and Board. I manage and lead the executive team who have clear accountabilities and annual objectives which are drawn from the Trust's strategy. In preparing this statement I have ensured that it meets the requirements of the model annual governance statement.

### The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Buckinghamshire Healthcare NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Buckinghamshire Healthcare NHS Trust for the year ended 31 March 2021 and up to the date of approval of the annual report and accounts.

### Capacity to handle risk

For a significant part of 2020/21, the NHS nationally was in its highest level of emergency preparedness, Incident Level 4, as a result of the COVID-19 pandemic. The Trust significantly changed its risk and reporting structures to enable it to respond to the situation.

During the COVID-19 pandemic, the Trust under the Civil Contingencies Act (2004) as a Category One responder, exercised its duties and standards in order to meet organisational needs. However, even in times where sustained business continuity plans are required to be used the Trust is still required to be properly governed. The Trust Standing Orders provide a framework for the action to be taken during a time when it may be necessary to undertake a temporary derogation of Standing Orders if required.

Therefore, in keeping with its Standing Orders and advice received from NHS England & Improvement (NHSE/I), the Trust Board took timely and effective steps to meet rapid decision-making requirements through its approval of the derogation of Standing Orders and use of 'emergency powers' at the Board meeting in March 2020. In addition, a standard operating procedure was implemented to ensure the maintenance of financial control and stewardship of public funds during the Trust's response to COVID-19. Examples of changes to structures included:

- Establishment of Bronze, Silver and Gold Command structures as per the Trust Emergency Preparedness and Response guidelines
- Accompanying Terms of Reference and revised risk reporting structure to ensure proportionate oversight of the unprecedented situation from clinical service areas through to the Board

- Revisions to delegated authority and oversight of decision-making, including revised financial Standard Operating Procedures to allow both increased responsiveness alongside increased Executive and Board scrutiny
- Increased briefing of Non-Executive members of the Board

Guidance received in March 2020 from NHS England (*Reducing burden and releasing capacity at NHS providers and commissioners to manage the COVID-19 pandemic*) was implemented; this entailed some streamlining of meetings and some postponement of non-urgent activity. This in turn meant some disruption to some of the routine risk management activity that would usually be completed on an annual basis; specifically, the Board Assurance Framework was not updated, and annual Board risk management training was not completed.

However, all risk management structures pertaining to the Level 4 incident were strengthened through the command structure detailed above. Risk-focused management meetings were maintained, as were all service line and corporate risk registers; and the assurance committee structure of the Board continued as usual, focused on the critical pillars of finance, workforce, quality and audit. Towards the end of 2020/21, the Trust invested in online risk management systems to further improve and strengthen the robustness of its risk and assurance reporting to Board.

The Trust continued to monitor all services and organisational performance to ensure continuity of business. Adaption was made to services and workforce provision to ensure key services were maintained. Key performance indicators on quality, safety and financial expenditure were maintained and reported as outlined above.

Workforce changes were made, including redeploying clinical staff to new areas and adopting home working where possible for areas such as corporate and support services. Where staff were redeployed to different or new areas, training and information were provided and updated if required.

To meet the demand for home working the Trust rapidly implemented a new and improved IT infrastructure system providing remote computer access and the ability to hold virtual patient consultations and team meetings.

Other business continuity issues such as the increased demand for intensive care areas and the increased use of oxygen have been met through the adaption of ward areas and the improvement in medical gas infrastructure.

### **The risk and control framework**

The Trust has a Risk Management Strategy and a Risk Management Policy, both of which are endorsed by the Trust Board. The Risk Management Strategy includes the Trust risk appetite statement and sets out the corporate and individual accountability for risk management as follows:

- The Trust Board's role in reviewing the management of extreme risks
- The Audit Committee's role in monitoring the effectiveness of the system for managing risks
- The roles of the Workforce, Finance and Quality Board committees in monitoring risks pertaining to their purpose.
- The Executive Management Committee role in moderating the scores of risks included on the Corporate Risk Register
- The Risk and Compliance Monitoring Group role in the review of risk registers and making recommendations to the Executive Management Committee

- The Chief Executive Officer's role as the person with overall responsibility for managing risk
- The responsibilities of each Executive Director in relation to specific areas of risk
- The requirement for Divisional and Service Delivery Unit leads, senior nurses and senior managers to carry out risk assessments, ensure that divisional staff are trained and competent to do the jobs asked, and to maintain essential services in times of emergency
- The responsibility for all staff to take reasonable care for their own safety and the safety of all others that may be affected by the Trust's business
- The scope and range of advice the Board and Trust staff can call upon

The Trust Risk Management Policy describes the process of risk identification and management which all staff are expected to follow. This includes explanation of risk assessment completion, organisational risk registers including the Corporate Risk Register, and the Board Assurance Framework.

Divisional and corporate risk registers are reviewed with divisional leads on a monthly basis at Risk & Compliance Monitoring Group and training is provided on an individual basis as requested or required. Health and Safety training is provided to appropriate individuals in teams across the Trust.

Risks are identified at service/ward/department level and recorded on their risk register. Risks scoring 9 or above are escalated to the Divisional Risk Register and are moderated at Divisional Board. Risks scoring 15 or above prior to mitigation are considered for inclusion on the Corporate Risk Register and this is monitored on a quarterly basis by Risk & Compliance Monitoring Group. Executive Management Committee moderates the Corporate Risk Register on a quarterly basis before it is reviewed at Trust Board Committees and Trust Board. Entries into the risk registers include description of the original risk, mitigating controls that have been taken, future actions planned to further mitigate the risk, and target dates for completion.

At the end of each Board Committee the Director for Governance summarises the risks that have been highlighted through reports received and discussions in the meeting; these are presented to Trust Board through the Board Committee Chair's reports.

All staff receive risk-related training as part of corporate induction upon joining the Trust, and annually as part of statutory training requirements. Line managers are responsible for ensuring their teams have fulfilled all statutory training requirements each year.

Additional advice on good practice can be obtained from a range of in house professional and specialist staff. Certain types of risk are also addressed via the engagement of external expertise. For example, the risk of fraud is managed and deterred via the appointment of an external Local Counter Fraud Specialist (LCFS).

As an organisation, clinical and corporate teams are encouraged to consider learnings relating to risk management both from internal and external sources, for example there are processes in place for sharing learnings both from reported incidents and clinical best practice, and a proportion of these will relate to how services predict and manage the elements of clinical and business risk that are a factor in the day-to-day delivery of healthcare services.

The Trust has an embedded learning culture through its work on excellence reporting which highlights key episodes of excellent work achieved by staff, the implementation of national clinical standards, the delivery of improvements from local and national clinical audits, the

Medical Examiner review of deaths process, and the focus on learning from all untoward incidents.

The risk management strategy also describes the Trust risk appetite statement. The Trust's current risk appetite statement was developed through an externally facilitated workshop and was approved by the Board in January 2021:

**The Trust recognises that its long-term sustainability depends upon the delivery of its strategic objectives and its relationships with its patients, staff, the public and strategic partners. As such, the Trust will not accept risks that materially impact on patient safety. However, the Trust has a greater appetite to take considered risks in terms of their impact on organisational issues. The Trust has greatest appetite to pursue innovation and challenge current working practices and reputational risk in terms of its willingness to take opportunities where positive gains can be anticipated, within the constraints of the regulatory environment.**

*Trust risk appetite statement, January 2021*

The Trust has an established Board Assurance Framework (BAF) through which the Board is provided with a mechanism for satisfying itself that its responsibilities are being discharged effectively; and informs the Board where the delivery of strategic objectives are at risk due to gaps in control and/or assurance.

Documented in the BAF are the levels of unmitigated risk, the controls put in place to minimise principal risks, and the residual risk. The BAF also seeks to give assurances that these controls are effective. Many of these controls are already well established in systems of working which reduce the likelihood of risks being realised.

Where gaps in control or assurance are identified, action plans with specific deadlines are developed and put into place. The BAF ensures that appropriate internal and external assurances are in place in relation to the management of all high-risk areas.

The BAF was not formally updated in 2020/21 although workshops were held in Quarter 4 to create the revised inputs into the BAF due to the changes brought about due to the pandemic. The Board will formally receive the post-pandemic BAF in quarter 1 2021-22.

Specific organisational and individual responsibilities for 2020/21 are detailed below.

#### *Trust Board*

The Board of Directors receives details of significant risks through regular Board reports. The finance report records all key financial risks. The performance report records all key operational risks and performance against key clinical quality outcomes. The Board actively encourages well-managed and -defined risk management, acknowledging that service development, innovation and improvements in quality require risk taking. This position is supported by the expectation that there is a demonstrated capability to anticipate and manage the relevant risks well. This approach is defined by the Board's risk appetite (see earlier).

The following changes to the Board took place during 2020/21:

- Rebecca Medlock, Board Affiliate, left on 24 February 2021 and Sandra Silva joined in her place
- Prof. Karol Sikora, Associate Non-Executive Director, left on 28 February 2021 and Mo Girach joined in his place
- Graeme Johnston, Non-Executive Director, left on 31 March 2021
- Prof. David Sines, Associate Non-Executive Director, left on 31 March 2021
- Dr Tina Kenny, Medical Director, left on 31 March 2021

### *Board Committees*

The Audit Committee has overall responsibility for ensuring effective risk management across the Trust. The Audit Committee receives the BAF and Corporate Risk Register (CRR). It is through these key processes the Committee is able to provide the Board with assurance on the robustness of the Trust's application its risk management processes. The other key Board Committees of Finance and Business Performance, Quality and Clinical Governance and the Strategic Workforce Committee regularly receive and consider the strength of assurance reflected within the risk management system and the actions being taken to manage risks.

### *Non-Executive Directors*

All Committees are chaired by a nominated Non-Executive Director. The Audit Committee, which has a pivotal role in providing assurance over the risk management processes of the Trust, has a membership of only Non-Executive Directors. Through the Non-Executive chairs and the Audit Committee membership, all have a responsibility to challenge robustly the effective management of risk and to seek reasonable assurance of adequate control.

### *Executive Directors*

Each Executive Director is responsible for a portfolio of services and has governance mechanisms in place for the delivery and risk management of that service.

The Chief Nurse is accountable for the development of strategic clinical risk and for ensuring there is a robust system in place for monitoring compliance with the Care Quality Commission (CQC) standards. They are also Director of Infection Prevention and Control for the Trust, and together with the Patient Safety Officer are responsible for managing patient safety, complaints, patient information and medical legal matters.

The Director of Finance oversees the adoption and operation of the Trust's Standing Financial Instructions including the rules relating to budgetary control, procurement, banking, losses and controls over income and expenditure transactions, and is the lead for counter fraud. The Director of Finance who attends the Audit Committee, but is not a member, liaises with internal audit, external audit and counter fraud services, who undertake programmes of audit with a risk-based approach.

The Medical Director is the Responsible Officer for Medical Revalidation.

The Chief Operating Officer is the Accountable Planning Emergency Officer for Emergency Preparedness, Resilience & Response (EPRR).

The Director of Strategy is the Senior Information Risk Owner (SIRO).

The Chief People Officer is accountable for the strategic management of the Trust's Workforce Strategy, Equality and Diversity compliance and employment processes.

The Commercial Director has delegated responsibility for the management of health and safety compliance and risk management.

The Director for Governance leads on the process for the strategic development and implementation of organisational risk management, communicating and escalating risk throughout the Trust, including recording the controls in place to manage risk and reporting on actions being taken to reduce risk to a reasonable level. The Director for Governance chairs the Risk & Compliance Monitoring Group which provides detailed oversight of the operational risks on behalf of the Executive Management Committee.

### *Executive Management Committee*

The Executive Management Committee reviews the BAF and CRR. The Committee is responsible for challenging the effectiveness of operational risk management, moderating risks to ensure consistency, and ensuring adequate controls are in place.

### **Quality governance arrangements**

The Trust's Quality Governance arrangements are managed via the Trust's Quality and Clinical Governance Committee (and its sub-committees) and via a number of associated systems and processes.

Clinical audit is supported by a central team, and the Quality and Clinical Governance Committee has received assurance on the design and delivery of the clinical audit programme through a range of clinical audit outcomes. The Committee has continued to challenge the organisation to provide greater assurance on closing the loop on identified audit actions.

The investigation of, and learning from, incidents are predominantly managed within Divisions and discussed at divisional and specialist clinical governance meetings. Serious Incidents are discussed and monitored at a corporate level via Executive-led internal Serious Incident approval panels which also has Clinical Commissioning Group (CCG) oversight.

To support learning there is a Serious Incident Learning Forum based on thematic analysis of incidents such as patient falls; in addition, further learning from serious events is widely shared at Academic Half Days. The Trust Board also receive Serious Incident reports at every meeting.

Complaints are managed by the central complaints team in partnership with the relevant Divisions. The rate of new complaints and percentage of complaints responded to within target are monitored regularly at Trust Board meetings.

The quality of performance information is primarily assessed via the Internal Audit programme. In 2020/21, the programme included review of the Trust processes for waiting list management, outpatients and medical flow.

Compliance with Care Quality Commission (CQC) registration requirements is ultimately assessed via inspections by the CQC, and the Trust was subject to such an inspection in the early part of 2019 (which resulted in an overall assessment of 'Good'). Quarterly engagement meetings have taken place with the CQC throughout 2020/21.

The Trust also monitors compliance with CQC registration requirements itself, primarily through a programme of in-house assurance visits/inspections. Such inspections, which are managed by the Clinical Governance and Corporate Nursing teams, also include patient representatives.

Our internal audit provider conducted a review of our governance around CQC requirements, reporting reasonable assurance in November 2020. Our CQC implementation group meetings were partially suspended this year due to the COVID-19 pandemic and as such routine reporting against the Trust-wide CQC action plan we developed following the last CQC inspection report in June 2019 was paused until Quarter 3. The audit reviewed our Perfect Ward inspections completed in June, July and August 2020, which include links to CQC regulations; it also reviewed against Regulation 9, 12 and 17. One action was recommended regarding implementing a review process for evidence before actions against CQC improvement plan are closed off.

We also have an annual comprehensive review of compliance with all relevant legislation, including CQC requirements. The process reviews and monitors progress against any gaps in compliance and provides the Trust Board with assurance. Each item of legislation has a managing lead who reviews and identifies any gaps in compliance; where any gaps are identified, an action plan to mitigate or resolve the gaps is described, along with details of how compliance is monitored and evidenced. The Executive lead then reviews and signs off the compliance and action plan where necessary. A process of peer review then takes place. This was completed in January 2021 and will be presented to the Board in May 2021.

The Ockenden review of maternity services at Shrewsbury and Telford Hospital NHS Trust was published on 10 December 2020. The Trust reviewed and submitted a response later that month, signed off by the Local Maternity System Chair and the Board Maternity Champion, to NHS England & Improvement, outlining the organisation's position against the immediate and essential actions. In January 2021, the Board reviewed a detailed Board Assurance Framework against all the actions detailed in the Ockenden review. A monthly maternity quality and performance meeting has been established from April 2021 to complement existing divisional reviews and quality meetings and the framework is under regular review at Board level.

The Integrated Performance Report is the Board level report that encompasses all key metrics of interest to the Board and the public regarding the performance of our acute and community healthcare services in terms of quality, workforce and finances. Over the past year, we have invested in external consultancy support to review and strengthen this report to ensure it provides a clear and comprehensive picture of the Trust's performance. The key metrics of the report are prepared by the Trust business intelligence function overseen by the Director of Performance and Planning. Executive leads then review and provide narrative to accompany the data. The report is produced bimonthly and presented at Trust Board in Public.

### **Management of risks to data security**

Risks to data security are managed and controlled through a range of methods, and the Trust undertakes an annual assessment against the Department of Health & Social Care, NHS England & Improvement ten data and cyber security standards which are published and monitored via the Data Security & Protection Toolkit. The annual submission of the Data Security & Protection Toolkit is monitored by the Trust Board and the latest assessment in March 2020 indicated a self-assessment of 'standards fully met'. The final submission date for 2020/21 has been extended from March to June 2021 to account for the pressure organisations are facing due to the COVID-19 pandemic.

Staff are empowered and encouraged to report all information security incidents, including those classed as 'near misses' in accordance with the Trust Risk Management Policy and Handling Reported Information Security Incidents Procedure and a confidential system for reporting information security breaches and near misses is in place and actively used. The Information Governance department has a role within the Trust to monitor, investigate and report on Information Security Incidents and, in conjunction with the Patient Safety Team, Board-level Senior Information Risk Owner and Caldicott Guardian, determine the severity status of incidents deemed as serious or potentially serious.

The Trust Caldicott Guardian is responsible for the establishment of procedures governing access to, and the use of, person-identifiable information and the transfer of that information to other bodies, where this is permitted. The Caldicott Guardian is supported by the Information Governance Manager and the Caldicott and Information Governance Committee, which monitors compliance with key legislation and the performance of the Trust through the Data Security & Protection Toolkit.

If an incident is a potential breach (under GDPR/DPA 18) it is triaged against the incident reporting system and guidance within the Data Security and Protection Toolkit. If the breach meets the threshold, incident details will be sent to the Information Commissioner's Office as the supervisory authority, and to the Department of Health & Social Care or NHS X, depending on the impact and nature.

### **Organisational major risks**

The major risks facing the organisation are as follows:

#### *Failure to consistently provide outstanding quality care that is compassionate, cost effective and safe*

This incorporates the risks associated with: inadequate staff resource; inability to control out of hospital demand; areas of digital immaturity; areas of aging estates infrastructure and links to infection prevention and control risks; gaps in learning; and the Trust's underlying financial deficit.

#### *Inability to generate surpluses, to fund capital development for investment in services*

This reflects risks linked to the Trust strategic financial plan, the burden of cost from the COVID-19 pandemic, variation in clinical productivity between services, structural financial challenges, commissioning gaps related to out of hospital demand, and gaps in workforce associated with the local cost of living and national workforce shortages in some professions.

#### *We do not recover services adequately, fail to meet public/regulator expectations, and do not play a leading role in the health, economic and social recovery of Buckinghamshire*

This reflects the Trust's ambitions as an anchor institution and make digital advances in managing whole population health and inequalities, as well as risks associated with the direct and indirect clinical harm caused by the COVID-19 pandemic, and necessary reforms to its urgent care pathway in anticipation of the future health needs of the local population.

#### *Inability to lead an organisation with the capacity and capability to deliver our best in everything we do*

This describes risks of the negative impact of the COVID-19 pandemic on staff morale, wellbeing and retention, changes in the integrated care system following publication of the government white paper in early 2021, variations in organisational culture, behaviours and inclusivity, and suboptimal use of data and business intelligence resources.

Actions to mitigate and address these risks will be described in the Trust 2021/22 Board Assurance Framework and are being managed through the Trust's governance processes.

### **Well-led**

The Trust is currently rated as Requires Improvement by the CQC/NHSI for the Well-led and Use of Resources domain. An external assessment of the Board pertaining to the Well-led domain and the Board's effectiveness will be procured in Quarter 1 2021-22 and completed in the first half of the year.

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

In May 2019 the Trust received enforcement action by NHSI FT4(5)(a), (b) and (d) due to the state of its finances at the time. The Trust met with NHSE/I through undertakings meetings throughout 2019/20 and succeeded in meeting the financial requirements set and achieving its revised financial plan.

Following correspondence from NHSE/I, a meeting took place on 05 May 2021 at which NHSE/I agreed to recommend the Trust's undertakings to be removed. The formal certification of this cannot be confirmed by the regulator until a scheduled meeting of the Regional Support Group (RSG) in early June, after the 31 May 2021 self-certification deadline. NHSE/I has agreed that verbal assurance given at the meeting on 05 May 2021 is sufficient for the Trust to certify compliance accordingly.

### **Embedding risk management in the organisation**

As noted earlier in this Statement, risks are identified, analysed and controlled in accordance with the Trust's Risk Management Policy, and a range of supporting systems and processes are in place to embed risk management activity. For example:

- The Trust's mandatory induction and ongoing training programme for all staff reflects the need for staff to have a sound basis in managing risks relating to Information Governance, Infection Prevention and Control, Fire Safety, Safeguarding Children and Vulnerable Adults, Health and Safety and Manual Handling
- Incident reporting is openly encouraged across the Trust, and lessons learned from incident investigations are disseminated, discussed and promoted.
- The Staff Support Handbook shares messaging that incident reporting is important, linking it to the Trust CARE values. It states that the Board and senior management have an expectation that incidents are reported, and that as part of the process, the Trust offers a commitment to support an environment where we can all collaborate on creating solutions and improvements.
- The potential to learn from incidents is highlighted in inductions and in shared learning through academic half day forums, lessons learned events, and through groups and committees which focus on quality, emphasising the value of incident reporting as useful data intelligence to support safety improvements.
- The Patient Safety Team has robust communication lines with Executives and also the Director of Medical Education, and the Freedom to Speak Up Guardian to ensure that conditions where staff feel safe to report incidents are fostered and maintained.
- Increasingly the role of Safety II is being incorporated into patient safety discussions throughout the trust, recognising the value of learning from what is done well through appreciative inquiry and excellence reporting.
- Emergency preparedness systems are in place to ensure the Trust is able to respond, take action to control and mitigate risks at Service Delivery Unit (SDU), Divisional and organisational levels.
- Risk is regularly discussed at a wide range of forums, including the Trust Board and its sub-committees (which set the tone for discussions at Divisional-, and departmental-level forums).
- Within each clinical division there are management teams in SDUs supported by clinical governance leads managing the risk in accordance with the Trust's Risk Management Policy and Procedure.
- Risk management is incorporated into the Trust's planning arrangements and Quality Impact Assessment (QIA) process, which is overseen by the Medical Director and Chief Nurse.
- Equality impact assessments form part of every Trust policy and business case, and a consideration of the possible impact or implications for equality are captured in every report presented at Executive Management Committee or the Board.

### **Workforce strategies**

The Trust complies with the 'Developing Workforce Safeguards' recommendations via the following methods:

- A bi-annual review of safe staffing levels is led by the Chief Nurse. The reviews follow the National Quality Board's 2016 guidance and cover the three necessary components: evidence-based tools, professional judgement and quality outcomes. During the Level 4 incident this has been replaced with more frequent review of workforce deployment linked to the Trust's emergency response.
- Individual risk assessments were completed for all staff in 2020/21, both clinical and non-clinical, in line with national requirements. A process is in place for Occupational Health to particularly support those declared as high risk, and mitigations are discussed and agreed with the individual and their manager to ensure their ongoing safety at work. There is now an ongoing programme for new starters and rotating junior doctors to complete these risk assessments and ensure they remain under review.
- COVID-19 vaccinations have been offered to all staff in line with national guidance and there is a rolling programme to offer to new starters. A range of support has also been offered to help ensure individuals have access to the relevant information and clinical advice about the vaccination, including regular webinars with clinical experts open to all.
- Recognising the enormous impact of the COVID-19 pandemic on staff physical health, mental health and wellbeing, the Trust put a significant focus on its health and wellbeing offering in 2020/21, including a winter care pack posted to every individual, pro-active mental health support in partnership with the Trust clinical psychologists for those experiencing the most extreme pressures (e.g. those redeployed and/or working in critical care), increasing availability of rest areas on-site, and delivering subsistence to staff working areas.
- The people strategies for the Integrated Care System and the Trust were revisited and updated in 2020/21 to reflect the impact of the COVID-19 pandemic on colleagues and the NHS People Plan published in July 2020. Towards our ambition for the organisation to be a great place to work, our priorities focus on: recruitment and resourcing; culture and leadership; supporting our staff; workforce development and planning; and releasing time to care (workforce productivity).
- All service changes including those related to skill mix and the introduction of new roles are subject to a Quality Impact Assessment (QIA) process led by the Medical Director and Chief Nurse
- The Trust Board reviews all workforce metrics on a bi-monthly basis and does so as part of its wider review of quality, safety, performance and finance metrics, to ensure that workforce challenges and risks are understood as part of the wider context of service delivery.
- Where there are critical service risks in relation to staffing and the safe delivery of care these, along with their associated mitigations are escalated to the Trust Board and external regulators as required.
- The Trust has a range of mechanisms in place for staff to raise concerns which includes accessing the Freedom To Speak Up Guardian or by contacting the named Non-Executive Director for Whistleblowing. The Trust also has a Guardian of Safe Working Hours in post for medical staff to raise concerns. Regular reports from both Guardians have been received at Board level in 2020/21.

The Trust is fully compliant with the registration requirements of the Care Quality Commission. In 2019/20 the Trust was awarded an overall rating of 'Good' by the Care Quality Commission (CQC) and 'Outstanding' for Caring.

The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the trust with reference to the guidance) within the past twelve months, as required by the *'Managing Conflicts of Interest in the NHS'* guidance.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The Trust's Public Sector Equality Duty publication is available on the Trust website and control measures are in place to ensure the Trust meets and complies with all its obligations under the equality, diversity and human rights legislation.

The Board supports supported the creation of four staff networks: Black, Asian, Minority Ethnic (BAME), Disability, LGBTQ+ (Lesbian, Gay, Bisexual, Transgender, Queer) and Spirituality.

In October 2020 the Board approved the Trust's annual Workforce Race Equality Standard and Workforce Disability Equality Standard action plans, designed to ensure the Trust progresses its aspiration to be an inclusive and compassionate organisation. Data from internal workforce processes and the national staff survey informed the key areas to address and from these the following goals were identified:

- A culture of inclusion and zero tolerance to discrimination
- Equality of experience and opportunity for all staff at the Trust
- Better accountability and ownership of the plan across the Trust

The specific targets for each set as follows:

- WRES:
  - The ethnic make-up of our Board and senior leaders will be 24% BAME, reflecting that of our workforce by 2022
  - There will be no inequality in our recruitment processes for BAME applicants by the end of 2021
- WDES:
  - There will be no inequality in recruitment for disabled applicants by end of 2021
  - All disabled staff will be provided with reasonable adjustments where needed by end of 2022

Internal Audit undertook a review of the Trust's Equality & Diversity during 2020/21 and this received substantial assurance. The cover sheets for all Executive Management Committee and Board reports include a section for the author to make members aware of any equality impacts or implications. Training has been provided to senior leaders and managers on the importance of ensuring equality matters are considered in all reports and recorded. All Trust policies include an equality impact assessment, as do business cases where relevant.

### **Review of economy, efficiency and effectiveness of the use of resources<sup>1</sup>**

The Trust is required to demonstrate that it achieves value for money for taxpayers by demonstrating economy, efficiency and effectiveness in the use of the resources available. The majority of the services we provide are commissioned by other NHS organisations and Local Authorities, accounting for approximately 91.7% of total income. Within the

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<sup>1</sup> Financial figures quoted in this section are subject to review by external audit.

prices that we are paid for most of this activity, (known as the tariff), there is the in-built national assumption that we will make efficiency savings.

In 2020/21 the Trust delivered a break-even position which includes £29.4m of COVID-19 funding. This compares to a deficit £29m outturn in 2019/20. To control COVID-19 spend and ensure value for money whilst also operating in a more flexible and agile way, comprehensive processes and financial governance arrangements have been implemented, with COVID-19 expenditure reported through the Trust's governance.

The 2020/21 outturn included the achievement of £8.1m of efficiency plans. This was £3m behind plan, primarily as a result of the impact of the COVID-19 pandemic on the Trust's capacity to focus on cost improvement schemes, as well as the impact of COVID-19 on the viability of some schemes. However, despite the pandemic, the Trust has continued to focus on efficiency, with examples below:

- Over twenty deep dives have been undertaken to analyse productivity and efficiency of services based on benchmarking against peers, with priority areas currently being progressed to make improvements.
- Embedding quality improvement continues to be central focus, with quality improvement huddles being implemented as part of a continuous improvement system, alongside a programme to build capabilities to enable all staff to make quality improvements which also result in waste reduction.
- Transformation programmes are now well defined with a focus on new models of service delivery which will contribute to financial sustainability alongside improvements in patient care and quality. This forms a focus for the 2021-22 efficiency plan which is based on fewer larger schemes.
- Management of business cases has been strengthened to support rigorous decision-making around investment and monitoring of return on investment.

In terms of capital, the Trust spent its full £71.3m capital allocation for 2020/21 which has enabled substantial modernisation of its IT infrastructure (mobile working, telephony, data centres, integrated network) and its estates (Same Day Emergency Centre, Innovation Centre, Paediatric ED, improved resilience in core infrastructure) as well as medical equipment enhancements.

The Trust's governance provides assurance regarding the use of resources, with regular scrutiny by the Executive Management Committee, Capital Management Group, Finance and Business Performance Committee, Audit Committee and Trust Board. A new Executive-level Transformation Board has also been established during 2020/21 to provide assurance that transformation plans are delivered successfully and that associated benefits relating to quality, people and money are realised. Governance for divisional performance, including financial performance, has also been strengthened during the year, with the establishment of monthly Performance, Quality and Financial Review meetings.

The Trust's external auditors are required to provide an opinion on whether they are satisfied that, in all significant respects, the Trust has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2021. The draft internal audit opinion is that the organisation has an adequate and effective framework for risk management, governance and internal control; however, further enhancements to the framework have been identified to ensure that it remains adequate and effective. Seven reports have been issued with reasonable (positive) opinion, including 'Key financial controls'; one with substantial positive assurance; four with partial assurance relating to: IT Procurement – Asset Tracking; Sickness Absence Management; Property Services Risk Management; and Financial Governance – Part Two; with no report receiving

an opinion of 'no assurance'. The details of these reports have been considered at the Audit Committee who also monitor implementation of actions to address identified weaknesses.

The 2021/22 budget has been agreed provisionally with a provisional full year deficit of £44m deficit, which includes £16m efficiencies. This plan is currently being revised following the issue of national planning guidance. This remains a challenging plan and will be subject to further Board discussion as the Trust understands the full impact of delivering business as usual alongside recovery within the ongoing context of COVID-19.

### **Information governance**

Any serious incidents that meet the required threshold are reported up to the Information Commissioner's Office via the Data Security & Protection Toolkit. For the period 2020/21 there were three serious incidents which were notified to the Information Commissioner's Office (ICO). These involved: a patient being given a discharge form belonging to another patient, with the ICO decision being no further action required; an email sent which contained some addresses and email addresses of other patients; and a patient file being found in a public area; the latter two are both under consideration by the ICO.

### **Data quality and governance**

The following processes are in place to assure the quality and accuracy of elective waiting time data (and to manage the risks to such quality and accuracy):

- The Trust has an 'Elective Care Access Policy and Procedure', which encompasses Standard Operational Procedures for waiting list management at all stages of a referral to treatment pathway. The Policy also states the responsibilities of key staff, including those for auditing data quality.
- The Trust also has a 'Data Quality Policy and Procedure', which describes the Trust's general approach to data quality, including the role of the Data Quality Group.
- There is a weekly validation process involving operational, management and information leads, to assure the quality of local and national waiting times including the Referral to Treatment 18-week pathway (RTT) reporting/data is up to date and correct.
- There is a regular checking process in place for RTT patients, who have been removed from the waiting list, following a non-patient interaction (validation). This is to assure data quality and pinpoint opportunities to focus on improvements or training that will provide continued alignment with the Access policy.
- For cancer, patient level information is reviewed daily as part of multi-disciplinary team meetings and tracing processes to support patient pathway management. A similar process to the RTT is used to manage waiting lists and patients on the cancer pathways.
- Over the past year much of the Trust's elective activity was paused in line with national guidance; during this time patients were reviewed for risk of clinical harm and prioritised accordingly. Due to the volume of patients impacted during the pandemic, the Trust is currently managing significant waiting lists and clinical teams across specialties are working together closely to ensure patients continue to be prioritised appropriately and the risk of clinical harm minimised, maximising use of independent sector capacity where possible.
- This year's internal audit programme included a review of the Trust's waiting list management and this received 'reasonable assurance'. The audit found that key performance indicators were being adequately reported and reviewed internally regularly. Three medium priority actions were recommended as follows: identifying training gaps and providing training where non-compliant; establishing a go live data for electronic Waiting List Care to be fully embedded; formally documenting actions for Access Performance Management Group meetings.

## **Review of effectiveness**

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee, the Finance & Business Performance Committee, the Quality & Clinical Governance Committee, and the Strategic Workforce Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Head of Internal Audit Opinion for 2020/21 states that “the organisation has an adequate and effective framework for risk management, governance and internal control. However, our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective”.

The last sentence of the Opinion reflects the fact that five reports undertaken by Internal Audit in 2020/21 have been issued with ‘partial assurance’ opinions; these were: IT Procurement – Asset Tracking; Sickness Absence Management; Property Services Risk Management; Finance Governance – Part Two; and Paediatrics - Education, Health and Care Plan. In each case the explanation for this opinion and recommended actions to strengthen the control framework have been considered by Audit Committee, and regular reports from internal audit allow the Committee to monitor the implementation and completion of these actions.

The Audit Committee approves the Internal Audit plan for the year and receives details of the findings from each of the Internal Audit reviews that are undertaken. Summary reports of relevant Internal Audit reviews are also submitted to the Executive Management Committee during the year.

## **Significant internal control issues**

The following significant internal control issues have been identified in 2020/21:

In May 2019, due to concerns about financial governance, NHS England & Improvement (NHSE/I) moved the Trust from Segment 2 to Segment 3 under the Single Oversight Framework; in response to this change, a series of ‘Undertakings’ meetings to assist the Trust in improving its financial position were established. The Trust received significant support from NHSE/I throughout 2019/20 and succeeded in meeting the financial requirements set and achieving its revised financial plan. Following correspondence from NHSE/I, a meeting took place on 05 May 2021 at which NHSE/I agreed to recommend the Trust’s undertakings to be removed. The formal certification of this cannot be confirmed by the regulator until a scheduled meeting of the Regional Support Group (RSG) in early June, after the 31 May 2021 self-certification deadline. NHSE/I has agreed that verbal assurance given at the meeting on 05 May 2021 is sufficient for the Trust to certify compliance accordingly.

Like almost all NHS providers, demand for services in excess of available capacity coupled with challenges associated with managing COVID-19 pressures drove non-compliance

against some regulatory standards in 2020/21. Our performance against the Accident & Emergency 4-hour target of 95% was 83.5%, and we were non-compliant with the Referral To Treatment Standards.

In 2020/21, the Trust reported three Never Events as follows:

- Wrong site biopsy (October 2020): this involved a biopsy of a patient's kidney where the left sided lesion was requested, but the right sided kidney was biopsied mistakenly.
- Retained foreign object in surgery (October 2020): this involved a patient who experienced an emergency return to theatre due to their deteriorating condition following complex surgery, which took many hours longer than would be expected for such a procedure. Following post-surgery symptoms, the closed surgical incision was re-opened, and a swab was located inside the wound.
- Unintentional connection of patient to air instead of oxygen (February 2021). Unusually for this category of Never Event, the patient had disconnected themselves from an oxygen cylinder and onto what they thought to be a piped oxygen outlet on the wall, but which was actually a medical air supply portal, adjacent to the oxygen supply.

### Conclusion

The significant internal control issues which have been identified in 2020/21 are described above.

Signed



Date:

17<sup>th</sup> May 2021

Neil Macdonald  
Chief Executive

**Meeting:** Trust Board Meeting in Public

**26 May 2021**

|                              |   |
|------------------------------|---|
| <b>Agenda item</b>           | Self-certification  |
| <b>Board Lead</b>            | Neil Macdonald, Chief Executive   |
| <b>Type name of author</b>   | Chloe Powell, CEO Business Manager  |
| <b>Attachments</b>           | Self-certification Condition G6 completed template and evidence pack<br>Self-certification FT4 completed template and evidence pack |
| <b>Purpose</b>               | Approval  |
| <b>Previously considered</b> | EMC 27 April 2021; Audit Committee 06 May 2021  |

### Executive Summary

The Trust is required by the Secretary of State to self-certify that it can meet the obligations set out in the NHS Provider Licence (which itself includes compliance with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009 and the Health and Social Care Act 2012, and having regard to the NHS Constitution) and that it has complied with governance requirements.

The aim of self-certification is for providers to provide assurance that they are compliant with the conditions.

Although not an NHS Foundation Trust, all NHS Trusts are legally subject to the equivalent of certain Provider Licence conditions.

The attached completed templates and evidence packs confirms our compliant areas with the relevant requirements of the NHS Provider Licence.

Following correspondence from NHSE/I, a meeting took place on 05 May 2021 at which NHSE/I agreed to recommend the Trust's undertakings to be removed. The formal certification of this cannot be confirmed by the regulator until a scheduled meeting of the Regional Support Group (RSG) in early June, after the 31 May 2021 self-certification deadline. NHSE/I has agreed that verbal assurance given at the meeting on 05 May 2021 is sufficient for the Trust to certify compliance accordingly.

Audit Committee members requested that we make clear that the Trust is declaring compliance as 'Confirmed' against FT4, pending receipt of the External Audit value for money opinion.

|                 |  |
|-----------------|--|
| <b>Decision</b> | The Board is requested to approve the self-certification for publication on the Trust website. |
|-----------------|--|

### Relevant strategic priority

|                  |                 |                |
|------------------|-----------------|----------------|
| <b>Quality</b> ☒ | <b>People</b> ☒ | <b>Money</b> ☒ |
|------------------|-----------------|----------------|

### Implications / Impact

|  |  |
|--|--|
| <b>Patient Safety</b>  | Governance regarding clinical and patient safety is described in the AGS.    |
| <b>Risk: link to Board Assurance Framework (BAF)/Risk Register</b> | The Trust risk management process is referred to in the attached document    |
| <b>Financial</b>   | The Trust financial process are referred to in the attached document         |
| <b>Compliance CQC Standards Good Governance</b>                    | The attached document meets the Trusts statutory requirements                |
| <b>Partnership: consultation / communication</b>                   | Internal and External Auditors are asked to comment on the attached document |
| <b>Equality</b>  | Equality issues are highlighted in the report                                |

**1 Introduction.**

As laid out in ‘Self-certification: guidance for NHS foundation trusts and NHS trusts’, “the annual self-certification provides assurance that NHS providers are compliant with the conditions of their NHS provider licence. Compliance with the licence is routinely monitored through the Single Oversight Framework but, on an annual basis, the licence requires NHS providers to self-certify as to whether they have:

- a) effective systems to ensure compliance with the conditions of the NHS provider licence, NHS legislation and the duty to have regard to the NHS Constitution (condition G6);
- b) complied with governance arrangements (condition FT4); and
- c) for NHS foundation trusts only, the required resources available if providing commissioner requested services (CRS) (condition CoS7).”

“Although NHS trusts do not need to hold a provider licence, directions from the Secretary of State require NHS Improvement to ensure that NHS trusts comply with conditions equivalent to those in the licence as it deems appropriate.”

**2 Condition G6**

- Condition G6(2) requires NHS providers to have processes and systems that:
  - identify risks to compliance with the licence, NHS acts and the NHS Constitution
  - guard against those risks occurring.
- Providers must complete a self-certification after reviewing whether their processes and systems were implemented in the previous financial year and were effective (condition G6(3)).
- Providers must publish their self-certification by 30 June (condition G6(4)).

**3 Condition FT4**

- Condition FT4 is about systems and processes for good governance. NHS providers must make a corporate governance statement under condition FT4(8) as to current and future compliance with condition FT4.
- Before making the statement, providers should review whether their governance systems and processes enable them to achieve compliance with condition FT4. There is no set approach, but we expect any compliant approach to involve a review of the effectiveness of board and committee structures, reporting lines and performance and risk management systems.

**4 Requirements and timelines**

NHS Providers need to self-certify the following conditions after the financial year end:

|                  |   |            |
|------------------|---|------------|
| Condition G6(3)  | The provider has taken all precautions to comply with the licence, NHS acts and NHS Constitution. | By 31 May  |
| Condition G6(4)  | Publication of condition G6(3) self-certification.  | By 30 June |
| Condition FT4(8) | The provider has complied with required governance arrangements.                                  | By 30 June |

Templates are provided to assist with our self-certification process, and the recommendation is to supplement with a process for supporting the declarations contained within. We are not required to return the templates to NHS England & Improvement unless specifically asked to do so; however, we publish our self-certification on our Trust website annually.

## **5 Recommendation**

Following correspondence from NHSE/I, a meeting took place on 05 May 2021 at which NHSE/I agreed to recommend the Trust's undertakings to be removed. The formal certification of this cannot be confirmed by the regulator until a scheduled meeting of the Regional Support Group (RSG) in early June, after the 31 May 2021 self-certification deadline. NHSE/I has agreed that verbal assurance given at the meeting on 05 May 2021 is sufficient for the Trust to certify compliance accordingly.

The Trust Board is asked to support the proposed:

- Condition G6 is formally signed-off as "Confirmed".
- Condition FT4 is formally signed off as "Confirmed".

## **APPENDICES**

Self-certification Condition G6 completed template and evidence pack

Self-certification FT4 completed template and evidence pack

This template may be used by Foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS Provider Licence.  
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

## Self-Certification Template - Conditions G6 and CoS7

Buckinghamshire Healthcare NHS Trust

*Insert name of organisation*



Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

*Systems or compliance with licence conditions - in accordance with General condition 6 of the NHS provider licence*

*Availability of resources and accompanying statement - in accordance with Continuity of Services condition 7 of the NHS provider licence (Foundation Trusts designated CRS providers only)*

These self-certifications are set out in this template.

### **How to use this template**

- 1) Save this file to your Local Network or Computer.
- 2) Enter responses and information into the yellow data-entry cells as appropriate.
- 3) Once the data has been entered, add signatures to the document.

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

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

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

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

**3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)**

**EITHER:**

3a After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. Not required

**OR**

3b After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services. Not required

**OR**

3c In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate. Not required

**Statement of main factors taken into account in making the above declaration**

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

In May 2019 the Trust received enforcement action by NHSI FT4(5)(a), (b) and (d) due to the state of its finances at the time. The Trust met with NHSE/I through undertakings meetings throughout 2019/20 and succeeded in meeting the financial requirements set and achieving its revised financial plan. Following correspondence from NHSE/I, a meeting took place on 05 May 2021 at which NHSE/I agreed to recommend the Trust's undertakings to be removed. The formal certification of this cannot be confirmed by the regulator until a scheduled meeting of the Regional Support Group (RSG) in early June, after the 31 May 2021 self-certification deadline. NHSE/I has agreed that verbal assurance given at the meeting on 05 May 2021 is sufficient for the Trust to certify compliance accordingly.

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

**Signature**

**Signature**

Name: Hattie Llewelyn-Davies

Name: Neil Macdonald

Capacity: Chair

Capacity: Chief Executive

Date:

Date:

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

## PROVIDER LICENCE – EVIDENCE OF COMPLIANCE

The provider has taken all precautions necessary to comply with the licence, NHS Acts and the NHS Constitution (Condition G6 (3))

| Licence condition         |   | Level of compliance | Evidence / Board assurance   | Comment where non-compliant or at risk of non-compliance and required action | Completion date |
|---------------------------|---|---------------------|--|--|-----------------|
| <b>GENERAL CONDITIONS</b> |   |                     |  |  |                 |
| G1                        | This condition requires licensees to provide (Monitor) NHSE/I with any information they may require for licensing functions.  | Compliant           | BHT has robust data collection and validation processes and has a good track record of producing and submitting large amounts of accurate, complete and timely information to regulators and other third parties to meet specific requirements.<br><br>Compliance confirmed as part of external CQC inspection in March 2019.  | N/A  | N/A             |
| G2                        | This condition contains an obligation for all licensees to publish such information as (Monitor) NHSE/I may require, in a manner that is made accessible to the public. | Compliant           | The Trust is committed to operating in an open and transparent manner and has robust governance arrangements to ensure that required information is made accessible to the public.<br><br>The Board meets in public and will continue to undertake the majority of Trust business in public meetings; agendas, minutes and associated papers are published on our website.<br><br>Our website contains a variety of information providing advice to the public and referrers who may require further information about services.<br><br>Copies of the Trust's Annual Report and Accounts and Quality Account are published on the website and the Trust operates a publication scheme for Freedom of Information requests. | N/A  | N/A             |
| G3                        | Payment of fees to (Monitor) NHSE/I   | N/A                 | <b>The Health &amp; Social Care Act 2012 ("The Act") gives (Monitor) NHSE/I the ability to charge fees and this condition obliges licence holders to pay fees to NHSE/I if requested.</b>  | N/A  | N/A             |

| Licence condition |   | Level of compliance | Evidence / Board assurance  | Comment where non-compliant or at risk of non-compliance and required action | Completion date |
|-------------------|---|---------------------|---|--|-----------------|
|                   |   |                     | <p>No requirements have been made by NHSE/I to charge fees. However, the obligation to pay fees is a condition and will be accounted for if necessary within the Trust's financial planning.</p> <p>The Trust pays fees annual to other parties such as the Care Quality Commission and NHS Resolution.</p>   |  |                 |
| G4                | Fit and proper persons as Governors and Directors (also applicable to those performing equivalent or similar functions) | Compliant           | <p>All employment contracts contain a clause concerning possible termination in the event of gross misconduct. The Trust disciplinary policy defines misconduct.</p> <p>The Trust operates a rolling programme of Disclosure &amp; Barring Service (DBS) checks for front line staff and for staff with access to sensitive information. The Board of Directors are subject to DBS checks on appointment and every 3 years thereafter.</p> <p>The Board of Directors adhere to a Code of Conduct that identifies expected standards of behaviour which includes clear references to the new FPP regulation.</p> <p>The constitution contains relevant clauses for governors and directors about eligibility, disqualification and removal.</p> <p>Non-Executive (via NHSE/I) and Executive Directors are required to sign an annual declaration that they remain a Fit and Proper Person (FPP).</p> <p>Compliance with the FPP Regulations confirmed as part of CQC inspection in March 2019.</p> | N/A  | N/A             |
| G5                | Having regard to (Monitor) NHSE/I guidance  | Compliant           | <p><b>This condition requires licensees to have regard to any guidance that NHSE/I issues.</b></p> <p>The Trust has had regard to NHSE/I guidance through the implementation of everything in the 'Reducing the burden' report.</p>   |  |                 |
| G6                | Systems for compliance with licence conditions  | Compliant           | <p><b>This requires providers to take all reasonable precautions against the risk of failure to comply with the licence and other important requirements.</b></p>   | N/A  | N/A             |

| Licence condition |   | Level of compliance | Evidence / Board assurance   | Comment where non-compliant or at risk of non-compliance and required action | Completion date |
|-------------------|---|---------------------|--|--|-----------------|
|                   | and related obligations                           |                     | <p>The Trust has an approved Risk Management Policy and a clear approach to identifying, managing, escalating and mitigating risk.</p> <p>The Board, Board Committees, and Executive management Committee monitors risk across the organisation.</p> <p>Internal and External Audit report on regulatory compliance.</p>   |  |                 |
| G7                | Registration with the Care Quality Commission     | Compliant           | <p><b>This licence condition requires providers to be registered with the Care Quality Commission and to notify NHSE/I if registration is cancelled.</b></p> <p>The Trust has full registration of all services with the CQC. The Trust was rated Good in March 2019 by the CQC.</p>   | N/A  | N/A             |
| G8                | Patient eligibility and selection criteria        | Compliant           | <p><b>This condition requires licence holders to set transparent eligibility and selection criteria for patients and to apply these in a transparent manner.</b></p> <p>The Trust publishes descriptions of the services it provides and who the services are for on the Trust website.</p> <p>Eligibility is defined through commissioners' contracts.</p> <p>Assurance is gained through the assessment stages to ensure that the appropriate services are provided.</p>   | N/A  | N/A             |
| G9                | Application of Section 5 (Continuity of Services) | Compliant           | <p><b>This condition applies to all licensees. It sets out the conditions under which a service will be designated as a Commissioner Requested Service.</b></p> <p>Licensees are required to notify NHSE/I at least 28 days prior to the expiry of a contractual obligation if no renewal or extension has been agreed.</p> <p>Licensees are required to continue to provide the service on expiry of the contract until NHSE/I issues a direction to continue service provision for a specified period or is advised otherwise.</p> <p>Services shall cease to be Commissioner Requested Services (CRS) if:</p> | N/A  | N/A             |

| Licence condition         |                          | Level of compliance | Evidence / Board assurance  | Comment where non-compliant or at risk of non-compliance and required action | Completion date |
|---------------------------|--------------------------|---------------------|---|--|-----------------|
|                           |                          |                     | <ul style="list-style-type: none"> <li>commissioners agree in writing that there is no longer a service need and the regulator has issued a determination in writing that the service is no longer a CRS;</li> <li>three years have elapsed since the 1 April 2013 or one year has elapsed since the commencement of the license, whichever is the latter; or</li> <li>the contract to provide a service has expired and the direction notice issued by NHSI specifying a further period of provision has expired.</li> </ul> <p>Licensees are required under this Condition, to notify NHSI of any changes in the description and quantity of services which they are under contractual or legal obligation to provide. Similar to the previous Mandatory Services, Commissioner Requested Services continue to be set within the contracts agreed with commissioners.</p> <p>The Trust has strong working relationships with its commissioning partners within the local health and social care system.</p> <p>The Board has a director responsible for leading on contract negotiations.</p> |  |                 |
| <b>PRICING CONDITIONS</b> |                          |                     |   |  |                 |
| P1                        | Recording of information | Compliant           | <p><b>Under this condition, NHSE/I may oblige licensees to record information, particularly information about their costs, in line with guidance to be published by (Monitor) NHSE/I.</b></p> <p>The Trust records all of its information about costs in line with current guidance and will comply fully with any new guidance.</p>  | N/A  | N/A             |
| P2                        | Provision of information | Compliant           | <p><b>Having recorded the information in line with Pricing condition 1 above, licensees can then be required to submit this information to NHSE/I.</b></p> <p>The Trust will comply fully with any new requirements to submit information to NHSE/I.</p>  | N/A  | N/A             |

| Licence condition                        |   | Level of compliance | Evidence / Board assurance  | Comment where non-compliant or at risk of non-compliance and required action | Completion date |
|--|---|---------------------|---|--|-----------------|
| P3                                       | Assurance report on submissions to (Monitor) NHSE/I           | Compliant           | <p><b>When collecting information for price setting, it will be important that the submitted information is accurate. This condition allows NHSE/I to oblige licensees to submit an assurance report confirming that the information that they have provided is accurate.</b></p> <p>The Audit Committee receives and monitors all Internal Audit reports including any specific reports on pricing.</p>  | N/A  | N/A             |
| P4                                       | Compliance with the National Tariff                           | Compliant           | <p><b>The Health and Social Care Act 2012 requires commissioners to pay providers a price which complies with, or is determined in accordance with, the National Tariff for NHS health care services. This licence condition imposes a similar obligation on licensees, i.e. the obligation to charge for NHS health care services in line with the National Tariff.</b></p> <p>The Trust follows national guidance which is consistent with the NHS payment system, with a value-based commissioning contract where variable payments are related to outcomes or activities.</p> | N/A  | N/A             |
| P5                                       | Constructive engagement concerning local tariff modifications | Compliant           | <p><b>The Act allows for local modifications to prices. This licence condition requires licence holders to engage constructively with commissioners, and to try to reach agreement locally, before applying to NHSE/I for a modification.</b></p> <p>The Trust will follow national guidance which is consistent with the NHS payment system, with a value based commissioning contract where variable payments are related to outcomes or activities.</p>  | N/A  | N/A             |
| <b>CHOICE AND COMPETITION CONDITIONS</b> |   |                     |   |  |                 |
| C1                                       | The right of patients to make choices                         | Compliant           | <p><b>This condition protects patients' rights to choose between providers by obliging providers to make information available and act in a fair way where patients have a choice of provider. This condition applies wherever patients have a choice under the NHS Constitution, or where a choice has been conferred locally by commissioners.</b></p> <p>The Trust complies fully with all guidance in relation to patient choice.</p>   | N/A  | N/A             |

| Licence condition                        |   | Level of compliance | Evidence / Board assurance   | Comment where non-compliant or at risk of non-compliance and required action | Completion date |
|--|---|---------------------|--|--|-----------------|
| C2                                       | Competition oversight                                   | Compliant           | <p><b>This condition prevents providers from entering into or maintaining agreements that have the object or effect of preventing, restricting or distorting competition to the extent that it is against the interests of health care users. It also prohibits licensees from engaging in other conduct that has the effect of preventing, restricting or distorting competition to the extent that it is against the interests of health care users.</b></p> <p>All licensed provider organisations will be treated as ‘undertakings’ under the terms of the Competition Act 1998. This means that all licensed providers will be deemed to be organisations engaging in an ‘economic activity’ for which the provisions of the Competition Act will apply. Licensed providers therefore need to comply with the Competition Act.</p> <p>The Trust Board and Executive Management Committee have access to expert advice to ensure compliance with this condition.</p> | N/A  | N/A             |
| <b>INTEGRATED CARE CONDITION</b>         |   |                     |  |  |                 |
| IC1                                      | Provision of integrated care                            | Compliant           | <p><b>The licensee shall not do anything that could reasonably be regarded as detrimental to enabling integrated care.</b></p> <p>The Trust is an active participant and leader in the local health and social care economy across the Buckinghamshire Integrated Care Partnership, and the Buckinghamshire, Oxfordshire &amp; Berkshire West Integrated Care System, and is working with partners to take forward models of integrated care.</p> <p>The Trust has a strong track record of working on integrated care pathways with other health and social care providers.</p>   | N/A  | N/A             |
| <b>CONTINUITY OF SERVICES CONDITIONS</b> |   |                     |  |  |                 |
| CoS1                                     | Continuing provision of Commissioner Requested Services | Compliant           | <p><b>This condition prevents licensees from ceasing to provide Commissioner Requested Services, or from changing the way in which they provides Commissioner Requested Services, without the agreement of relevant commissioners.</b></p>   | N/A  | N/A             |

| Licence condition |  | Level of compliance | Evidence / Board assurance   | Comment where non-compliant or at risk of non-compliance and required action | Completion date |
|-------------------|--|---------------------|--|--|-----------------|
|                   |  |                     | <p>The Trust has strong working relationships with its commissioning partners within the local health and social care economy.</p> <p>The Board has a director responsible for leading on contract negotiations.</p> <p>The Trust has a strong track record of delivering service transformation, efficiency, productivity and quality improvement to meet the needs of the local population.</p>  |  |                 |
| CoS2              | Restriction on the disposal of assets                      | Compliant           | <p><b>This licence condition ensures that licensees keep an up to date register of relevant assets used in the provision of Commissioner Requested Services. It also creates a requirement for licensees to obtain NHSE/I's consent before disposing of these assets when (Monitor) NHSE/I is concerned about the ability of the licensee to carry on as a going concern.</b></p> <p>The Finance Department maintains a capital asset register for all depreciable assets valued at over £5,000 on purchase, or group assets valued individually over £1,000, and when grouped together functionally, valued at more than £5,000.</p> <p>The Estates Department maintains a property and property leases register and the Contracts team a register of contracts (including non-estates leases).</p> | N/A  | N/A             |
| CoS3              | Standards of corporate governance and financial management | Compliant           | <p><b>This condition requires licensees to have due regard to adequate standards of corporate governance and financial management.</b></p> <p>In May 2019 the Trust received enforcement action by NHSI FT4(5)(a), (b) and (d) due to the state of its finances at the time. The Trust met with NHSE/I through undertakings meetings throughout 2019/20 and succeeded in meeting the financial requirements set and achieving its revised financial plan.</p>  | N/A  | N/A             |

| Licence condition |  | Level of compliance | Evidence / Board assurance   | Comment where non-compliant or at risk of non-compliance and required action | Completion date |
|-------------------|--|---------------------|--|--|-----------------|
|                   |  |                     | <p>Following correspondence from NHSE/I, a meeting took place on 05 May 2021 at which NHSE/I agreed to recommend the Trust's undertakings to be removed. The formal certification of this cannot be confirmed by the regulator until a scheduled meeting of the Regional Support Group (RSG) in early June, after the 31 May 2021 self-certification deadline. NHSE/I has agreed that verbal assurance given at the meeting on 05 May 2021 is sufficient for the Trust to certify compliance accordingly.</p> <p>The Single Oversight Framework will be used by NHSE/I to determine compliance.</p> <p>The Trust has a suite of governance documents including:</p> <ul style="list-style-type: none"> <li>• Standing Financial Instructions; and</li> <li>• Reservation of Powers to the Board and Delegation of Powers.</li> </ul> <p>Governance and financial reports to Board meetings and Board Committees confirming details of the Trust's governance and financial management and information which supports the Governance and Continuity of Services declarations.</p> |  |                 |
| CoS4              | Undertaking from the ultimate controller | N/A                 | <p><b>This condition requires licensees to put in place a legally enforceable agreement with their 'ultimate controller' to stop ultimate controllers from taking any action that would cause licensees to breach the license conditions. This is best described as a 'parent/subsidiary company' arrangement. If no such controlling arrangements exist then this condition would not apply.</b></p> <p>Should a controlling arrangement come into being, the ultimate controller will be required to put in place arrangements to protect the assets and services within 7 days.</p> <p>Directors and Trustees of Charities are not regarded by NHSI as 'Ultimate Controllers'.</p>  | N/A  | N/A             |

| Licence condition                      |  | Level of compliance | Evidence / Board assurance   | Comment where non-compliant or at risk of non-compliance and required action | Completion date |
|--|--|---------------------|--|--|-----------------|
|  |  |                     | <i>This licence condition would not apply as the Trust is not an NHS Foundation Trust.</i>   |  |                 |
| CoS5                                   | Risk pool levy   | N/A                 | <p><b>This licence condition obliges licensees to contribute, if required, towards the funding of the 'risk pool' – this is like an assurance mechanism to pay for vital services if a provider fails.</b></p> <p>The regulatory Risk Pool Levy has not come into effect to date.</p> <p>The Trust currently contributes to the NHS Resolution risk pool for clinical negligence, property expenses and public and employment liability schemes.</p>                                   | N/A  | N/A             |
| CoS6                                   | Cooperation in the event of financial stress                 | Compliant           | <p><b>This licence condition applies when a licensee fails a test of sound finances, and obliges the licensee to cooperate with NHSE/I and any of its appointed persons in these circumstances in order to protect services for patients.</b></p> <p>The Trust has maintained a Continuity of Service/Financial Sustainability rating of 3 for the last 12 months.</p> <p>The Trust has a positive and compliant track record of co-operating with external bodies and regulators.</p> | N/A  | N/A             |
| CoS7                                   | Availability of Resources                                    | Compliant           | <p><b>This licence condition requires licensees to act in a way that secures access to the resources needed to operate Commissioner Requested Services.</b></p> <p>As with the provision of Mandatory Services, the Trust has well-established services in place and currently provides all of the Commissioner Requested Services to a high standard.</p> <p>The Trust has forward plans and agreements in place with commissioners that meet this condition.</p>                     | N/A  | N/A             |
| <b>NHS FOUNDATION TRUST CONDITIONS</b> |  |                     |  |  |                 |
| FT1                                    | Information to update the register of NHS Foundation Trusts. | N/A                 | This licence condition ensures that NHS Foundation Trusts provide required documentation to (Monitor) NHSE/I.  | N/A  | N/A             |

| Licence condition |   | Level of compliance | Evidence / Board assurance   | Comment where non-compliant or at risk of non-compliance and required action | Completion date |
|-------------------|---|---------------------|--|--|-----------------|
|                   |   |                     | <i>This licence condition would not apply as the Trust is not an NHS Foundation Trust.</i>   |  |                 |
| FT2               | Payment to NHSI in respect of registration and related costs.   | N/A                 | <p>If (Monitor) NHSE/I moves to funding by collecting fees, we may need this licence condition to charge additional fees to NHS Foundation Trusts to recover the costs of registration. (Monitor) NHSE/I would consult stakeholders before introducing such a fee.</p> <p><i>This licence condition would not apply as the Trust is not an NHS Foundation Trust.</i></p>   | N/A  | N/A             |
| FT3               | Provision of information to advisory panel.   | N/A                 | <p>The Act gives (Monitor) NHSE/I the ability to establish an advisory panel that will consider questions brought by governors. It is (Monitor)'s NHSE/I's current intention to establish this panel. This licence condition requires NHS Foundation Trusts to provide the information requested by an advisory panel.</p> <p><i>This licence condition would not apply as the Trust is not an NHS Foundation Trust.</i></p>   | N/A  | N/A             |
| FT4               | <p>NHS Foundation Trust Governance arrangements</p> <p><i>Although BHT is not an NHS Foundation Trust it must comply with the governance framework.</i></p> | Compliant           | <p>This condition will enable NHSE/I to continue oversight of governance of NHS Foundation Trusts and NHS Trusts.</p> <p>In summary, licensees are required to:</p> <ul style="list-style-type: none"> <li>• have systems and processes and standards of good corporate governance;</li> <li>• have regard for the guidance published by NHSI;</li> <li>• have effective Board Committee Structures</li> <li>• have clear accountabilities and reporting lines throughout the organisation and maintain appropriate capacity and capability of the Board;</li> <li>• comply with healthcare standards;</li> <li>• have effective financial management, control and decision making; and</li> <li>• maintain accurate information</li> </ul> <p>The Board undertakes an annual review of:</p> | N/A  | N/A             |

| Licence condition | Level of compliance | Evidence / Board assurance   | Comment where non-compliant or at risk of non-compliance and required action | Completion date |
|-------------------|---------------------|--|--|-----------------|
|                   |                     | <ul style="list-style-type: none"> <li>• Board effectiveness; Strategic objectives and risks to delivery through the Board Assurance Framework, Strategic Risk Register and Annual Plan</li> <li>• Board committee and assurance framework; their terms of reference and performance against these;</li> <li>• Standing Financial Instructions and Reservation of Powers to the Board and Delegation of Powers.</li> <li>• Rules of Procedure</li> </ul> <p>Other forms of assurance include;</p> <ul style="list-style-type: none"> <li>• Overall Good with Outstanding for caring rating by CQC in March 2019</li> <li>• Managerial and professional lines of accountability and clinical leadership;</li> <li>• Annual Governance Statement;</li> <li>• Audit Committee scrutiny;</li> <li>• Internal Controls Framework</li> <li>• Internal and External Audit reports;</li> <li>• Integrated Performance reports received by the Board each month;</li> <li>• Annual appraisals and development plans;</li> <li>• Performance Management Framework;</li> <li>• Annual Report and Quality Account;</li> <li>• Monthly reports to the Board from Committee Chairs;</li> <li>• Strategies and policies kept under regular review;</li> <li>• Trust Board development programme.</li> </ul> |  |                 |

This template may be used by Foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS Provider Licence.  
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

## Self-Certification Template - Condition FT4

Buckinghamshire Healthcare NHS Trust

*Insert name of  
organisation*



Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

*Corporate Governance Statement - in accordance with Foundation Trust condition 4 (Foundations Trusts and NHS trusts)  
Certification on training of Governors - in accordance with s151(5) of the Health and Social Care Act (Foundation Trusts only)*

These self-certifications are set out in this template.

### How to use this template

- 1) Save this file to your Local Network or Computer.
- 2) Enter responses and information into the yellow data-entry cells as appropriate.
- 3) Once the data has been entered, add signatures to the document.

Corporate Governance Statement (FTs and NHS trusts)

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

| Corporate Governance Statement  | Response  | Risks and Mitigating actions   |
|---|-----------|--|
| 1 The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.  | Confirmed | The Trust has had no conditions imposed upon it preventing it from discharging its statutory responsibilities. The Trust was assessed as Good in its COG assessment.   |
| 2 The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time  | Confirmed | The Board takes account of all appropriate guidance.   |
| 3 The Board is satisfied that the Licensee has established and implements:<br>(a) Effective board and committee structures;<br>(b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and<br>(c) Clear reporting lines and accountabilities throughout its organisation.  | Confirmed | The Board has clear Terms of Reference as detailed in the Trusts Standing Orders.<br>(a) Each of the Committees of the Board has agreed Terms of Reference which are regularly reviewed and each Committee has a Non-Executive (NED) Chair with NEDs being in the majority of each Committee.<br>(b) Each Committee monitors compliance with against operational and contractual requirements and provides assurance to the Board through regular written reports highlighting risks and mitigations.<br>(c) There are clear reporting lines throughout the organisation demonstrated by organisational charts showing lines of accountability. There is a performance framework in place.   |
| 4 The Board is satisfied that the Licensee has established and effectively implements systems and/or processes:<br>(a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;<br>(b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations;<br>(c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;<br>(d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);<br>(e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;<br>(f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;<br>(g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and<br>(h) To ensure compliance with all applicable legal requirements. | Confirmed | (a) The Trust operates efficiently and effectively, the External Audit value for money opinion is pending and will be published through the Annual Report & Accounts<br>(b) Timely and effective operational reports are received, discussed and monitored through the Trust's committee structure<br>(c) The Trust is compliant with all of the various standards and has no restrictions applied by any of these regulators<br>(d) The Trust remains a going concern and this is confirmed by External Audit.<br><br>In May 2019 the Trust received enforcement action by NHSI FT4(5)(a), (b) and (d) due to the state of its finances at the time. The Trust met with NHSEI through undertakings meetings throughout 2019/20 and succeeded in meeting the financial requirements set and achieving its revised financial plan.<br>Following correspondence from NHSEI, a meeting took place on 05 May 2021 at which NHSEI agreed to recommend the Trust's undertakings to be removed. The formal certification of this cannot be confirmed by the regulator until a scheduled meeting of the Regional Support Group (RSG) in early June, after the 31 May 2021 self-certification deadline. NHSEI has agreed that verbal assurance given at the meeting on 05 May 2021 is sufficient for the Trust to certify compliance accordingly.<br><br>(e) Timely, up to date, comprehensive information is received by the Board and the Committees.<br>(f) There is a clear Board Assurance Framework and Corporate Risk Register in place along with a risk management system to identify and manage material risk and compliance.<br>(g) There is regular, timely and comprehensive information on the Trust's business plans and contracts. The Internal Audit provider is external to the Trust and has an annual plan which is reported to the Audit Committee.<br>(h) The Trust complies with its legal requirements. |
| 5 The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure:<br>(a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;<br>(b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;<br>(c) The collection of accurate, comprehensive, timely and up to date information on quality of care;<br>(d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;<br>(e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and<br>(f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.   | Confirmed | The Trust has sufficient capability at Board level to provide effective organisational leadership through the Medical Director and Chief Nurse on the quality of care provided, this is supported by the organisation's rating of 'Outstanding for Caring' by the Care Quality Commission. The Trust Values and strategic objectives clearly articulate the focus on the quality of care provision. The Board receives regular patient stories and clinical reports from lead clinicians. The Board receives regular reports on quality standards in the Integrated Performance Report, and the Quality and Clinical Governance Committee monitors detailed areas for improvement through divisional deep dives. This integrated approach allows the Board to provide continuous oversight for improving the quality of care.  |
| 6 The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.  | Confirmed | The Board has reviewed its capacity and capability and declares the Trust Board has sufficient numbers of Directors and skills. All of the Board of Directors have complied with and meet the requirements of their Fit and Proper Persons Assessment.   |

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

Signature

Signature

Name Hania Llewellyn-Davies, Chair

Name Neil Macdonald, CEO

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A

Please Respond

[Yellow dashed box for financial year]

Certification on training of governors (FTs only)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where required.

Training of Governors

- 1 The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.

[Yellow dashed box for response]

Please Respond

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

Signature

Signature

Name [Yellow dashed box]

Name [Yellow dashed box]

Capacity [job title here] [Yellow dashed box]

Capacity [job title here] [Yellow dashed box]

Date [Yellow dashed box]

Date [Yellow dashed box]

Further explanatory information should be provided below where the Board has been unable to confirm declarations under s151(5) of the Health and Social Care Act

A



## PROVIDER LICENCE – EVIDENCE OF COMPLIANCE

The provider has taken all precautions necessary to comply with the licence, NHS Acts and the NHS Constitution (Condition FT4)

| Corporate Governance Statement |   | Response  | Evidence / Board assurance  |
|--------------------------------|---|-----------|---|
| 1.                             | The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.  | Confirmed | <ul style="list-style-type: none"> <li>The Director for Governance and Director of Finance provide expertise on standards of governance as they apply to the NHS and advise the Board and organisation accordingly</li> <li>Reviews of elements of governance are carried out by the CQC, NHS Improvement, External Audit, and Internal Audit</li> <li>The Trust has a Declaration of Interests policy and process</li> <li>The Trust Board of Directors comply with the requirements of the Fit and Proper Persons test</li> </ul>   |
| 2.                             | The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time  | Confirmed | The Board and relevant Committees are briefed on guidance issued by NHS Improvement in relation to governance.  |
| 3.                             | The Board is satisfied that the Licensee has established and implements: <ol style="list-style-type: none"> <li>Effective board and committee structures;</li> <li>Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and</li> <li>Clear reporting lines and accountabilities throughout its organisation.</li> </ol> | Confirmed | <ul style="list-style-type: none"> <li>The Board and Committees are set up in line with Monitor's Code of Governance for Foundation Trusts as far as it applies to NHS Trusts</li> <li>The Trust has Standing Orders, Standing Financial Instructions and Committee Terms of Reference reviewed in year by the Board</li> <li>Board and Committee Self-reflection on effectiveness is evident in minutes of Board meetings and Committees</li> <li>Review of effectiveness of Audit Committee and performance in each committee</li> <li>Chair's observation of each Committee and feedback to each Committee Chair</li> <li>Organisational structure charts showing lines of accountability</li> <li>Performance Management Framework and processes</li> </ul> |
| 4.                             | <ol style="list-style-type: none"> <li>The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;</li> </ol>   | Confirmed | In May 2019 the Trust received enforcement action by NHSI FT4(5)(a), (b) and (d) due to the state of its finances at the time. The Trust met with NHSE/I through undertakings meetings throughout 2019/20 and succeeded in meeting the financial requirements set and achieving its revised financial plan. Following correspondence from NHSE/I, a meeting took place on 05 May 2021 at which NHSE/I agreed to recommend the Trust's undertakings to be removed. The formal certification of this cannot be confirmed by the regulator until a scheduled meeting of the Regional Support Group (RSG) in early June, after the 31 May 2021 self-certification deadline. NHSE/I has agreed that verbal   |

| Corporate Governance Statement  | Response         | Evidence / Board assurance   |
|---|------------------|--|
| <p>b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations;</p> <p>c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;</p> <p>d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);</p> <p>e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;</p> <p>f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;</p> <p>g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and</p> <p>h) To ensure compliance with all applicable legal requirements.</p> |                  | <p>assurance given at the meeting on 05 May 2021 is sufficient for the Trust to certify compliance accordingly.</p> <ul style="list-style-type: none"> <li>• Board and committee forward plans</li> <li>• Board agendas and minutes</li> <li>• Annual Governance Statement</li> <li>• Internal and External Audit</li> <li>• Local Counter Fraud Specialist Annual report</li> <li>• Auditor review of going concern declaration</li> <li>• Risk Management Strategy and Policy</li> <li>• Board Assurance Framework</li> <li>• Corporate Risk Register</li> <li>• Comprehensive business planning process involved Board and Committee sign off</li> <li>• Emergency Planning, Resilience and Response compliance reported to Finance and Business Performance Committee</li> <li>• Information Governance Toolkit submission</li> <li>• Compliance with laws and regulations paper to the Board</li> </ul> |
| <p>5. The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure:</p> <p>a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;</p>  | <p>Confirmed</p> | <ul style="list-style-type: none"> <li>• Board development programme including Board self-review</li> <li>• Quality Impact Assessment process</li> <li>• Leadership programme</li> <li>• Quality report to Board</li> <li>• Range of internal and external assurances to Quality and Clinical Governance Committee including clinical audit and other reviews</li> <li>• Monthly mortality reporting</li> </ul>  |

| Corporate Governance Statement  | Response         | Evidence / Board assurance  |
|---|------------------|---|
| <p>b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;</p> <p>c) The collection of accurate, comprehensive, timely and up to date information on quality of care;</p> <p>d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;</p> <p>e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and</p> <p>f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate</p> |                  | <ul style="list-style-type: none"> <li>• Patient Experience Group</li> <li>• Programme of patient and public involvement reported to the Board</li> <li>• Feedback processes such as Friends and Family Test and complaints process</li> <li>• Range of patient stories to Board</li> <li>• Engagement with Healthwatch and the Health and Adult Health and Social Care Select Committee</li> </ul> |
| <p>6. The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence</p>   | <p>Confirmed</p> | <ul style="list-style-type: none"> <li>• Strategic Workforce Committee forward plan and meeting minutes</li> <li>• Workforce performance reports</li> <li>• Staff survey</li> <li>• CQC reports</li> </ul>  |

**Meeting:** Trust Board Meeting in Public

**26 May 2021**

|                              |  |
|------------------------------|--|
| <b>Agenda item</b>           | BHT Pol 089 Governance Manual  |
| <b>Board Lead</b>            | Neil Macdonald, Chief Executive  |
| <b>Type name of author</b>   | Sue Manthorpe, Director for Governance<br>Chloe Powell, CEO Business Manager |
| <b>Attachments</b>           | BHT Pol 089 BHT Governance Manual v11  |
| <b>Purpose</b>               | Approval   |
| <b>Previously considered</b> | EMC 16 February and 27 April 2021; Audit Committee 06 May 2021               |

### Executive Summary

NHS Trusts are required by law to make Standing Orders (SOs), which regulate the way in which the proceedings and business of the Trust will be conducted.

High standards of corporate and personal conduct are essential in the NHS. The Standing Orders, incorporating the Standing Financial Instructions (SFIs), and Scheme and Limits of Delegations, identify who in the Trust is authorised to do what and individual's responsibilities.

This consolidated document renamed as 'BHT Governance Manual' incorporates BHT Pol 089 Standing Orders and Standing Financial Instructions, and BHT Pol 061 Limits of Delegation.

The regulations which determine the way that the Trust Board operates and is governed are defined in the Standing Orders. Financial responsibilities and authorities are described in the SFIs and Scheme and Limits of Delegation. All employees of the Trust need to be aware of their responsibilities and authorities described in this document.

This version follows reviews at Executive Management Committee and Audit Committee as noted above. Amendments have been made in this version to address the feedback received. This front sheet also includes further information on the proposal to permanently increase our limit above which a waiver of SFIs is required from £5,000 to £20,000.

|                 |  |
|-----------------|--|
| <b>Decision</b> | The Board is requested to approve BHT Pol 089 v11. |
|-----------------|--|

### Relevant strategic priority

|                  |                 |                |
|------------------|-----------------|----------------|
| <b>Quality</b> ☒ | <b>People</b> ☒ | <b>Money</b> ☒ |
|------------------|-----------------|----------------|

### Implications / Impact

|  |   |
|--|---|
| <b>Patient Safety</b>  | Patient safety is considered as part of the core functions of safety and quality described throughout the document.   |
| <b>Risk: link to Board Assurance Framework (BAF)/Risk Register</b> | The documents provides information on the management of risk and links to the Risk management process of the Trust.   |
| <b>Financial</b>   | The document provides information on the Trust Financial processes and the rules that govern these.   |
| <b>Compliance NHS Regulation Good Governance</b>                   | This document ensures the Trust meets its statutory requirements.   |
| <b>Partnership: consultation / communication</b>                   | In the implementation of the Trust Standing Orders there may be requirement to consult or work with external partners such as the Local Counter Fraud Authority or External Audit.  |
| <b>Equality</b>  | The policy outlines the processes, behaviours and public service values expected of the Board and colleagues throughout the organisation. An Equality Impact Assessment screening questionnaire has been completed and can be found in Annex 4. |

## **1 Introduction**

NHS Trusts are required by law to make Standing Orders (SOs), which regulate the way in which the proceedings and business of the Trust will be conducted.

Regulation 19 of the NHS Trusts (Membership and Procedure) Regulations, 1990 (as amended) requires the meetings and proceedings of an NHS Trust to be conducted in accordance with the rules set out in the Schedule to those Regulations and with Standing Orders made under Regulation 19(2).

These Standing Orders and associated documents are extremely important. High standards of corporate and personal conduct are essential in the NHS. As the NHS is publicly funded, it is accountable to Parliament for the services it provides and for the effective and economical use of taxpayers' money.

The Standing Orders, Standing Financial Instructions, procedures and the rules and instructions made under them provide a framework and support for the public service values which are essential to the work of the NHS of:

- Accountability – the ability to stand the test of Parliamentary scrutiny, public judgements on propriety and professional codes of conduct.
- Probity – an absolute standard of honesty in dealing with the assets of the Trust; integrity in decisions affecting patients, staff and suppliers, and in the use of information acquired in the course of NHS duties.
- Openness – transparency about NHS activities to promote confidence between the organisation and its staff, patients and the public.

### **Standing Financial Instructions**

Standing Financial Instructions (SFIs) detail the regulatory framework, financial responsibilities, policies and procedures to be maintained by the Trust. The SFIs are designed to ensure financial transactions are carried out in accordance with the law and government policy in order to achieve probity, accuracy, economy efficiency and effectiveness.

### **Scheme of Reservation and Delegation**

The Scheme of Reservation and Delegation sets out the powers (be that decisions, authorities or duties) reserved to the Board and the powers which may be delegated to sub committees, directors and other officers. Together with the other documents contained within this manual it provides a comprehensive framework for the Trusts business conduct. It sets out levels of decision-making in the current management structure of the Trust.

### **Codes of Accountability and Conduct**

The Codes of accountability and conduct set out the ground rules within which Board, directors and staff must operate in conducting the business of the Trust.

All Executive and Non-Executive Directors and staff are expected to be aware of the existence of these documents contained in this governance manual, understand when they should be referred to and, where necessary and appropriate to their role, make themselves familiar with the detailed provisions.

## 2 Review

Every two years the Trust is required to review and, if necessary, update the Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation.

This review has been completed by the Finance team, Procurement team, Director for Governance (retired) and CEO Business Manager, to ensure the information contained in the manual remains up to date.

As part of the review each of documents outlined above have been consolidated into this Governance Manual to provide a single source of the key rules under which the Trust is managed and governed.

Many of the changes completed have no implications on the substance of the documents contained in the Manual and relate to correcting referencing errors and typos. Changes of particular note include:

- changes to the limits of delegation to reflect current roles and responsibilities:
  - a) Executive Directors increase from £200k to £250k
  - b) Head of Midwifery increased from £5k to £100k to align with similar roles
  - c) General Managers and equivalent increased from £5k to £10k
  - d) Matrons increased from £250 to £5k
  - e) Ward managers increased from £250 to £500
- reference to the business case approval process
- limit for Capital Management Group (CMG) to approve capital investment has changed from £100k to £1m, and added authority for CMG to approve revenue up to £100k associated with capital investment

In addition, through this policy the Board is requested to approve the proposal to permanently move the limit above which a waiver of Standing Financial Instructions is required from £5k to £20k, in so doing making permanent the temporary arrangements introduced during 2020-21. To provide some context for this: in 2019-20 the Procurement team recorded 257 waivers with a total worth of £12.03m. Had the threshold been £20k instead of £5k there would have been 115 waivers worth £10.45m; so there were 142 waivers between £5k and £20k with a total value of £1.58m. These thresholds have been benchmarked and are in line with other providers.

## 3 Action required from the Board

The documents contained in this Governance Manual follow the model for NHS Trusts produced by Department of Health and Social Care (DHSC). The Board can be assured therefore that none of the changes recommended deviate from the statutory provisions or directions of the DHSC.

**The Board is asked to approve the consolidated BHT Governance Manual.**

## 4 Appendices

BHT Pol 089 BHT Governance Manual

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 Please check the intranet for the most up to date version.

## BHT Governance Manual

This policy has been renamed from 'STANDING ORDERS, RESERVATION AND DELEGATION of POWERS and STANDING FINANCIAL INSTRUCTIONS' and now incorporates BHT Pol 061 Limits of Delegation Policy

|                                       |   |
|---------------------------------------|---|
| <b>Version:</b>                       | 11  |
| <b>Approved and ratified by:</b>      | Trust Board   |
| <b>Date approved:</b>                 | May 2021 (TBC)  |
| <b>Author:</b>                        | CEO Business Manager  |
| <b>Lead Director:</b>                 | Chief Executive   |
| <b>Name of responsible committee:</b> | Trust Board   |
| <b>Document reference:</b>            | BHT Pol 089   |
| <b>Date re-issued:</b>                | June 2021 (TBC)   |
| <b>Review date:</b>                   | June 2023   |
| <b>Location:</b>                      | swanlive/policies-guidelines/standing-financial-instructions-and-limits |
| <b>Target Audience:</b>               | All directors, managers and staff                                       |
| <b>Equality Impact Assessment:</b>    | April 2021  |

### Document history

| Version | Issue | Reason for change  | Authorising body                     | Date             |
|---------|-------|--|--------------------------------------|------------------|
| 11      |       | Complete review; consolidation of BHT Pol 061 with BHT Pol 089       | Trust Board                          | May 2021 (TBC)   |
| 10      | a     | Two-yearly review  | Trust Board                          | 23 March 2019    |
| 9       | a     | Two-yearly review  | Trust Board                          | 27 July 2016     |
| 8       | a     | Review and update  | Trust Board                          |                  |
| 7       | b     | Update of version 7a to reflect the voting structure of the Board    | Trust Board                          | 30 May 2012      |
| 7       | a     | Minor amendments   | Trust Board                          | 5 October 2011   |
| 7       |       | Formal Review  | Approved: Trust Management Committee | 1 October 2010   |
|         |       |  | Ratified: Trust Board                | 23 November 2010 |
| 6       | a     | Excluded Limits of Delegation  |                                      | January 2009     |
| 6       |       | Based on model document issued by Department of Health in March 2006 |                                      | January 2008     |

#### Associated documents

| BHT Ref     | Title   | Location/Link                               |
|-------------|---|---|
| BHT Pol 019 | Declaration of Interests Policy               | swanlive/policies-guidelines/code-conduct   |
| BHT Pol 032 | Disciplinary Policy and Procedure             | swanlive/policies-guidelines/staff-policies |
| BHT Pol 135 | Monitoring Compliance with Legislation Policy | swanlive/policies-guidelines/corporate      |
| BHT Pol 041 | Counter Fraud and Bribery Policy              | swanlive/policies-guidelines/code-conduct   |

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## SECTION A – Interpretation and definitions for Standing Orders and Standing Financial Instructions

- 0.1 Save as otherwise permitted by law, at any meeting the Chairperson of the Trust shall be the final authority on the interpretation of Standing Orders (on which they should be advised by the Chief Executive or Trust Board Business Manager).
- 0.2 Any expression to which a meaning is given in these Standing Orders and Standing Financial Instructions is defined as follows:
- 0.2.1 **"Accountable Officer"** means the NHS Officer responsible and accountable for funds entrusted to the Trust. The officer shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the Chief Executive.
- 0.2.2 **"Trust"** means the Buckinghamshire Healthcare NHS Trust.
- 0.2.3 **"Board"** means the Board of Directors – the Chairperson, Executive, and Non-Executive Directors of the Trust collectively as a body.
- 0.2.4 **"Budget"** means a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.
- 0.2.5 **"Budget holder"** means the director or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation.
- 0.2.6 **"Chairperson of the Board (or Trust)"** is the person appointed by the Secretary of State for Health to lead the Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression "the Chairperson of the Trust" shall be deemed to include the Senior Independent Director of the Trust if the Chairperson is absent from the meeting or is otherwise unavailable.
- 0.2.7 **"Chief Executive"** means the chief officer of the Trust. The Chief Executive is the Trust's Accountable Officer.
- 0.2.8 **"Commissioning"** means the process for determining the need for and for obtaining the supply of healthcare and related services either by clinical Commissioning groups, the National Commissioning Board, the Trust itself or others. Can sometimes be referred to as "purchasing" or "procuring" healthcare.
- 0.2.9 **"Committee"** means a committee or sub-committee created and appointed by the Trust.
- 0.2.10 **"Committee members"** means persons formally appointed by the Board or delegated body to sit on or to chair specific committees.
- 0.2.11 **"Contracting and procuring"** means the systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.
- 0.2.12 **"DOF"** means Director of Finance, the Director with responsibility for oversight of Trust finances (and other areas as defined in their specific job description).
- 0.2.13 **"Executive Management Committee" (EMC)** means the senior management committee whose role includes the development and implementation of strategy, operational plans, policies, procedures and budgets.
- 0.2.14 **"Finance and Business Performance Committee"** means a committee whose functions are concerned with the arrangements for the purpose of monitoring and improving the financial and business performance for which the Buckinghamshire Healthcare NHS Trust has responsibility

- 0.2.15 **"Funds held on trust"** shall mean those funds which the Trust holds on date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under S.90 of the NHS Act 1977, as amended. Such funds may or may not be charitable.
- 0.2.16 **"Member"** means officer or non-officer member of the Board as the context permits. Member in relation to the Board does not include its Chairperson.
- 0.2.17 **"Associate Member"** means a person appointed to perform specific statutory and non-statutory duties which have been delegated by the Board for them to perform and these duties have been recorded in an appropriate Board minute or other suitable record.
- 0.2.18 **"Membership, Procedure and Administration Arrangements Regulations"** means NHS Membership and Procedure Regulations (SI1990/2024) and subsequent amendments.
- 0.2.19 **"Nominated officer"** means an officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.
- 0.2.20 **"Non-officer Member"** means a member of the Trust who is not an officer of the Trust and is not to be treated as an officer by virtue of regulation 1(3) of the Membership, Procedure and Administration Arrangements Regulations.
- 0.2.21 **"Officer"** means employee of the Trust or any other person holding a paid appointment or office with the Trust.
- 0.2.22 **"Officer Member"** means a member of the Trust who is either an officer of the Trust or is to be treated as an officer by virtue of regulation 1(3) (i.e. the Chairperson of the Trust or any person nominated by such a Committee for appointment as a Trust member).
- 0.2.23 **"Quality and Clinical Governance Committee"** means a committee whose functions are concerned with the arrangements for the purpose of monitoring and improving the safety and quality of healthcare for which the Buckinghamshire Healthcare NHS Trust has responsibility.
- 0.2.24 **"Secretary"** means a person or a person who is undertaking the duties of Board Secretary appointed to act independently of the Board to provide advice on corporate governance issues to the Board and the Chairperson and monitor the Trust's compliance with the law, Standing Orders, and Department of Health, NHS England/Improvement guidance. In the case of Buckinghamshire Healthcare NHS Trust this is the Trust Board Business Manager.
- 0.2.25 **"SFIs"** means Standing Financial Instructions.
- 0.2.26 **"SOs"** means Standing Orders.
- 0.2.27 **"SOFIs"** means Standing Orders and Standing Financial Instructions.
- 0.2.28 **"Senior Independent Director"** means the Non-Executive Director appointed by the Board to take on the Chairperson's duties if the Chairperson is absent for any reason.
- 0.2.29 **"Strategic Workforce Committee"** means a committee whose functions are concerned with the arrangements for the purpose of receiving assurance on workforce, organisational development, and health and safety issues for which the Buckinghamshire Healthcare NHS Trust has responsibility.

## **SECTION B – Standing Orders**

### **1.1 Statutory Framework**

- 1.1.1 The Buckinghamshire Healthcare NHS Trust (the Trust) is a statutory body which came into existence on 1 April 2003 under The Buckinghamshire Hospitals NHS Trust (Establishment) Order 2002 No 2419, (the Establishment Order). The Trust's name was changed to the Buckinghamshire Healthcare NHS Trust on 1 November 2010 (Change of Name) Order 2010 No 2461.
- 1.1.2 The principal place of business of the Trust is Stoke Mandeville Hospital, Mandeville Road, Aylesbury HP21 8AL.
- 1.1.3 NHS Trusts are governed by Act of Parliament, Mainly the National Health Service Act 1977 (NHS Act 1977), the National Health Service and Community Care Act 1990 (NHS & CC Act 1990) as amended by the Health Authorities Act 1995, the Health Act 1999, the Health and Social Care Act 2012 and the Health and Social Care Act (Safety and Quality) 2015).
- 1.1.4 The functions of the Trust are conferred by this legislation.
- 1.1.5 As a statutory body, the Trust has specified powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable as well as to the Secretary of State for Health.
- 1.1.6 The Trust also has statutory powers under the legislation to fund projects jointly planned with local authorities, voluntary organisations and other bodies.
- 1.1.7 The Code of Accountability requires the Trust to adopt Standing Orders for the regulation of its proceedings and business. The Trust must also adopt Standing Financial Instructions (SFIs) as an integral part of Standing Orders setting out the responsibilities of individuals.
- 1.1.8 The Trust will also be bound by such other statutes and legal provisions which govern the conduct of its affairs.

### **1.2 NHS Framework**

- 1.2.1 In addition to the statutory requirements the Secretary of State through the Department of Health issues further directions and guidance. These are normally issued under cover of a circular or letter.
- 1.2.2 The Code of Accountability requires that, inter alia, Boards draw up a schedule of decisions reserved to the Board and ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives (a scheme of delegation). The code also requires the establishment of audit and remuneration committees with formally agreed terms of reference. The Codes of Conduct makes various requirements concerning possible conflicts of interest of Board members.
- 1.2.3 The Code of Practice on Openness in the NHS sets out the requirements for public access to information on the NHS. The Freedom of Information Act 2000 which came into effect on 1 January 2005 supersedes the Code of Practice on Access to Government Information 1997 (The Code of Practice).

### **1.3 Delegation of Powers**

- 1.3.1 The Trust has powers to delegate and make arrangements for delegation. The Standing Orders set out the detail of these arrangements. Under the Standing Order relating to the Arrangements for the Exercise of Functions (SO 5) the Trust is given powers to "make arrangements for the exercise, on behalf of the Trust of any of their functions by a committee, sub-committee or joint committee appointed by virtue of Standing Order 4 or by an officer of

the Trust, in each case subject to such restrictions and conditions as the Trust thinks fit or as the Secretary of State may direct". Delegated Powers are covered in a separate section (Reservation of Powers to the Board and Delegation of Powers Section D). This document has effect as if incorporated into the Standing Orders. Delegated Powers are covered in 'Schedule of Matters reserved to the Board and Scheme of Delegation' and have effect as if incorporated into the Standing Orders and Standing Financial Instructions.

## **1.4 Integrated Governance**

The Board operates an integrated governance approach covering the full range of corporate, financial, clinical, information and research governance. Guidance from the Department of Health on integrated governance was first issued in 2006.

- 1.4.1 Governance describes the processes the Trust uses to ensure it:
- is led and managed properly;
  - delivers what it is expected and required to, and;
  - manages risks that might prevent that delivery.
- 1.4.2 At the heart of these processes is decision making informed by intelligent information covering the full range of performance against objectives and targets for corporate, financial, clinical, service, information and research functions. The processes themselves are integrated into the way the Trust operates and define its internal control, which in turn is reported on as a formal statement in the annual accounts (the statement of internal control).

## **2 THE TRUST BOARD: COMPOSITION OF MEMBERSHIP, TENURE AND ROLE OF MEMBERS**

### **2.1 Composition of the Membership of the Trust Board**

- 2.1.1 In accordance with the Membership, Procedure and Administration Arrangements regulations the voting membership of the Board shall be:
- (a) The Chairperson of the Trust (Appointed by NHS Improvement (NHSI) under delegated authority from the Secretary of State);
  - (b) Up to 5 Non-executive members (appointed by NHSI under delegated authority from the Secretary of State);
  - (c) Up to 5 Executive members (but not exceeding the number of Non-executive members) who will be the Chief Executive; the Director of Finance; the Chief Medical Officer; the Chief Nurse; and the Chief Operating Officer
- 2.1.2 The Trust shall have not more than 11 and not less than 8 members (unless otherwise determined by the Secretary of State for Health and set out in the Trust's Establishment Order or such other communication from the Secretary of State).
- 2.1.3 In addition to officer members of the Board, the Trust may have other Executive Directors, Associate Non-Executive Directors, and Board Affiliates, who take part in Board discussions and deliberations; however, these Directors do not have any voting rights in Board decisions.

### **2.2 Appointment of Chairperson and Members of the Trust**

- 2.2.1 Appointment of the Chairperson and Members of the Trust - Paragraph 2(1) of the NHS Act 2006 provides that the Chair is appointed by the Secretary of State for health and Social Care provides that the Chairperson is appointed by the Secretary of State, but otherwise the appointment and tenure of office of the Chairperson and members are set out in the Membership, Procedure and Administration Arrangements Regulations.

### **2.3 Terms of Office of the Chairperson and Members**

- 2.3.1 The regulations setting out the period of tenure of office of the Chairperson and members and for the termination or suspension of office of the Chairperson and members are contained in Sections 2 to 4 of the Membership, Procedure and Administration Arrangements and Administration Regulations.

## **2.4 Appointment and Powers of Senior Independent Director**

- 2.4.1 Subject to Standing Order 2.4.2 below, the Chairperson and members of the Trust may appoint one of their numbers, who is not also an executive member, to be Senior Independent Director, for such period, not exceeding the remainder of his/her term as a Non-Executive member of the Trust, as they may specify on appointing him/her.
- 2.4.2 Any member so appointed may at any time resign from the office of Senior Independent Director (SID) by giving notice in writing to the Chairperson. The Chairperson and members may thereupon appoint another member as Vice-Chairperson in accordance with the provisions of Standing Order 2.4.1.
- 2.4.3 Where the Chairperson of the Trust has died or has ceased to hold office, or where they have been unable to perform their duties as Chairperson owing to illness or any other cause, the Senior Independent Director shall act as Chairperson until a new Chairperson is appointed or the existing Chairperson resumes their duties, as the case may be; and references to the Chairperson in these Standing Orders shall, so long as there is no Chairperson able to perform those duties, be taken to include references to the Senior Independent Director.

## **2.5 Joint Members**

- 2.5.1 Where more than one person is appointed jointly to a post mentioned in regulation 2(4)(a) of the Membership, Procedure and Administration Arrangements Regulations those persons shall count for the purpose of Standing Order 2.1 as one person.
- 2.5.2 Where the office of a member of the Board is shared jointly by more than one person:
- (a) either or both of those persons may attend or take part in meetings of the Board;
  - (b) if both are present at a meeting, they should cast one vote if they agree;
  - (c) in the case of disagreements, no vote should be cast;
  - (d) the presence of either or both of those persons should count as the presence of one person for the purposes of Standing Order 3.11 Quorum.

## **2.6 Patient and Public Involvement**

- 2.6.1 Sections 242 and 244 of The National Health Service Act 2006, and section 233 of the Local Government and Public Involvement in Health Act 2007 state (in summary) that an NHS Trust must make arrangements with regards to the health services for which it is responsible, which secure that users of those services whether directly, or through representatives are involved in:
- a) the planning of the provision of those services
  - b) the development and consideration of proposals for changes in the way those services are provided, and
  - c) decisions to be made by that body affecting the operation of those services
- but only if:**
- 2.6.2 Implementation of the proposal would have an impact on the manner in which the services are delivered to users of those services, or the range of health services available to those users.
- 2.6.3 The Board has made these arrangements through publication and implementation of a Communications and Engagement Strategy ratified by the Board in September 2017.

## 2.7 Role of Members

2.7.1 The Board will function as a corporate decision-making body, Executive and Non-Executive Members will be full and equal members. Their role as members of the Board of Directors will be to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions.

**(a) Executive Members**

Executive Members shall exercise their authority within the terms of these Standing Orders and Standing Financial Instructions and the Scheme of Delegation.

**(b) Chief Executive**

The Chief Executive shall be responsible for the overall performance of the executive functions of the Trust. He/she is the Accountable Officer for the Trust and shall be responsible for ensuring the discharge of obligations under Financial Directions and in line with the requirements of the Accountable Officer Memorandum for Trust Chief Executives.

**(c) Director of Finance (DOF)**

The DOF shall be responsible for the provision of financial advice to the Trust and to its members and for the supervision of financial control and accounting systems. He/she shall be responsible along with the Chief Executive for ensuring the discharge of obligations under relevant Financial Directions.

**(d) Non-Executive Members**

The Non-Executive Members shall not be granted, nor shall they seek to exercise any individual executive powers on behalf of the Trust. They may however, exercise collective authority when acting as members of or when chairing a committee of the Trust which has delegated powers.

**(e) Chairperson**

The Chairperson shall be responsible for the operation of the Board and chair all Board meetings when present. The Chairperson has certain delegated executive powers. The Chairperson must comply with the terms of appointment and with these Standing Orders.

The Chairperson shall liaise with NHS Improvement over the appointment of Non-Executive Directors and once appointed shall take responsibility either directly or indirectly for their induction, their portfolios of interests and assignments, and their performance.

The Chairperson shall work in close harmony with the Chief Executive and shall ensure that key and appropriate issues are discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform the debate and ultimate resolutions.

## 2.8 Corporate role of the Board

2.8.1 All business shall be conducted in the name of the Trust.

2.8.2 All funds received in trust shall be held in the name of the Trust as corporate trustee.

2.8.3 The powers of the Trust established under statute shall be exercised by the Board meeting in public session except as otherwise provided for in Standing Order 3.

2.8.4 The Board shall define and regularly review the functions it exercises on behalf of the Secretary of State.

## 2.9 Schedule of Matters reserved to the Board and Scheme of Delegation

The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These powers and decisions are set out in the 'Schedule of Matters Reserved to the Board' and shall have effect as if incorporated into the Standing Orders. Those powers which it has delegated to officers and other bodies are contained in the Scheme of Delegation (see section D).

## **2.10 Lead Roles for Board Members**

The Chairperson will ensure that the designation of Lead roles or appointments of Board members as required by the Department of Health or as set out in any statutory or other guidance will be made in accordance with that guidance or statutory requirement (e.g. appointing a Lead Board Member with responsibilities for Infection Control or Child Protection Services etc.).

## **3 MEETINGS OF THE TRUST**

### **3.1 Calling meetings**

- 3.1.1 Ordinary meetings of the Board shall be held at regular intervals at such times and places as the Board may determine.
- 3.1.2 The Chairperson of the Trust may call a meeting of the Board at any time.
- 3.1.3 One third or more members of the Board may requisition a meeting in writing. If the Chairperson refuses, or fails, to call a meeting within seven days of a requisition being presented, the members signing the requisition may forthwith call a meeting.

### **3.2 Notice of Meetings and the Business to be transacted**

- 3.2.1 Before each meeting of the Board a written notice specifying the business proposed to be transacted shall be delivered to every member at least three clear days before the meeting. The notice shall be signed by the Chairperson or by an officer authorised by the Chairperson to sign on their behalf. Want of service of such a notice on any member shall not affect the validity of a meeting.
- 3.2.2 In the case of a meeting called by members in default of the Chairperson calling the meeting, the notice shall be signed by those members.
- 3.2.3 No business shall be transacted at the meeting other than that specified on the agenda, or emergency motions allowed under Standing Order 3.6.
- 3.2.4 A member desiring a matter to be included on an agenda shall make his/her request in writing to the Chairperson at least ten clear days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than ten days before a meeting may be included on the agenda at the discretion of the Chairperson.
- 3.2.5 Before each meeting of the Board a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed at the Trust's principal offices at least **three** clear days before the meeting, (required by the Public Bodies (Admission to Meetings) Act 1960 Section 1 (4) (a)).

### **3.3 Agenda and Supporting Papers**

- 3.3.1 The Agenda will be sent to members **five days** before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be dispatched no later than three clear days (not working days) before the meeting, save in emergency.
- 3.3.2 The Trust will publish a copy of Board papers on the Trust website (making the papers available publicly) in line with the requirements (3.3.1) above. Spare sets of papers will

always be available on the day of the Board meeting when meeting physically.

### **3.4 Petitions**

- 3.4.1 Where a petition has been received by the Trust the Chairperson shall include the petition as an item for the agenda of the next meeting.

### **3.5 Notice of Motion**

- 3.5.1 Subject to the provision of Standing Orders 3.7 'Motions: Procedure at and during a meeting' and 3.8 'Motion to rescind a resolution', a member of the Board wishing to move a motion shall send a written notice to the Chief Executive who will ensure that it is brought to the immediate attention of the Chairperson.
- 3.5.2 The notice shall be delivered at least five clear days before the meeting. The Chief Executive shall include in the agenda for the meeting all notices so received that are in order and permissible under governing regulations. This Standing Order shall not prevent any motion being withdrawn or moved without notice on any business mentioned on the agenda for the meeting.

### **3.6 Emergency Motions**

- 3.6.1 Subject to the agreement of the Chairperson, and subject also to the provision of Standing Order 3.7 'Motions: Procedure at and during a meeting', a member of the Board may give written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared to the Board at the commencement of the business of the meeting as an additional item included in the agenda. The Chairperson's decision to include the item shall be final.

### **3.7 Motions: Procedure at and during a meeting**

#### **3.7.1 Who may propose?**

A motion may be proposed by the Chairperson of the meeting or any member present. It must also be seconded by another member.

#### **3.7.2 Contents of motions**

The Chairperson may exclude from the debate at their discretion any such motion of which notice was not given on the notice summoning the meeting other than a motion relating to:

- the reception of a report;
- consideration of any item of business before the Trust Board;
- the accuracy of minutes;
- that the Board proceed to next business;
- that the Board adjourn;
- that the question be now put.

#### **3.7.3 Amendments to motions**

- A motion for amendment shall not be discussed unless it has been proposed and seconded.
- Amendments to motions shall be moved relevant to the motion and shall not have the effect of negating the motion before the Board.
- If there are a number of amendments, they shall be considered one at a time. When a motion has been amended, the amended motion shall become the substantive motion before the meeting, upon which any further amendment may be moved.

#### **3.7.4 Rights of reply to motions**

##### a) Amendments

The mover of an amendment may reply to the debate on their amendment immediately

prior to the mover of the original motion, who shall have the right of reply at the close of debate on the amendment, but may not otherwise speak on it.

b) Substantive/original motion

The member who proposed the substantive motion shall have a right of reply at the close of any debate on the motion.

### **3.7.5 Withdrawing a motion**

A motion, or an amendment to a motion, may be withdrawn.

### **3.7.6 Motions once under debate**

When a motion is under debate, no motion may be moved other than:

- an amendment to the motion;
- the adjournment of the discussion, or the meeting;
- that the meeting proceed to the next business;
- that the question should be now put;
- the appointment of an 'ad hoc' committee to deal with a specific item of business;
- that a member/director be not further heard;
- a motion under Section I (2) or Section I (8) of the Public Bodies (Admissions to Meetings) Act 1960 resolving to exclude the public, including the press (see Standing Order 3.17).

In those cases where the motion is either that the meeting proceeds to the 'next business' or 'that the question be now put' in the interests of objectivity these should only be put forward by a member of the Board who has not taken part in the debate and who is eligible to vote.

If a motion to proceed to the next business or that the question be now put, is carried, the Chairperson should give the mover of the substantive motion under debate a right of reply, if not already exercised. The matter should then be put to the vote.

## **3.8 Motion to Rescind a Resolution**

3.8.1 Notice of motion to rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the member who gives it and also the signature of three other members, and before considering any such motion of which notice shall have been given, the Board may refer the matter to any appropriate Committee or the Chief Executive for recommendation.

3.8.2 When any such motion has been dealt with by the Board it shall not be competent for any director/member other than the Chairperson to propose a motion to the same effect within six months. This Standing Order shall not apply to motions moved in pursuance of a report or recommendations of a Committee or the Chief Executive.

## **3.9 Chairperson of Meeting**

3.9.1 At any meeting of the Board the Chairperson, if present, shall preside. If the Chairperson is absent from the meeting, the Senior Independent Director (if the Board has appointed one), if present, shall preside.

3.9.2 If the Chairperson and Senior Independent Director are absent, such member (who is not also an Officer/Executive Member of the Trust) as the members present shall choose shall preside.

## **3.10 Chairperson's ruling**

The decision of the Chairperson of the meeting on questions of order, relevancy and regularity (including procedure on handling motions) and their interpretation of the Standing Orders and Standing Financial Instructions, at the meeting, shall be final.

### **3.11 Quorum**

- 3.11.1 No business shall be transacted at a meeting unless at least one-third of the whole number of the Chairperson and members (including at least one member who is also an Officer/Executive Member of the Trust and two members who is not) is present.
- 3.11.2 An Officer in attendance for an Executive Director (Officer Member) but without formal acting up status may not count towards the quorum.
- 3.11.3 If the Chairperson or member has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest (see Standing Order 7.1) that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

### **3.12 Voting**

- 3.12.1 Save as provided in Standing Orders 3.13 - Suspension of Standing Orders and 3.14 - Variation and Amendment of Standing Orders, every question put to a vote at a meeting shall be determined by a majority of the votes of members present and voting on the question. In the case of an equal vote, the person presiding (i.e.: the Chairperson of the meeting) shall have a casting vote.
- 3.12.2 At the discretion of the Chairperson all questions put to the vote shall be determined by oral expression or by a show of hands, unless the Chairperson directs otherwise, or it is proposed, seconded and carried that a vote be taken by paper ballot.
- 3.12.3 If at least one third of the members present so request, the voting on any question may be recorded so as to show how each member present voted or did not vote (except when conducted by paper ballot).
- 3.12.4 If a member so requests, their vote shall be recorded by name.
- 3.12.5 In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote.
- 3.12.6 A manager who has been formally appointed to act up for an Officer Member during a period of absence, incapacity or temporarily to fill an Executive Director vacancy shall be entitled to exercise the voting rights of the Officer Member.
- 3.12.7 A manager attending the Board meeting to represent an Officer Member during a period of absence, incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Officer Member. An Officer's status when attending a meeting shall be recorded in the minutes.
- 3.12.8 For the voting rules relating to joint members see Standing Order 2.5.

### **3.13 Suspension of Standing Orders**

- 3.13.1 Except where this would contravene any statutory provision or any direction made by the Secretary of State or the rules relating to the Quorum (SO 3.11), any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the whole number of the members of the Board are present (including at least one member who is an Officer Member of the Trust and one member who is not) and that at least two-thirds of those members present signify their agreement to such suspension. The reason for the suspension shall be recorded in the Trust Board's minutes.
- 3.13.2 A separate record of matters discussed during the suspension of Standing Orders shall be

made and shall be available to the Chairperson and members of the Trust.

3.13.3 No formal business may be transacted while Standing Orders are suspended.

3.13.4 The Audit Committee shall review every decision to suspend Standing Orders.

### **3.14 Variation and amendment of Standing Orders**

3.14.1 These Standing Orders shall not be varied except in the following circumstances:

- upon a notice of motion under Standing Order 3.5;
- upon a recommendation of the Chairperson or Chief Executive included on the agenda for the meeting;
- that two thirds of the Board members are present at the meeting where the variation or amendment is being discussed, and that at least half of the Trust's Non-Officer members vote in favour of the amendment;
- providing that any variation or amendment does not contravene a statutory provision or direction made by the Secretary of State.

### **3.15 Record of Attendance**

3.15.1 The names of the Chairperson and Directors/members present at the meeting shall be recorded.

### **3.16 Minutes**

3.16.1 The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they shall be signed by the person presiding at it.

3.16.2 No discussion shall take place upon the minutes except upon their accuracy or where the Chairperson considers discussion appropriate.

### **3.17 Admission of public and the press**

#### **3.17.1 Admission and exclusion on grounds of confidentiality of business to be transacted**

The public and representatives of the press may attend all meetings of the Trust, but shall be required to withdraw upon the Board as follows:

'that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest', Section 1 (2), Public Bodies (Admission to Meetings) Act 1960.

*If necessary, guidance should be sought from the officer member responsible for Freedom of Information Lead to ensure correct procedure is followed on matters to be included in the exclusion.*

#### **3.17.2 General disturbances**

The Chairperson (or Senior Independent Director if one has been appointed) or the person presiding over the meeting shall give such directions as he thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Trust's business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Board resolving as follows:

'That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Board to complete its business without the presence of the public'. Section 1(8) Public Bodies (Admissions to Meetings) Act 1960.

**3.17.3 Business proposed to be transacted when the press and public have been excluded from a meeting**

Matters to be dealt with by the Board following the exclusion of representatives of the press, and other members of the public, as provided in (1) and (2) above, shall be confidential to the members of the Board.

Members and Officers or any employee of the Trust in attendance shall not reveal or disclose the contents of papers marked 'In Confidence' or minutes headed 'Items Taken in Private' outside of the Trust, without the express permission of the Trust. This prohibition shall apply equally to the content of any discussion during the Board meeting which may take place on such reports or papers.

**3.17.4 Use of Mechanical or Electrical Equipment for Recording or Transmission of Meetings**

Nothing in these Standing Orders shall be construed as permitting the introduction by the public, or press representatives, of recording, transmitting, video or similar apparatus into meetings of the Trust or Committee thereof. Such permission shall be granted only upon resolution of the Trust.

**3.18 Observers at Trust meetings**

3.18.1 The Trust will decide what arrangements and terms and conditions it feels are appropriate to offer in extending an invitation to observers to attend and address any of the Trust Board's meetings and may change, alter or vary these terms and conditions as it deems fit.

**4 APPOINTMENT OF COMMITTEES AND SUB-COMMITTEES**

**4.1 Appointment of Committees**

4.1.1 Subject to such directions as may be given by the Secretary of State for Health, the Board may appoint committees of the Trust.

4.1.2 The Trust shall determine the membership and terms of reference of committees and sub-committees and shall if it requires to, receive and consider reports of such committees.

**4.2 Joint Committees**

4.2.1 Joint committees may be appointed by the Trust by joining together with one or more other organisations, or other Trusts consisting of, wholly or partly of the Chairperson and members of the Trust or other health service bodies, or wholly of persons who are not members of the Trust or other health bodies in question.

4.2.2 Any committee or joint committee appointed under this Standing Order may, subject to such directions as may be given by the Secretary of State or the Trust or other health bodies in question, appoint sub-committees consisting wholly or partly of members of the committees or joint committee (whether or not they are members of the Trust or health bodies in question) or wholly of persons who are not members of the Trust or health bodies in question or the committee of the Trust or health bodies in question.

**4.3 Applicability of Standing Orders and Standing Financial Instructions to Committees**

4.3.1 The Standing Orders and Standing Financial Instructions of the Trust, as far as they are applicable, shall, as appropriate, apply to meetings and any committees established by the Trust. In which case the term "Chairperson" is to be read as a reference to the Chairperson of other committee as the context permits, and the term "member" is to be read as a reference to a member of other committee also as the context permits. (There is no requirement to hold meetings of committees established by the Trust in public.)

#### **4.4 Terms of Reference**

- 4.4.1 Each such committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board), as the Board shall decide and shall be in accordance with any legislation and regulation or direction issued by the Secretary of State. Such terms of reference shall have effect as if incorporated into the Standing Orders.

#### **4.5 Delegation of powers by Committees to Sub-Committees**

- 4.5.1 Where committees are authorised to establish sub-committees, they may not delegate executive powers to the sub-committee unless expressly authorised by the Trust Board.

#### **4.6 Approval of Appointments to Committees**

- 4.6.1 The Board shall approve the appointments to each of the committees which it has formally constituted. Where the Board determines, and regulations permit, that persons, who are neither members nor officers, shall be appointed to a committee the terms of such appointment shall be within the powers of the Board as defined by the Secretary of State. The Board shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance.

#### **4.7 Appointments for Statutory functions**

- 4.7.1 Where the Board is required to appoint persons to a committee and/or to undertake statutory functions as required by the Secretary of State, and where such appointments are to operate independently of the Board such appointment shall be made in accordance with the regulations and directions made by the Secretary of State.

#### **4.8 Committees established by the Trust Board**

- 4.8.1 The committees, sub-committees, and joint committees established by the Board are:

##### **Audit Committee**

- 4.8.2 The requirements of the Audit Committee are built on the work of the Cadbury Committee, Greenbury Reports and reports by Smith, Higgs and Turnbull (“Combined Code – Principles of Good Governance and Code of Best practice”) and subsequent guidance and best practice in the private and public sector. They reflect the growing role within the NHS of the committee in developing integrated governance arrangements and providing assurance that bodies are well managed across the whole range of their activities.
- 4.8.3 The Committee is a non-executive committee of the Board, consisting of not less than three non-executives, one of which should have significant financial experience. Head of External and Internal Audit and Counter Fraud attend the Committee – it is normal in the Trust for the DOF and Trust Board Business Manager to attend regularly. It must meet at least four times a year. The Committee membership, frequency and quoracy are described in its Terms of Reference.
- 4.8.4 The Committee is authorised to investigate any activity in its terms of reference, providing assurance to the Board in relation to the Board Assurance Framework, Governance, Risk Management and Internal Control. The Trust’s financial statements, annual report and annual governance statement are reviewed by the Audit Committee prior to submission to the Board. The Committee’s powers are described in its Terms of Reference and in the Scheme of Reservation and Delegation. Please also see Section 11 of the SFIs for more detail on the requirements for the Trust Audit Committee.

##### **Quality and Clinical Governance Committee**

- 4.8.5 The Quality and Clinical Governance Committee has delegated authority to ensure the ongoing development and delivery of the Trust’s Patient Safety and Quality Strategy and that this drives the Trust’s overall strategy.

- 4.8.6 The Trust's arrangements reflect the national drive for greater quality in healthcare, with a focus on safety, effectiveness and patient experience and reflect the reforms and principles set out in the July 2010 White Paper *Equity and excellence: Liberating the NHS* and the Francis Report, published in February 2013: which highlighted the fundamental responsibility of providing safe care which sits with the Trust Board.
- 4.8.7 There is significant regulation in place for healthcare providers that is designed to ensure delivery of high quality and safe services and the Committee has responsibility for seeking assurance in respect of that and ensuring actions are taken in respect of corrective measures. The Committee membership, frequency and quoracy are described in its Terms of Reference.
- 4.8.8 In summary, the Committee undertakes a number of duties, including (this list is not exhaustive):
- Ensuring that accurate and appropriate returns are submitted in response to regulators' requirements;
  - Ensuring the implementation, delivery and monitoring of the Trust's Safety and Quality Strategy;
  - Ensuring the management of the safety in line with legislation, standards and regulation;
  - Seeking assurances that the quality of patient services is of the appropriate standard and that risk and safety issues are being managed appropriately;
  - Seeking assurances that the Patient Experience Strategy is part of everyday business and that patient feedback and involvement is happening;
  - Sign off the Trust's Quality Account;
  - Overview of Clinical Audit.
- 4.8.9 The Committee's powers are described in its Terms of Reference and in the Scheme of Reservation and Delegation.

#### **Finance and Business Performance Committee**

- 4.8.10 The Trust has established a Finance and Business Performance Committee. The purpose of the Finance and Performance Committee is to:
- provide the Board with assurance concerning all aspects of finance and operational performance relating to the provision of care and services in support of getting the best clinical outcomes and experience for patients;
  - oversee all aspects of the financial arrangements of the Trust. It will provide the Board with assurance that the financial issues of the Trust are being appropriately addressed, and will provide the Board with information and advice on key issues; and
  - have oversight of the Trust's performance management framework and will, as required, focus on specific issues where the Trust's performance is deteriorating or there are issues of concern.
- 4.8.11 The Committee provides assurance to the Board that the business plan and supporting strategies are in place and fit for purpose. The Committee membership, frequency and quoracy are described in its Terms of Reference.
- 4.8.12 The Committee's powers are described in its Terms of Reference and in the Scheme of Reservation and Delegation.

#### **Nominations and Remuneration Committee**

- 4.8.13 The Nominations and Remuneration Committee's role is to establish and monitor the level and structure of reward for executive directors, ensuring transparency, fairness and consistency. The Committee shall receive reports from the Chairperson of the Board of Directors on the annual appraisal of the Chief Executive and from the Chief Executive on the annual appraisals of executive directors, as part of determining their remuneration.

- 4.8.14 The Committee, which will meet at least twice per year, is comprised of the Board Chair and all Non-Executive Directors. A minimum of three members should be present at meetings who are independent of management. The Committee membership, frequency and quoracy are described in its Terms of Reference.

#### **Charitable Funds Committee**

- 4.8.15 In line with its role as a corporate trustee for any funds held in trust, either as charitable or non-charitable funds, the Board will establish a Trust and Charitable Funds Committee to administer those funds in accordance with any statutory or other legal requirements or best practice required by the Charities Commission.
- 4.8.16 The Buckinghamshire Healthcare NHS Trust is the Corporate Trustee of the Charity governed by the law applicable to Trusts, principally the Trustee Act 2000 and the Charities Act 1993 and 2006. The Board has devolved responsibility for the on-going management of funds to the Charitable Funds Committee, which administers the funds on behalf of the Corporate Trustee. As such the Committee acts independently of the Board. Members of the Committee are not individual trustees under charity law but act as agents on behalf of the Corporate Trustee.
- 4.8.17 The Committee membership, frequency and quoracy are described in its Terms of Reference.
- 4.8.18 The provisions of this Standing Order must be read in conjunction with Standing Order 2.9 and Standing Financial Instruction 28. The Committee's powers are described in its Terms of Reference and in the Scheme of Reservation and Delegation.

#### **Strategic Workforce Committee**

- 4.8.19 The purpose of the Strategic Workforce Committee is to:
- provide the Board with assurance regarding delivery of the People Strategy and Organisational Development Strategy;
  - oversee all aspects of the workforce and organisational development arrangements of the Trust, including equality, diversity and inclusion; and
  - provide the Board with assurance that the workforce and organisational development issues of the Trust are being appropriately addressed and will provide the Board with information and advice on key issues.
- 4.8.20 The Committee will regularly review the Trust's workforce performance and will, when required, focus on specific issues where the Trust's performance is deteriorating or there are issues of concern.
- 4.8.21 The Committee membership, frequency and quoracy are described in its Terms of Reference.

#### **Other Committees**

- 4.8.22 The Board may also establish such other committees as required to discharge the Trust's responsibilities.

## **5 ARRANGEMENTS FOR THE EXERCISE OF TRUST FUNCTIONS BY DELEGATION**

### **5.1 Delegation of Functions to Committees, Officers or other bodies**

- 5.1.1 Subject to such directions as may be given by the Secretary of State, the Board may make arrangements for the exercise, on behalf of the Board, of any of its functions by a committee, sub-committee appointed by virtue of Standing Order 4, or by an officer of the Trust, or by another body as defined in Standing Order 5.1.2 below, in each case subject to such restrictions and conditions as the Trust thinks fit.
- 5.1.2 Legislation allows for regulations to provide for the functions of Trust's to be carried out by third parties. In accordance with The Trusts (Membership, Procedure and Administration

Arrangements) Regulations 2000 the functions of the Trust may also be carried out in the following ways:

- (i) by another Trust;
- (ii) jointly with any one or more of the following: NHS Trusts, NHSI or Commissioners;
- (iii) by arrangement with the appropriate Trust or Commissioners, by a joint committee or joint sub-committee of the Trust and one or more other health service bodies;
- (iv) in relation to arrangements made under S63(1) of the Health Services and Public Health Act 1968, jointly with NHSI, NHS Trusts or Commissioners.

5.1.3 Where a function is delegated by these Regulations to another Trust, then that Trust or health service body exercises the function in its own right; the receiving Trust has responsibility to ensure that the proper delegation of the function is in place. In other situations, i.e. delegation to committees, sub-committees or officers, the Trust delegating the function retains full responsibility.

## **5.2 Emergency Powers and urgent decisions**

5.2.1 The powers which the Board has reserved to itself within these Standing Orders (see Standing Order 2.9) may in emergency or for an urgent decision be exercised by the Chief Executive and the Chairperson after having consulted at least two non-executive members. The exercise of such powers by the Chief Executive and Chairperson shall be reported to the next formal meeting of the Board in public session for formal ratification.

## **5.3 Delegation to Committees**

5.3.1 The Board shall agree from time to time to the delegation of executive powers to be exercised by other committees, or sub-committees, or joint-committees, which it has formally constituted in accordance with directions issued by the Secretary of State. The constitution and terms of reference of these committees, or sub-committees, or joint committees, and their specific executive powers shall be approved by the Board in respect of its sub-committees.

5.3.2 When the Board is not meeting as the Trust in public session it shall operate as a committee and may only exercise such powers as may have been delegated to it by the Trust in public session.

## **5.4 Delegation to Officers**

5.4.1 Those functions of the Trust which have not been retained as reserved by the Board or delegated to other committee or sub-committee or joint committee shall be exercised on behalf of the Trust by the Chief Executive. The Chief Executive shall determine which functions he/she will perform personally and shall nominate officers to undertake the remaining functions for which he/she will still retain accountability to the Trust.

5.4.2 The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals which shall be considered and approved by the Board. The Chief Executive may periodically propose amendment to the Scheme of Delegation which shall be considered and approved by the Board.

5.4.3 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of the DOF to provide information and advise the Board in accordance with statutory or Department of Health requirements. Outside these statutory requirements the roles of the DOF shall be accountable to the Chief Executive for operational matters.

## **5.5 Schedule of Matters Reserved to the Trust and Scheme of Delegation of powers**

- 5.5.1 The arrangements made by the Board as set out in the "Schedule of Matters Reserved to the Board" and "Scheme of Delegation" of powers shall have effect as if incorporated in these Standing Orders.

## **5.6 Duty to report non-compliance with Standing Orders and Standing Financial Instructions**

- 5.6.1 If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Board for action or ratification. All members of the Board and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

## **6 OVERLAP WITH OTHER TRUST POLICY STATEMENTS/ PROCEDURES, REGULATIONS AND THE STANDING FINANCIAL INSTRUCTIONS**

### **6.1 Policy statements: general principles**

- 6.1.1 The Board will from time to time agree and approve Policy statements/ procedures which will apply to all or specific groups of staff employed by Buckinghamshire Healthcare NHS Trust. The decisions to approve such policies and procedures will be recorded in an appropriate Board minute and will be deemed where appropriate to be an integral part of the Trust's Standing Orders and Standing Financial Instructions.

### **6.2 Specific Policy statements**

- 6.2.1 Notwithstanding the application of SO 6.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following Policy statements:
- the Conflicts of Interest Policy for Buckinghamshire Healthcare NHS Trust staff;
  - the staff Disciplinary and Appeals Procedures adopted by the Trust both of which shall have effect as if incorporated in these Standing Orders.

### **6.3 Standing Financial Instructions**

- 6.3.1 Standing Financial Instructions adopted by the Board in accordance with the Financial Regulations shall have effect as if incorporated in these Standing Orders.

### **6.4 Specific guidance**

- 6.4.1 Notwithstanding the application of SO 6.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with all legislation and guidance issued by the Secretary of State for Health.
- 6.4.2 A comprehensive list of legislation and regulation as it applies to the Trust can be found in the Monitoring Compliance and Legislation policy.

## **7 DUTIES AND OBLIGATIONS OF BOARD MEMBERS/DIRECTORS AND SENIOR MANAGERS UNDER THESE STANDING ORDERS**

### **7.1 Declaration of Interests**

#### **7.1.1 Requirements for Declaring Interests and applicability to Board Members**

- 7.1.1.1 The NHS Code of Accountability requires Board Members to declare interests which are relevant and material to the NHS Board of which they are a member. All existing Board

members should declare such interests. Any Board members appointed subsequently should do so on appointment.

### **7.1.2 Interests which are relevant and material**

7.1.2.1 Interests which should be regarded as "relevant and material" are:

- a) Directorships, including Non-Executive Directorships held in private companies or PLCs (with the exception of those of dormant companies);
- b) Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS;
- c) Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS;
- d) A position of Authority in a charity or voluntary organisation in the field of health and social care;
- e) Any connection with a voluntary or other organisation contracting for NHS services;
- f) Research funding/grants that may be received by an individual or their department;
- g) Interests in pooled funds that are under separate management.

7.1.2.2 Any member of the Board who comes to know that the Trust has entered into or proposes to enter into a contract in which he/she or any person connected with him/her (as defined in Standing Order 7.3 below and elsewhere) has any pecuniary interest, direct or indirect, the Board member shall declare his/her interest by giving notice in writing of such fact to the Trust as soon as practicable.

### **7.1.3 Advice on Interests**

7.1.3.1 If Board members have any doubt about the relevance of an interest, this should be discussed with the Chairperson of the Trust or with the Trust's Company Secretary.

7.1.3.2 Influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

### **7.1.4 Recording of Interests in Board minutes**

7.1.4.1 At the time Board members' interests are declared, they should be recorded in the Board minutes.

7.1.4.2 Any changes in interests should be declared at the next Board meeting following the change occurring and recorded in the minutes of that meeting.

### **7.1.5 Publication of declared interests in Annual Report**

7.1.5.1 Board members' directorships of companies likely or possibly seeking to do business with the NHS should be published in the Trust's annual report. The information should be kept up to date for inclusion in succeeding annual reports.

### **7.1.6 Conflicts of interest which arise during the course of a meeting**

7.1.6.1 During the course of a Board meeting, if a conflict of interest is established, the Board member concerned should withdraw from the meeting and play no part in the relevant discussion or decision. (See overlap with SO 7.3.)

## **7.2 Register of Interests**

- 7.2.1 The Chief Executive will ensure that a Register of Interests is established to record formally declarations of interests of Board or Committee members. In particular, the Register will include details of all directorships and other relevant and material interests (as defined in SO 7.1.2) which have been declared by both Executive and Non-Executive Board members.
- 7.2.2 These details will be kept up to date by means of an annual review of the Register in which any changes to interests declared during the preceding twelve months will be incorporated.
- 7.2.3 The Register will be available to the public and the Chief Executive will take reasonable steps to bring the existence of the Register to the attention of local residents and to publicise arrangements for viewing it.

### **7.3 Exclusion of Chairperson and Members in proceedings on account of pecuniary interest**

#### **7.3.1 Definition of terms used in interpreting 'Pecuniary' interest**

For the sake of clarity, the following definition of terms is to be used in interpreting this Standing Order:

- (i) "spouse" shall include any person who lives with another person in the same household (and any pecuniary interest of one spouse shall, if known to the other spouse, be deemed to be an interest of that other spouse);
- (ii) "contract" shall include any proposed contract or other course of dealing.
- (iii) "Pecuniary interest"

Subject to the exceptions set out in this Standing Order, a person shall be treated as having an indirect pecuniary interest in a contract if: -

- a) he/she, or a nominee of his/her, is a member of a company or other body (not being a public body), with which the contract is made, or to be made or which has a direct pecuniary interest in the same, or
- b) he/she is a partner, associate or employee of any person with whom the contract is made or to be made or who has a direct pecuniary interest in the same.

#### iv) Exception to Pecuniary interests

A person shall not be regarded as having a pecuniary interest in any contract if: -

- a) neither he/she or any person connected with him/her has any beneficial interest in the securities of a company of which he/she or such person appears as a member, or
- b) any interest that he/she or any person connected with him/her may have in the contract is so remote or insignificant that it cannot reasonably be regarded as likely to influence him/her in relation to considering or voting on that contract, or
- c) those securities of any company in which he/she (or any person connected with him/her) has a beneficial interest do not exceed £5,000 in nominal value or one per cent of the total issued share capital of the company or of the relevant class of such capital, whichever is the less.

Provided however, that where paragraph (c) above applies the person shall nevertheless be obliged to disclose/declare their interest in accordance with Standing Order 7.1.2.2.

### 7.3.2 Exclusion in proceedings of the Trust Board

- (i) Subject to the following provisions of this Standing Order, if the Chairperson or a member of the Board has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Board at which the contract or other matter is the subject of consideration, at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.
- (ii) The Secretary of State may, subject to such conditions as he/she may think fit to impose, remove any disability imposed by this Standing Order in any case in which it appears to him/her in the interests of the National Health Service that the disability should be removed. (See SO 7.3.3 on the 'Waiver' which has been approved by the Secretary of State for Health).
- (iii) The Board may exclude the Chairperson or a member of the Board from a meeting of the Board while any contract, proposed contract or other matter in which he/she has a pecuniary interest is under consideration.
- (iv) Any remuneration, compensation or allowance payable to the Chairperson or a Member by virtue of paragraph 11 of Schedule 5A to the National Health Service Act 1977 (pay and allowances) shall not be treated as a pecuniary interest for the purpose of this Standing Order.
- (v) This Standing Order applies to a committee or sub-committee and to a joint committee or sub-committee as it applies to the Trust and applies to a member of any such committee or sub-committee (whether or not he/she is also a member of the Trust) as it applies to a member of the Trust.

### 7.3.3 Waiver of Standing Orders made by the Secretary of State for Health

#### (1) Power of the Secretary of State to make waivers

Under regulation 11(2) of the NHS (Membership and Procedure Regulations SI 1999/2024 ("the Regulations"), there is a power for the Secretary of State to issue waivers if it appears to the Secretary of State in the interests of the health service that the disability in regulation 11 (which prevents a Chairperson or a member from taking part in the consideration or discussion of, or voting on any question with respect to, a matter in which he has a pecuniary interest) is removed. A waiver has been agreed in line with sub-sections (2) to (4) below.

#### (2) Definition of 'Chairperson' for the purpose of interpreting this waiver

For the purposes of paragraph 7.3.3.(3) (below), the "relevant Chairperson" is –

- (a) at a meeting of the Trust, the Chairperson of that Trust;
- (b) at a meeting of a Committee –
  - (i) in a case where the member in question is the Chairperson of that Committee, the Chairperson of the Trust;
  - (ii) in the case of any other member, the Chairperson of that Committee.

#### (3) Application of waiver

A waiver will apply in relation to the disability to participate in the proceedings of the Trust on account of a pecuniary interest.

It will apply to:

- (i) A member of the Buckinghamshire Healthcare NHS Trust (“the Trust”), who is a healthcare professional, within the meaning of regulation 5(5) of the Regulations, and who is providing or performing, or assisting in the provision or performance, of:
  - (a) services under the National Health Service Act 2006; or
  - (b) services in connection with a pilot scheme under NHS legislationfor the benefit of persons for whom the Trust is responsible.
- (ii) Where the ‘pecuniary interest’ of the member in the matter which is the subject of consideration at a meeting at which he is present: -
  - (a) arises by reason only of the member’s role as such a professional providing or performing, or assisting in the provision or performance of, those services to those persons;
  - (b) has been declared by the relevant Chairperson as an interest which cannot reasonably be regarded as an interest more substantial than that of the majority of other persons who: –
    - (i) are members of the same profession as the member in question,
    - (ii) are providing or performing, or assisting in the provision or performance of, such of those services as he provides or performs, or assists in the provision or performance of, for the benefit of persons for whom the Trust is responsible.
- (4) Conditions which apply to the waiver and the removal of having a pecuniary interest

The removal is subject to the following conditions:

- (a) the member must disclose his/her interest as soon as practicable after the commencement of the meeting and this must be recorded in the minutes;
- (b) the relevant Chairperson must consult the Chief Executive before making a declaration in relation to the member in question pursuant to paragraph 7.3.3 (2) (b) above, except where that member is the Chief Executive.
- (c) **in the case of a meeting of the Trust:**
  - (i) the member may take part in the consideration or discussion of the matter which must be subjected to a vote and the outcome recorded;
  - (ii) may not vote on any question with respect to it.
- (d) **in the case of a meeting of the Committee:**
  - (i) the member may take part in the consideration or discussion of the matter which must be subjected to a vote and the outcome recorded;
  - (ii) may vote on any question with respect to it; but
  - (iii) the resolution which is subject to the vote must comprise a recommendation to, and be referred for approval by, the Trust Board.

## 7.4 Standards of Business Conduct

#### **7.4.1 Trust Policy and National Guidance**

All Trust staff and members of must comply with the Trust's Conflicts of Interest Policy and the national guidance contained in HSG(93)5 on 'Standards of Business Conduct for NHS staff' (the guidance contained within this document referring to the 'Prevention of Corruption Acts 1889 - 1916' has been superseded by the 'Bribery Act 2010') (see SO 6.2).

#### **7.4.2 Interest of Officers in Contracts**

- i) Any officer or employee of the Trust who comes to know that the Trust has entered into or proposes to enter into a contract in which he/she or any person connected with him/her (as defined in SO 7.3) has any pecuniary interest, direct or indirect, the Officer shall declare their interest by giving notice in writing of such fact to the Chief Executive or the Trust's Board/Company Secretary as soon as practicable.
- ii) An Officer should also declare to the Chief Executive any other employment or business or other relationship of his/her, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.
- iii) The Trust will require interests, employment or relationships so declared to be entered in a register of interests of staff.

#### **7.4.3 Canvassing of and Recommendations by Members in Relation to Appointments**

- i) Canvassing of members of the Trust or of any Committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.
- ii) Members of the Trust shall not solicit for any person any appointment under the Trust or recommend any person for such appointment; but this paragraph of this Standing Order shall not preclude a member from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

#### **7.4.4 Relatives of Members or Officers**

- i) Candidates for any staff appointment under the Trust shall, when making an application, disclose in writing to the Trust whether they are related to any member or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him/her liable to instant dismissal.
- ii) The Chairperson and every member and officer of the Trust shall disclose to the Board any relationship between himself/herself and a candidate of whose candidature that member or officer is aware. It shall be the duty of the Chief Executive to report to the Board any such disclosure made.
- iii) On appointment, members (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Trust whether they are related to any other member or holder of any office under the Trust.
- iv) Where the relationship to a member of the Trust is disclosed, the Standing Order headed 'Disability of Chairperson and members in proceedings on account of pecuniary interest' (SO 7) shall apply.

## **8 CUSTODY OF SEAL, SEALING OF DOCUMENTS AND SIGNATURE OF DOCUMENTS**

### **8.1 Custody of Seal**

- 8.1.1 The common seal of the Trust shall be kept by the Chief Executive or a nominated Manager by him/her in a secure place.

## **8.2 Sealing of Documents**

- 8.2.1 Where it is necessary that a document shall be sealed, the seal shall be affixed in the presence of two Executive Directors duly authorised by the Chief Executive, and not also from the originating department, and shall be attested by them.

## **8.3 Register of Sealing**

- 8.3.1 The Chief Executive shall keep a register in which he/she, or another manager of the Authority authorised by him/her, shall enter a record of the sealing of every document.

## **8.4 Signature of documents**

- 8.4.1 Where any document will be a necessary step in legal proceedings (including the signing of contracts and agreements) on behalf of the Trust, it shall, unless any enactment otherwise requires or authorises, be signed by the Chief Executive or any Executive Director.
- 8.4.2 In land transactions, the signing of certain supporting documents will be delegated to Managers and set out clearly in the Scheme of Delegation but will not include the main or principal documents effecting the transfer (e.g. sale/purchase agreement, lease, contracts for construction works and main warranty agreements or any document which is required to be executed as a deed).

# **9 MISCELLANEOUS**

## **9.1 Joint Finance Arrangements**

The Board may confirm contracts to purchase from a voluntary organisation or a local authority using its powers under Section 28A of the NHS Act 1977. The Board may confirm contracts to transfer money from the NHS to the voluntary sector or the health related functions of local authorities where such a transfer is to fund services to improve the health of the local population more effectively than equivalent expenditure on NHS services, using its powers under Section 28A of the NHS Act 1977, as amended by section 29 of the Health Act 1999.

See overlap with Standing Financial Instruction 19.7.

## SECTION C – Standing Financial Instructions

### 10.1 Introduction

- 10.1.1 These Standing Financial Instructions (SFIs) are issued in accordance with the Trust (Functions) Directions 2000 issued by the Secretary of State which require that each Trust shall agree Standing Financial Instructions for the regulation of the conduct of its members and officers in relation to all financial matters with which they are concerned. They shall have effect as if incorporated in the Standing Orders (SOs).
- 10.1.2 These Standing Financial Instructions detail the financial responsibilities and policies adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Schedule of Decisions Reserved to the Board and the Scheme of Delegation adopted by the Trust.
- 10.1.3 These Standing Financial Instructions identify the financial responsibilities which apply to everyone working for the Trust and its constituent organisations including Trading Units. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes. All financial procedures must be approved by the DOF.
- 10.1.4 Should any difficulties arise regarding the interpretation or application of any of the Standing Financial Instructions then the advice of the DOF must be sought before acting. The user of these Standing Financial Instructions should also be familiar with and comply with the provisions of the Trust's Standing Orders (dealing with non-financial aspects).
- 10.1.5 The failure to comply with Standing Financial Instructions and Standing Orders can in certain circumstances be regarded as a disciplinary matter that could result in dismissal.**
- 10.1.6 **Overriding Standing Financial Instructions** – If for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit Committee for referring action or ratification. All members of the Board and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the DOF as soon as possible. The DOF will exercise their judgement in respect of actions when potential breaches are notified.

### 10.2 Responsibilities and delegation

#### 10.2.1 The Trust Board

10.2.1.1 The Board exercises financial supervision and control by:

- (a) formulating the financial strategy;
- (b) requiring the submission and approval of budgets within approved allocations/overall income;
- (c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money);

- (d) defining specific responsibilities placed on members of the Board and employees as indicated in the Scheme of Delegation document.

10.2.1.2 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the 'Reservation of Matters Reserved to the Board' document above. All other powers have been delegated to such other committees as the Trust has established.

## **10.2.2 The Chief Executive and Director of Finance (DOF)**

10.2.2.1 The Chief Executive and DOF will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

10.2.2.2 Within the Standing Financial Instructions, it is acknowledged that the Chief Executive is ultimately accountable to the Board, and as Accountable Officer, to the Secretary of State, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities; is responsible to the Chairperson and the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

10.2.2.3 It is a duty of the Chief Executive to ensure that Members of the Board and, employees and all new appointees are notified of, and put in a position to understand their responsibilities within these Instructions.

## **10.2.3 The Director of Finance (DOF)**

10.2.3.1 The DOF is responsible for:

- (a) implementing the Trust's financial policies and for coordinating any corrective action necessary to further these policies;
- (b) maintaining an efficient and effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;
- (c) ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time;
- (d) without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the DOF include:
  - (i) the provision of financial advice to other members of the Board and employees;
  - (ii) the design, implementation and supervision of systems of internal financial control;
  - (iii) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

## **10.2.4 Board Members and Employees**

- 10.2.4.1 All members of the Board and all employees, severally and collectively, are responsible for:
- a. the security of the property of the Trust;
  - b. avoiding loss;
  - c. exercising economy, efficiency and effectiveness in the use of resources;
  - d. conforming the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation.

## **10.2.5 Contractors and their employees**

- 10.2.5.1 Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.
- 10.2.5.2 For all members of the Board and any employees who carry out a financial function, the form in which financial records are kept and the manner in which members of the Board and employees discharge their duties must be to the satisfaction of the DOF.

# **11 AUDIT**

## **11.1 Audit Committee**

- 11.1.1 In accordance with Standing Orders (please see para 4.8.1), the Board shall formally establish an Audit Committee with clearly defined terms of reference and following guidance from the NHS Audit Committee Handbook (2011), which will provide an independent and objective review of assurances in respect of all Trust systems of control by:
- a) reviewing opinions and recommendations from Internal Audit, External Audit and also Local counter Fraud Services in recommending the adoption of financial and quality accounts
  - b) considering views and opinions from other external regulatory bodies (for example the Care Quality Commission);
  - c) reviewing the effectiveness and efficiency of financial, non-financial and information systems and monitoring the integrity of the financial statements and reviewing significant financial reporting judgments;
  - d) review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), that supports the achievement of the Trust's corporate objectives;
  - e) monitoring compliance with Standing Orders and Standing Financial Instructions;
  - f) reviewing schedules of losses and special payments and making recommendations to the Board;
  - g) reviewing the arrangements in place to support the Board Assurance Framework process prepared on behalf of the Board and advising the Board accordingly.
- 11.1.2 Where the Audit Committee considers there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wishes to raise, the Chairperson of the Audit Committee should raise the matter at a full meeting of the Board. Exceptionally, the matter may need to be referred to the Department of Health. (To the DOF in the first instance).

- 11.1.3 It is the responsibility of the DOF to ensure an adequate Internal Audit service is provided and the Audit Committee shall be involved in the selection process when/if an Internal Audit service provider is changed.

## **11.2 Director of Finance (DOF)**

- 11.2.1 The DOF is responsible for:
- (a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function;
  - (b) ensuring that the Internal Audit is adequate and meets the NHS mandatory audit standards;
  - (c) deciding at what stage to involve the police, in conjunction with the (Local Security Management Specialist LSMS), in cases of misappropriation and other irregularities not involving fraud or corruption;
  - (d) ensuring that an annual internal audit report is prepared for the consideration of the Audit (and the Board). The report must cover:
    - (i) a clear opinion on the effectiveness of internal control in accordance with current assurance framework guidance issued by the Department of Health including for example compliance with control criteria and standards;
    - (ii) major internal financial control weaknesses discovered;
    - (iii) progress on the implementation of internal audit recommendations;
    - (iv) progress against plan over the previous year;
    - (v) strategic audit plan covering the coming three years;
    - (vi) a detailed plan for the coming year.
- 11.2.2 The DOF or designated auditors are entitled without necessarily giving prior notice to require and receive:
- a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;
  - (b) access at all reasonable times to any land, premises or members of the Board or employee of the Trust;
  - (c) the production of any cash, stores or other property of the Trust under a member of the Board and an employee's control; and
  - (d) explanations concerning any matter under investigation.

## **11.3 Role of Internal Audit**

- 11.3.1 The responsibilities of internal audit are set out in the International Standards for the Professional Practice of Internal Auditing, published by the Chartered Institute of Internal Auditors (CIIA in the UK and Ireland). Internal Audit will essentially review and evaluate the risk management, control and governance arrangements that the organisation has in place, and also to appraise and report upon:

- (a) the extent of compliance with, and the financial effect of relevant, established policies, plans and procedures;
- (b) the adequacy and application of financial and other related management controls;
- (c) the suitability of financial and other related management data;
- (d) the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:
  - (i) fraud and other offences;
  - (ii) waste, extravagance, inefficient administration;
  - (iii) poor value for money or other causes.
- (e) .
- (f) The degree of implementation achieved in relation to recommendations agreed by management during the prior and current financial year are tracked every month by Internal Audit as well as the Trust and presented to the Audit Committee. This will serve to inform the adequacy of the Trust's speed and efficiency in implementing control recommendations.

11.3.2 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the DOF and the LSMS must be notified immediately.

11.3.3 The Head of Internal Audit will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chairperson and Chief Executive of the Trust.

11.3.4 The Head of Internal Audit shall be accountable to the DOF. The reporting system for internal audit shall be agreed between the DOF, the Audit Committee and the Chief Internal Auditor. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit Standards. The reporting system shall be reviewed at least every three years.

11.3.5 Internal Audit will ensure that the level and quality of audit resource is appropriate and available given the level of assurance required.

11.3.6 Internal Audit will also give consideration to government initiatives such as spending reviews and other austerity measures which impact upon the NHS and provision of health services where they can impact upon risk management, governance and internal controls.

11.3.7 Internal Audit are expected to meet with the Trust's External Auditors regularly, either through Committee meetings or otherwise, to confirm the scope of the work in the area of Internal Financial Control in order to ensure that they can continue to place their planned level of reliance on the work of internal audit.

## **11.4 External Audit**

11.4.1 The External Auditor is appointed by and paid for by the Trust. The Audit Committee must ensure a cost-efficient service. If there are any problems relating to the service provided by the External Auditor, then this should be raised with the External Auditor and referred on to the relevant oversight body.

## **11.5 Fraud and Corruption**

- 11.5.1 In line with their responsibilities, the Trust Chief Executive and DOF shall monitor and ensure compliance with Directions issued by the Secretary of State for Health on fraud and corruption.
- 11.5.2 The Trust shall nominate the Director of Finance to carry out the duties of the Local Counter Fraud Specialist (LCFS) as specified by the Department of Health Counter Fraud and Corruption Manual and guidance.
- 11.5.3 The Bribery Act 2010 replaces the "Prevention of Corruption Acts 1889 - 1916" with new corporate and individual offences as defined within Section 17 of these Standing Financial Instructions. All staff and contractors should be made aware of the Act to ensure compliance. Any breach of the Act may result in criminal proceedings.
- 11.5.4 The LCFS shall report to the Trust DOF and shall work with staff in NHS Protect in accordance with the Department of Health Fraud and Corruption Manual.
- 11.5.5 The "Counter Fraud Policy and Response Plan" sets out the action to be taken both by persons detecting a suspected fraud and those persons responsible for investigating it.
- 11.5.6 The LCFS will attend Audit Committee meetings when necessary and has a right of access to all Audit Committee members, the Chair and Chief Executive of the Trust.
- 11.5.7 The LCFS shall be accountable to the Trust DOF. The reporting system for Counter Fraud services shall be agreed between the DOF, the Audit Committee and the LCFS. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Counter Fraud and Corruption Manual and guidance. The reporting system shall be reviewed at least every 3 years.
- 11.5.8 The LCFS will provide a written report, at least annually, on counter fraud work within the Trust. In addition, regular updates on counter fraud work undertaken at the Trust shall be provided to the Audit committee throughout the year.

## **11.6 Security Management**

- 11.6.1 In line with their responsibilities, the Trust Chief Executive will monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS site security management.
- 11.6.2 The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified by the Secretary of State for Health guidance on NHS site security management.
- 11.6.3 The Chief Executive has overall responsibility for controlling and coordinating the physical security of Trust sites. However, key tasks are delegated to the Commercial Director responsible for Security Management and the appointed Local Security Management Specialist (LSMS).

## **12 ANNUAL ACCOUNTS AND REPORTS**

- 12.1 The DOF, on behalf of the Trust, will:
  - (a) prepare financial returns in accordance with the accounting policies and guidance given by the Department of Health and the Treasury, the Trust's accounting policies, and International Financial Reporting Standards;
  - (b) prepare and submit annual financial reports to the Department of Health certified in accordance with current guidelines;

- (c) submit financial returns to the Department of Health for each financial year in accordance with the timetable prescribed by the Department of Health.
- 12.2 The Trust's annual accounts must be audited by a correctly appointed auditor. The Trust's audited annual accounts must be presented to a public meeting and made available to the public.
- 12.3 The Trust will publish an annual report, in accordance with guidelines on local accountability, and present it at a public meeting. The document will comply with the Department of Health's Manual for Accounts.

## **13 BANK ACCOUNTS**

### **13.1 General**

- 13.1.1 The Trust will make changes to its banking arrangements in line with instructions provided by the Government Banking Service (GBS).
- 13.1.2 The Board shall approve the banking arrangements.

### **13.2 Bank Accounts**

- 13.2.1 The DOF is responsible for:
  - (a) commercial bank accounts and Government Banking Service accounts;
  - (b) establishing separate bank accounts for the Trust's non-exchequer funds;
  - (c) ensuring payments made from commercial bank or accounts do not exceed the amount credited to the account except where arrangements have been made;
  - (d) reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn.
  - (e) monitoring compliance with Department of Health guidance on the level of cleared funds.
  - (f) ensuring payments made from the Trust credit cards do not exceed the authorised limits assigned to each card and that the cards are used solely for the purposes of Trust business in line with Trust procedures.

### **13.3 Banking Procedures**

- 13.3.1 The DOF will prepare detailed instructions on the operation of bank and GBS accounts which must include:
  - (a) the conditions under which each commercial bank and account is to be operated;
  - (b) those authorised to sign cheques or other orders drawn on the Trust's accounts.
- 13.3.2 The DOF must advise the Trust's bankers in writing of the conditions under which each account will be operated.

### **13.4 Tendering and Review**

- 13.4.1 The DOF will review the commercial banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's commercial banking business.
- 13.4.2 Competitive tenders should be sought at least every five years. The results of the

tendering exercise should be reported to the Board.

## **14 INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS**

### **14.1 Income Systems**

- 14.1.1 The DOF is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collecting and coding of all monies due.
- 14.1.2 The DOF is also responsible for the prompt banking of all monies received.

### **14.2 Fees and Charges**

- 14.2.1 The Trust shall follow the Department of Health's advice in the "Costing" Manual in setting prices for NHS service agreements.
- 14.2.2 The DOF is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health or by Statute. Independent professional advice on matters of valuation shall be taken as necessary.
- 14.2.3 All employees must inform the DOF promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

### **14.3 Debt Recovery**

- 14.3.1 The DOF is responsible for the appropriate recovery action on all outstanding debts.
- 14.3.2 Income not received should be dealt with in accordance with losses procedures.
- 14.3.3 Overpayments should be detected (or preferably prevented) and recovery initiated.

### **14.4 Security of Cash, Cheques and other Negotiable Instruments**

- 14.4.1 The DOF is responsible for:
  - (a) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;
  - (b) ordering and securely controlling any such stationery;
  - (c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines;
  - (d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust;
  - (e) ensuring that Trust credit cards are kept within a secure location and used appropriately in line with Trust procedures.
- 14.4.2 Official money shall not under any circumstances be used for the encashment of private cheques or IOUs.
- 14.4.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the DOF.
- 14.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

## **15 INCOME - NHS CONTRACTS FOR PROVISION OF SERVICES**

## **15.1 Introduction - commissioning healthcare in the NHS**

- 15.1.1 These SFIs have been significantly revised to take account of the national contract for commissioning healthcare services and the rules surrounding it. It is important to understand the principles of the contract to appreciate the instructions set out in these SFIs concerning work done in the Trust.
- 15.1.2 The main source of income to fund Trust services is from Contracts with Clinical Commissioning Groups (CCGs) as well as NHS England (specialised Commissioners). The Local Authority are expected to take the lead on behalf of the local population, seeking their views as well as assessing their needs to act as the catalyst for service improvement and commission the health care services they require.
- 15.1.3 The key mechanism in the way patients access NHS services in secondary care (e.g.: an acute trust) is the GP's role in referring people – the GP acts as the gatekeeper to secondary care services (as provided in an acute trust).
- 15.1.4 NHS guidance outlines ambitions to deliver world-class commissioning, in turn delivering better health outcomes, narrowing health inequalities and adding years to life.

## **15.2 The NHS Standard contract**

- 15.2.1 A national contract for CCGs and NHS England of healthcare services is now mandatory, unless under national direction (e.g. Level 4 incident). The contract is based upon principles of cooperation and competition and Commissioners must use it as the basis for all agreements with NHS acute trusts.

The NHS Standard contract is available at: [www.england.nhs.uk/nhs-standard-contract/](http://www.england.nhs.uk/nhs-standard-contract/).

## **15.3 Trust responsibilities to agree the contract with Commissioners**

- 15.3.1 The Chief Executive, as the Accountable Officer, is responsible for ensuring the Trust enters into suitable Contracts with service commissioners for the provision of NHS services. They will be advised by the DOF.
- 15.3.2 A good contract will result from a dialogue of clinicians, users, carers, public health professionals and managers. It will reflect knowledge of local needs and inequalities. This will require the Chief Executive to ensure that the Trust works with all partner agencies involved in both the delivery and the commissioning of the service required. The contract will apportion responsibility for handling a particular risk to the party or parties in the best position to influence the event and financial arrangements should reflect this. In this way the Trust can jointly manage risk with all interested parties.

## **15.4 Contractual control and reports to Board**

- 15.4.1 The Chief Executive, as the Accountable Officer, will need to ensure that regular reports are provided to the Board detailing actual and forecast income from the contract. These will in turn be the responsibility of the DOF.
- 15.4.2 Additionally, the DOF will devise and maintain systems of contractual control. These will include:
  - (a) Monthly reconciliation of Trust activity data with the data used by Commissioners and the agreement of the figures used to confirm payment with the Commissioners;
  - (b) The monthly identification of any dispute that could lead to financial penalty and its escalation for speedy resolution;
  - (c) Monthly reports to the Board in a form approved by the Board;
  - (d) The issue of timely, accurate and comprehensible advice and activity reports to relevant

budget holders and other key staff, covering the areas for which they are responsible;

- (e) Investigation and reporting of variances from activity and income;
- (f) Monitoring of management action to correct variances.

## **15.5 Work done that is not covered or restricted by the contract**

15.5.1 Trust staff responsible for making decisions about healthcare procedures should not normally commit Trust resources for work/procedures that are either not covered by the contract or subject to specific restriction unless there is reasonable justification to do so. It is expected that such instances are exceptional.

15.5.2 Staff making healthcare decisions must be aware of the contractual requirements for the provision of services for which they are responsible and the Chief Executive, through Trust Directors, has a responsibility to ensure systems are in place to enable that and support common sense management of any grey area.

15.5.3 Responsibilities to effect the above can be described as follows:

- (a) the DOF must ensure that the hierarchy of managers and clinicians overseeing healthcare decision making is clearly aware of what Commissioners are commissioning, provide this information at Divisional and specialty levels and to individual staff as necessary;
- (b) For areas where there is likely to be potential uncertainty (for example identification of previously unspecified healthcare needs related to an excluded procedure) the DOF is responsible for putting in place effective processes to deal with that eventuality (for example a pro forma approval process with the Commissioners);
- (c) Individual staff who carry responsibility for healthcare decision making should make themselves aware of the contractual requirements. This means that they are expected to involve themselves in business planning and operational management, liaise actively with Trust managers and access and read Trust communications (notably the intranet).
- (d) Where an issue arises that provides a conflict with clinical governance, individual staff have a responsibility to notify that through the Trust's integrated governance and risk management processes and seek a resolution.

15.5.4 It is explicitly acknowledged that this is a complex area. Healthcare is complex, individual and includes safety and clinical governance considerations whose specificity cannot be legislated for in every case, however good a contract document. Many decisions require on the spot judgements that may need to be made immediately. Trust staff should therefore follow these principles:

- (a) The patient's immediate needs and safety outweighs any other consideration;
- (b) If there is uncertainty over or a potential clash with contractual requirements and there is time to do so, the Commissioners should be contacted and asked to confirm in writing that a procedure can proceed;
- (c) If Trust guidance or instruction is incorrect, unclear or poorly considered it should be highlighted through Trust governance structures and resolved;
- (d) Trust guidance or instruction that is adequately validated, formally agreed and tested should only be ignored in very exceptional circumstances;
- (e) Persistent failure to follow formally notified Trust guidance or instruction is unreasonable and unacceptable.

- 15.5.5 In addition, any persistent and unreasonable failure to provide information necessary to secure payment from the Commissioners, and that results in financial loss, will also be taken as a breach of these SFIs.

## **16 ALLOCATIONS, PLANNING, BUDGETS, BUDGETARY CONTROL, AND MONITORING**

### **16.1 Preparation and Approval of Plans and Budgets**

- 16.1.1 The Director of Strategy on behalf of the Chief Executive will compile and submit to the Board a Business Plan which takes into account financial targets and forecast limits of available resources as advised by the DOF. The Business Plan will contain:
- (a) a statement of the significant assumptions and risks on which the plan is based;
  - (b) details of major changes in workload, delivery of services or resources required to achieve the plan.
- 16.1.2 Prior to the start of the financial year the DOF will, on behalf of the Chief Executive, prepare and submit a Trust budget for approval by the Board. The budget will:
- (a) be in accordance with the aims and objectives set out in the Business Plan;
  - (b) accord with workload and workforce plans;
  - (c) be produced following discussion with appropriate budget holders;
  - (d) be prepared within the limits of available funds;
  - (e) identify potential risks.
- 16.1.3 The DOF shall monitor financial performance against budget and plan, periodically review them, and report to the Board of major changes in workload, delivery of services or resources required to achieve the plan.
- 16.1.4 All budget holders must provide information as required by the DOF to enable budgets to be compiled. The DOF should foster ownership of budgets by actively involving budget holders in the setting of budgets and savings plans.
- 16.1.5 All budget holders will sign up to their allocated budgets (including savings plans) at the commencement of each financial year. A budget holder who declines to do so cannot remain a budget holder, whatever the reason for their non acceptance of the budget.

### **16.2 Budget Holders**

- 16.2.1 The DOF is responsible for specifying the criteria allowing an individual to be a budget holder and may, without prior notification, withdraw that permission or restrict their delegated authority at any point if there is reasonable justification to do so.
- 16.2.2 The budget holder must have a specific objective in their annual objectives describing their responsibilities as a budget holder and their manager has a responsibility to ensure they carry out those responsibilities. Annual Appraisals should record budget holders' performance in delivering this objective.
- 16.2.3 The budget holders must make themselves aware of all relevant Trust guidance, procedures and instructions on financial management – **ignorance is not an excuse** for failure to follow procedures or instructions.
- 16.2.4 The DOF has a responsibility to ensure that adequate training is delivered on an on- going basis to budget holders to help them manage successfully and the budget holder has a

responsibility to attend that training and identify and use other development aids to help them be equipped to perform the budget holder function.

### **16.3 Budgetary Delegation**

- 16.3.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing (recorded on an authorised signatory pro-forma or through the electronic records of the Trust's financial systems) and be accompanied by a clear definition of:
- (a) the amount of the budget (from the budget statement);
  - (b) the purpose(s) of each budget heading (from the budget statement);
  - (c) individual and group responsibilities (from the local business plan and individual objectives);
  - (d) authority to exercise virement (from the authorised signatory pro-forma);
  - (e) achievement of planned levels of service (from the local business plan and individual objectives);
  - (f) the provision of regular reports (from the local business plan and individual objectives).
- 16.3.2 Budget holders are responsible for all expenditure against their budget and the use of Trust resources to deliver work outlined in their local business plans and in Commissioners contracts. In relation to the requirements of section 15.5 (work done that is not covered or restricted by the Commissioners contract) budget holders are responsible for taking all reasonable action to minimise the use of Trust resources for work that will not be paid for by the Commissioners.
- 16.3.3 Budget holders do not have any authority to incur capital expenditure against revenue budgets and vice versa.
- 16.3.4 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.
- 16.3.5 Non-recurring budgets **must not** be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the DOF. This includes things like the recruitment of permanent staff to cover maternity leave or other temporary staff absence.

### **16.4 Budgetary Control and Reporting**

- 16.4.1 The DOF will devise and maintain systems of budgetary control. These will include:
- (a) monthly financial reports to the Board in a form approved by the Board containing:
    - \* income and expenditure to date showing trends and forecast year-end position;
    - \* movements in working capital;
    - \* Movements in cash and capital;
    - \* capital project spend and projected outturn against plan;
    - \* explanations of any material variances from plan.
    - \* details of any corrective action where necessary and the Chief Executive's and/or DOF's view of whether such actions are sufficient to correct the situation;
  - (b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible.
  - (c) investigation and reporting of variances from financial, activity, income, workload and

workforce budgets;

- (d) monitoring of management action to correct variances; and
- (e) arrangements for the authorisation of budget transfers.

16.4.2 Each Budget Holder is responsible for ensuring that:

- (a) any likely overspending or reduction of income which cannot be met by virement within the overall Trust income and expenditure budget control total is not incurred without prior written consent of the Chief Executive (as set out in Trust delegated procedures);
- (b) an action plan (appropriate to the materiality of the shortfall, but recorded) is provided to correct any overspending/under-collection of income in their budgets;
- (c) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement;
- (d) any income included within their budget is subject to a formal written contractual agreement specifying the amount, services covered, notice period and other relevant information;
- (e) no permanent employees are appointed without the approval of the Chief Executive (as set out in Trust delegated procedures) other than those provided for within the available resources and staffing establishment as approved by the Board.
- (f) Financial savings agreed in budgets at the start of the year are delivered and that any overspending elsewhere in the budget that reduces those savings is compensated by additional savings, virement or permission to overspend.

16.4.3 The DOF is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Business Plan and a balanced budget.

## **16.5 Capital Expenditure**

16.5.1 The general rules applying to delegation and reporting shall also apply to capital expenditure. (the particular applications relating to capital are contained in SFI 24). Revenue budget holders do NOT have any authority to incur capital spend against revenue budgets and vice versa.

## **16.6 Monitoring Returns**

16.6.1 The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to the requisite monitoring organisation.

# **17 TENDERING AND CONTRACTING**

## **17.1 Duty to comply with Standing Orders and Standing Financial Instructions**

17.1.1 The procedure for making all contracts by or on behalf of the Trust shall comply with these Standing Orders and Standing Financial Instructions (except where Standing Order No.3.13 Suspension of Standing Orders is applied).

17.1.2 These SOs and SFIs apply also to where the Trust elects to invite tenders for the supply of health care services.

17.1.3 All contracts will:

- be within the Trust powers as delegated by the Secretary of
- comply with relevant Department of Health and Social Care guidance as advised by the

Head of Procurement

- incorporate such of the Standard NHS terms and conditions as are applicable.
- endeavour to obtain best value for money

17.1.4 All personnel involved in tendering and contacting activities must be aware of the Bribery Act 2010 and must ensure that all dealings with other organisations and their staff do not bring them in breach of the Act that could leave them open to criminal proceedings being commenced.

## **17.2 Legislation Governing Public Procurement**

17.2.1 Relevant UK legislation prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in these Standing Orders and Standing Financial Instructions.

## **17.3 Reverse eAuctions**

17.3.1 The Trust should have policies and procedures in place for the control of all tendering activity carried out through Reverse eAuctions. For further guidance on Reverse eAuctions refer to [www.ogc.gov.uk](http://www.ogc.gov.uk).

## **17.4 Capital Investment Manual and other Department of Health Guidance**

17.4.1 The Trust shall comply as far as is practicable with the requirements of the Department of Health and Social Care guidance on procurement.

## **17.5 Formal Competitive Tendering**

### **17.5.1 General Applicability**

17.5.1.1 The Trust shall ensure that competitive tenders are invited for:

- the supply of goods, materials and manufactured articles;
- the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the DH);
- for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens);
- for disposals.

### **17.5.2 Health Care Services**

17.5.2.1 Where the Trust elects to invite tenders for the supply of healthcare services these Standing Orders and Standing Financial Instructions shall apply as far as they are applicable to the tendering procedure and need to be read in conjunction with Standing Financial Instruction No.15 and No. 20.

### **17.5.3 Exceptions and instances where formal tendering need not be applied**

17.5.3.1 Formal tendering procedures need not be applied where:

- i. the estimated expenditure or income does not, or is not reasonably expected to, exceed £20,000;
- ii. where the supply is proposed under special arrangements negotiated by the DHSC in which event the said special arrangements must be complied with;
- iii. regarding disposals as set out in Standing Financial Instructions 25
- iv. The expenditure is for maintenance and the only supplier available is the original equipment manufacturer. The equipment must have previously been through an appropriate procurement route.

17.5.3.2 Formal tendering procedures **may be waived** in the following circumstances:

- i. in very exceptional circumstances where the Chief Executive decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstances are detailed in an appropriate Trust record.
- ii. where the requirement is covered by an existing contract.
- iii. where appropriate framework agreements are in place and have been approved by the Board.
- iv. where a consortium arrangement is in place that comply with Public Contracts Regulations (2015).
- v. where the timescale genuinely precludes competitive tendering but failure to plan the work properly would not be regarded as a justification for a single tender.
- vi. where specialist expertise is required and is available from only one source.
- vii. when the task is essential to complete the project and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate.
- viii. there is a clear benefit to be gained from maintaining continuity with an earlier project. However, in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering.
- ix. for the provision of legal advice and services providing that any legal firm or partnership commissioned by the Trust is regulated by the Law Society for England and Wales for the conduct of their business (or by the Bar Council for England and Wales in relation to the obtaining of Counsel's opinion) and are generally recognised as having sufficient expertise in the area of work for which they are commissioned.

17.5.3.3 The DOF will ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work.

17.5.3.4 The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

17.5.3.5 Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate Trust record and reported to the Audit Committee at each meeting.

#### **17.5.4 Fair and Adequate Competition**

17.5.4.1 Where the exceptions set out in SFI Nos. 17.1 and 17.5.3 apply, the Trust shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, and in no case less than two firms/individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required.

#### **17.5.5 Building and Engineering Construction Works**

17.5.5.1 Competitive Tendering cannot be waived for building and engineering construction works and maintenance (other than in accordance with Concode) without DHSC approval.

#### **17.5.6 Items which subsequently breach thresholds after original approval**

17.5.6.1 Items estimated to be below the limits set in this Standing Financial Instruction for which formal tendering procedures are not used which subsequently prove to have a value above

such limits shall be reported to the Chief Executive, and be recorded in an appropriate Trust record.

17.5.6.2 Where the likely contract value exceeds £50,000 formal tendering will be undertaken.

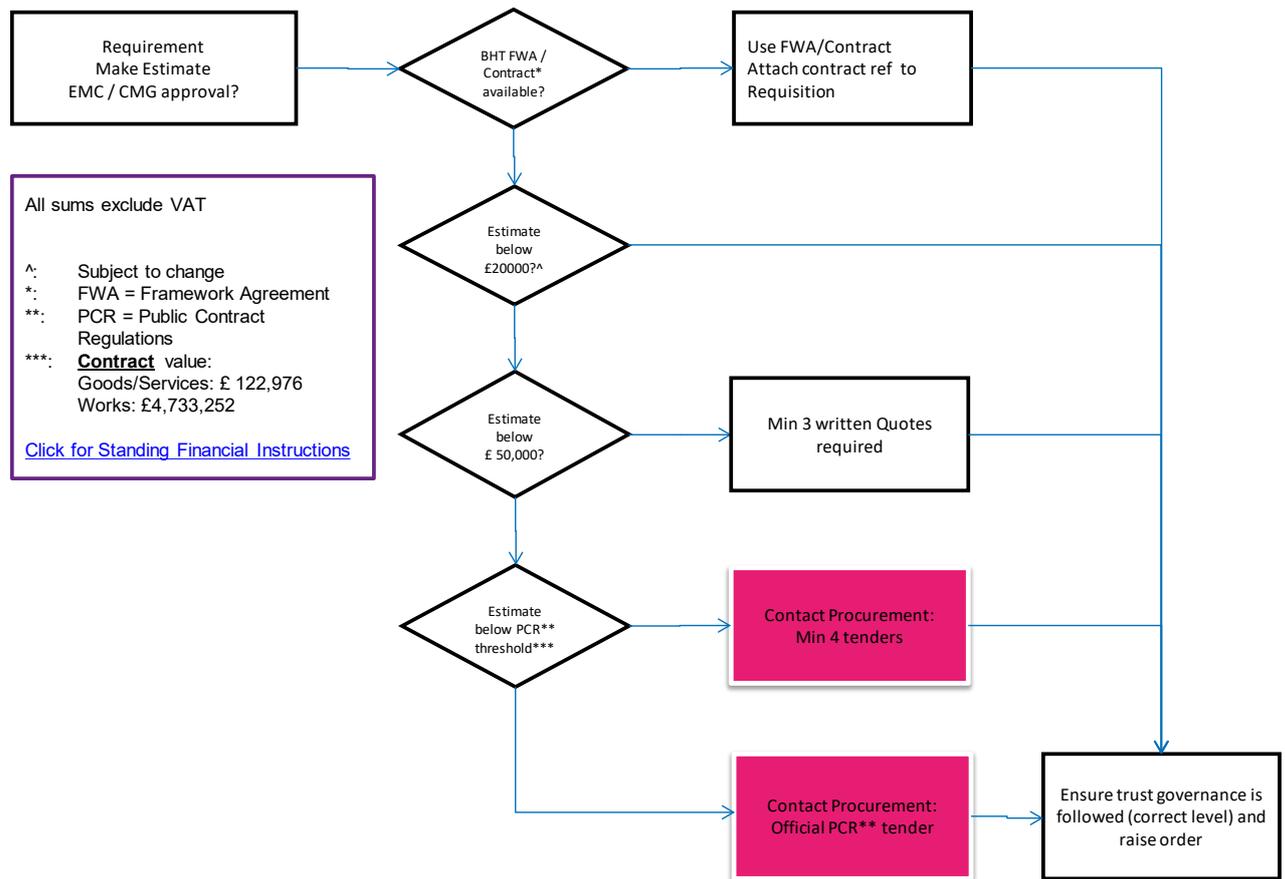
17.5.6.3 Following receipt of a requisition for goods, services or works likely to cost in excess of £50,000, Procurement will advise the budget-holder that a formal tender is required and request details of the project team to be involved in completing this. Procurement will facilitate the tendering process on behalf of the budget-holder.

## 17.6 Contracting/Tendering Procedure

### 17.6.1 Process

17.6.2 Procurement will follow the process as set out in the flow chart below for the procurement of goods or services dependent on the likely cost as tabled below:

| Limits   | Procedure  |
|--|--|
| £0 - £20,000 excluding VAT   | Obtain best value  |
| £20,000 to £50,000 excluding VAT                                   | Quotations: At least 3 to be requested and at least 3 returned                 |
| £50,000 excluding VAT to Current PCR Threshold Limit excluding VAT | Formal tendering: At least 3 tenders to be requested and at least 3 returned   |
| More than Current PCR Threshold Limit excluding VAT                | Formal tendering complying with PCR  |
| Works £5,000 to Current PCR Limit which excludes VAT               | Formal tendering: At least 4 tenders to be issued and at least 3 returned      |
| PCR Threshold Link which shows current limits                      | <a href="http://www.ojec.com/Thresholds.aspx">www.ojec.com/Thresholds.aspx</a> |



### 17.6.3 Invitation to tender

- i. All tenders will be taken through the Procurement electronic tendering system
- ii. All invitations to tender shall state the date and time as being the latest time for the receipt of tenders.
- iii. All invitations to tender shall state that no tender will be accepted unless they are submitted via then Trust e-procurement system
- iv. Every tender for goods, materials, services or disposals shall comply as a minimum to the NHS Standard Contract Conditions.
- v. Every tender for building or engineering works (except for maintenance work, when NHS Property Services guidance shall be followed) shall embody or be in the terms of the current edition of one of the Joint Contracts Tribunal Standard Forms of Building Contract or Department of the Environment (GC/Wks) Standard forms of contract amended to comply with NHS Property Services Concode; or, when the content of the work is primarily engineering, the General Conditions of Contract recommended by the Institution of Mechanical and Electrical Engineers and the Association of Consulting Engineers (Form A), or (in the case of civil engineering work) the General Conditions of Contract recommended by the Institute of Civil Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors. These documents shall be modified and/or amplified to accord with Department of Health guidance and, in minor respects, to cover special features of individual projects.

### 17.6.4 Receipt and safe custody of tenders

- (i) The Procurement Department will be responsible for the receipt of the tenders via the e-procurement system.
- (ii) The date and time of receipt of each tender will be recorded on the e-procurement system.

- (iii) Officers from the Procurement Department will be responsible for the safe custody until the time of their evaluation. The tenders will be returned to an electronic safe and locked until the due date for the receipt of bids from invited suppliers.

#### **17.6.5 Opening tenders and Register of tenders**

- (i) As soon as practical after the date and time stated as being the latest time for the receipt of tenders, they shall be opened by the Head of Procurement or a member of the Procurement team.
- (ii) The Head of Procurement as guardian for the electronic tendering system is responsible for ensuring all tenders are treated as confidential and retained for inspection. The system provides a register of:
  - The name of all firms or individuals invited to tender;
  - The names of firms or individuals from which tenders have been received;
  - The date the tenders were opened.

#### **17.6.6 Admissibility and acceptance of a tender**

- i) If for any reason the designated officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are amended, insufficient, incomplete or not qualified) no contract shall be awarded without the approval of the Chief Executive.
- ii) If fewer than three tenders are received, the Head of Procurement or Director of Finance shall, as far as practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust.
- iii) Any discussions with a tenderer which are deemed necessary to clarify technical aspects of the tender before the award of a contract will not disqualify the tender.
- iv) The most economically advantageous tender shall be accepted as determined by the tender evaluation criteria set by the tender project team at the start of the tender process.
- v) No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.
- vi) The use of these procedures must demonstrate that the award of the contract was on the basis of the most economically advantageous tender.
- vii) Where only one tender is sought and/or received, the Chief Executive and DOF shall, as far as practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust.

#### **17.6.7 Late tenders**

- i) Tenders received after the due time and date, but prior to the opening of the other tenders, may only be considered if the Chief Executive or his/her nominated officer decides that there are exceptional circumstances that are outside of their control. i.e. dispatched in good time but delayed through no fault of the tenderer.
- ii) Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders and only then if the tenders that have been duly opened have not left the custody of the Chief Executive or his/her nominated officer or if the process of evaluation and adjudication has not started.
- iii) While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential, recorded and held in safe custody by the Chief Executive or his/her nominated officer.

- iv) That best value for money was achieved.
- v) All tenders should be treated as confidential and should be retained for inspection.

#### 17.6.8 Tender reports to the Trust Board

- i) Reports to the Board will be made on an exceptional circumstance base only.

#### 17.6.9 Firms invited to tender or quote

- i) The Head of Procurement on behalf of the Chief Executive will ensure the Trust's register of firms/individuals suitable for the supply of goods or services is kept via electronic tendering system and that the Trust will access such other registers available for use by the NHS, for example:
  - Government frameworks
  - Constructionline
  - Procure 21+
  - Crown Commercial Service
  - The London Procurement Partnership
  - NHS Supply Chain
- ii) The Head of Procurement will determine which register/framework agreements may be used.
- iii) The Head of Procurement shall ensure all tenders provide open competition and comply with relevant DHSC guidance.
- iv) Exceptions to usual procurement arrangements – Waiver Requests. The waiving of competitive tendering procedures should not be used to:
  - avoid competition
  - for administrative convenience
  - to award further work to a consultant originally appointed through a competitive procedure
  - where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented using a waiver form obtained from the Head of Procurement.
- v) It is Trust policy that all requests to progress with waivers must receive prior approval through the waiving of Standard Financial Instructions procedure. This will require the completion of a waiver form. Waiver forms still require authorisation in line with the Trust's Scheme of Delegation. This is set out in the table below:

| Employee                               | Expenditure            |
|--|------------------------|
| Chief Executive or Director of Finance | £20,000 - £99,999.99   |
| Chief Executive                        | £100,000 - £999,999.99 |
| Chair and Chief Executive              | ≥ £1,000,000           |

- vi) UK law via the Public Contract Regulations (2015) applies at all times.
- vii) The Public Contract Regulations cannot be waived, and Procurement will advise budget holders as to how compliance can be achieved.
- viii) The Audit Committee may, at its discretion, invite regular users of the waiver and procedures to explain the need and to advise how this action may be avoided.
- ix) The Head of Procurement will provide a bi-monthly report to the Audit Committee detailing the use made of waivers.
- x) Authorised waivers are reported to each Audit Committee meeting.

## **17.7 Quotations: Competitive and non-competitive**

### **17.7.1 General Position on quotations**

- (i) Quotations are required where formal tendering procedures are not adopted and where the intended expenditure or income exceeds or is reasonably expected to exceed £20,000 but not exceed £50,000 (excluding VAT) over the life of the contract.

### **17.7.2 Competitive Quotations**

- (i) Quotations should be obtained from at least 3 firms/individuals based on specifications or terms of reference prepared by, or on behalf of, the Trust.
- (ii) Quotations should be in writing unless the Chief Executive or his/her nominated officer determines that it is impractical to do so in which case quotations may be obtained by telephone. Confirmation of telephone quotations should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record.
- (iii) All quotations should be treated as confidential and should be retained for inspection.
- (iv) The Chief Executive or his/her nominated officer should evaluate the quotation and select the quote which gives the best value for money. If this is not the lowest quotation if payment is to be made by the Trust, or the highest if payment is to be received by the Trust, then the choice made and the reasons why should be recorded in a permanent record.

### **17.7.3 Non-Competitive Quotations**

Non-competitive quotations in writing may be obtained in the following circumstances (waiver procedures still apply):

- (i) the supply of proprietary or other goods of a special character and the rendering of services of a special character, for which it is not, in the opinion of the responsible officer, possible or desirable to obtain competitive quotations;
- (ii) the supply of goods or manufactured articles of any kind which are required quickly and are not obtainable under existing contracts;
- (iii) miscellaneous services, supplies and disposals;

### **17.7.4 Where it is not possible to obtain three quotations/tenders**

- (i) This may occur where the goods or services are only available from a single supplier
- (ii) In very exceptional circumstances where formal tendering procedures would not be practicable, or the estimated expenditure or income would not warrant formal tendering procedures and the circumstances are detailed in an appropriate Trust record.
- (iii) Where specialist expertise is required and is available from only one source
- (iv) When an unforeseeable task is required for a recently completed project and engaging different consultants for the new task would be inappropriate
- (v) Where there is a clear benefit to be gained from maintaining continuity with an earlier project. However, in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering.
- (vi) Where permitted by DH guidance; details of which shall be documented in the waiver form.
- (vii) Where a tender process has been properly followed, but insufficient returns have been received.

- (viii) Where the Chief Executive recommends urgent capital works need to be carried out. In this case, written confirmation must be obtained from the Chief Executive and forwarded to the Director of Finance with an agreed timetable for completion of procedures.

#### **17.7.5 Quotations to be within Financial Limits**

No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with Standing Financial Instructions except with the authorisation of either the Chief Executive or DOF.

### **17.8 Authorisation of Tenders and Competitive Quotations**

- 17.8.1 Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied with, formal authorisation and awarding of a contract may be decided by the staff as set out in accordance with the Limits of Delegation in section D.
- 17.8.2 These levels of authorisation may be varied or changed and need to be read in conjunction with the Trust Board's Scheme of Delegation.
- 17.8.3 Formal authorisation must be put in writing. In the case of authorisation by the Board this shall be recorded in their minutes.

### **17.9 Instances where formal competitive tendering or competitive quotation is not required**

- 17.9.1 Where competitive tendering or a competitive quotation is not required the Trust should adopt one of the following alternatives:
  - a) The Trust shall use NHS National Frameworks for the procurement of all goods and services unless the Chief Executive or nominated officers deem it inappropriate. The decision to use alternative sources must be documented.
  - b) If the Trust does not use the NHS National Frameworks where tenders or quotations are not required because expenditure is below £5,000, the Trust shall procure goods and services in accordance with procurement procedures approved by the DOF.

### **17.10 Private Finance for capital procurement (see overlap with SFI 23.2)**

- 17.10.1 The Trust should normally market-test for PFI (Private Finance Initiative funding) when considering a capital procurement. When the Board proposes, or is required, to use finance provided by the private sector the following should apply:
  - (a) The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.
  - (b) Where the sum exceeds delegated limits, a business case must be referred to the appropriate Department of Health for approval or treated as per current guidelines.
  - (c) The proposal must be specifically agreed by the Board of the Trust.
  - (d) The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

### **17.11 Contract and Contract Variation**

- 17.11.1 The Board shall regularly review and shall at all times maintain and ensure the capacity and capability of the Trust to provide the mandatory goods and services referred to in its Terms of Authorisation and related schedules.
- 17.11.2 The Chief Executive as Accounting Officer, is responsible for ensuring the Trust enters into

suitable contracts with NHS England Clinical Commissioning Groups and other commissioners for the provision of services and for considering the extent to which any NHS Standard Contracts issued by the Department of health or NHS Improvement are mandatory for Service Contracts.

17.11.3 Where the Trust enters into a relationship with another organisation for the supply or receipt of other services, clinical or non-clinical, the responsible officer should ensure that an appropriate contract is present and signed by both parties.

17.11.4 All Service Contracts and other contracts shall be legally binding, shall comply with best costing practice and shall be devised so as to manage contractual risk, in so far as is reasonably achievable in the circumstances of each contract, whilst optimising the Trust opportunity to generate income for the benefit of the trust and its service users.

## **17.12 Compliance requirements for all contracts**

17.12.1 The Board may only enter into contracts on behalf of the Trust within the statutory powers delegated to it by the Secretary of State and shall comply with:

- (a) The Trust's Standing Orders and Standing Financial Instructions;
- (b) All statutory provisions;
- (c) any relevant directions including the Capital Project Management Procedure Manual
- (d) such of the NHS Standard Contract Conditions as are applicable.
- (e) contracts with Foundation Trusts must be in a form compliant with appropriate NHS guidance.
- (f) Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.
- (g) In all contracts made by the Trust, the Board shall endeavour to obtain best value for money by use of all systems in place. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

## **17.13 Framework**

17.13.1 A framework agreement is an umbrella agreement between one or more contracting authorities and one or more economic operators setting out all or some of the terms on which the parties can enter into contracts (call-offs) throughout the term of the umbrella agreement.

17.13.2 Call-offs are based on the terms of the framework agreement and may be either direct award or through further competition.

The terms of the framework agreement must be adhered to.

## **17.14 Personnel and Agency or Temporary Staff Contracts**

- (i) The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts. In the case of Agency or Temporary staff this applies only if the supply is from agencies/ companies covered by NHS framework agreements. The supply of staff from Personnel Service Contracts or non-framework Agencies or must follow the procurement rules for goods and services set out in section 17.1 to 17.12.
- (ii) To meet business requirements, it may sometimes be necessary for the Trust to cover substantive or temporary (project) posts on an interim basis.
- (iii) The use of temporary staffing must not breach the budgets establishment or agreed value in the case of short-term projects.

- (iv) Temporary staffing should not be viewed as a long-term solution. All efforts should be made to avoid the use of temporary staff e.g. Bank workers.
- (v) Temporary staffing should only be procured from approved supplier framework agreements.
- (vi) Interim/temporary staff in roles that are likely to extend beyond 6 months, these should be considered for fixed term or permanent recruitment.
- (vii) All temporary staffing must be procured through authorised route and in-line with current Trust policy.
- (viii) Where temporary staff are covering an established post, they will automatically be treated as “employed” and within HMRC’s IR35 regulation. This means that either the Trust or the approved agency will deduct tax and national insurance from the temporary staff pay.
- (ix) An IR35 assessment must be completed by either the Human Resources-Temporary Staffing team or Finance – Financial Control to determine the temporary staff IR35 status and meet the requirements of the HMRC’s Intermediaries Regulation.
- (x) Where temporary staff using personal service companies is assessed as within IR35 the invoice must be forwarded to the Trusts on site payroll department for processing through the payroll.
- (xi) Where temporary staffs using personal service companies are assessed as outside IR35 the temporary staff is deemed to be a supply of service the procurement falls within non-pay and SFI 17 applies in full

## **17.15 Healthcare Services Agreements (see overlap with SFI 20)**

17.15.1 Service agreements with NHS providers for the supply of healthcare services shall be drawn up in accordance with the NHS and Community Care Act 1990 and administered by the Trust. Service agreements with many NHS bodies are not normally contracts in law and therefore not enforceable by the courts. However, a contract with a Foundation Trust is a legal document and is enforceable in law.

17.15.2 The Chief Executive shall nominate officers to commission service agreements with providers of healthcare.

## **17.16 Disposals (See overlap with SFI 25)**

17.16.1 Competitive Tendering or Quotation procedures shall not apply to the disposal of:

- (a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or his/her nominated officer;
- (b) obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Trust;
- (c) items to be disposed of with an estimated sale value of less than £1,000, this figure to be reviewed on a periodic basis;
- (d) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;
- (e) land or buildings concerning which DH guidance has been issued but subject to compliance with such guidance.

## **17.17 In-house Services**

17.17.1 The Chief Executive shall be responsible for ensuring that best value for money can be

demonstrated for all services provided on an in-house basis. The Trust may also determine from time to time that in-house services should be market tested by competitive tendering.

17.17.2 In all cases where the Board determines that in-house services should be subject to competitive tendering the following groups shall be set up:

- Specification group, comprising the Chief Executive or nominated officer/s and specialist.
- In-house tender group, comprising a nominee of the Chief Executive and technical support.
- Evaluation team, comprising normally a specialist officer, a supplies officer and a DOF representative. For services having a likely annual expenditure exceeding £100,000, a non-Executive member should be a member of the evaluation team.

17.17.3 All groups should work independently of each other and individual officers may be a member of more than one group but no member of the in-house tender group may participate in the evaluation of tenders.

17.17.4 The evaluation team shall make recommendations to the Board.

17.17.5 The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.

## **17.18 Applicability of SFIs on Tendering and Contracting to funds held in trust (see overlap with SFI 28)**

17.18.1 These Instructions shall not only apply to expenditure from Exchequer funds but also to works, services and goods purchased from the Trust's trust funds and private resources.

## **18. PAY EXPENDITURE**

### **18.1 Remuneration and Terms of Service (see overlap with SO 4)**

18.1.1 In accordance with Standing Orders the Board shall establish a Remuneration Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting. (See NHS guidance contained in the Higgs report.)

18.1.2 The Committee's main functions are:

- a) To advise the Board about performance, development, succession planning and appropriate remuneration and terms of service for the Chief Executive and all Executive Directors, guided by NHS policy and best practice. Advice to the Board on remuneration includes all aspects of salary as well as arrangements for termination of employment and other contractual terms.
- b) To make such recommendations to the Board on the succession planning and on the remuneration, allowances and terms of service of the Chief Executive and, on the advice of the Chief Executive, the Executive Directors, to ensure that they are fairly motivated and rewarded for their individual contribution to the organisation – having proper regard to the organisation's circumstances and performance and to the provision of national arrangements.
- c) To monitor and evaluate the performance and development of the Chief Executive and, on the advice of the Chief Executive, the Executive Directors.
- d) To advise the Board and oversee appropriate contractual arrangements for the Chief Executive and Executive Directors including the proper calculation and scrutiny of termination payments taking account of such national guidance as appropriate.

- e) The Chief Executive is responsible for ensuring that the Chief People Officer brings forward the necessary information in a timely manner to enable the Committee to discharge its functions and takes appropriate follow-up action.

18.1.3 The Trust will pay allowances to the Chairperson and non-Executive members of the Board in accordance with instructions issued by the Secretary of State for Health. Subject to legal requirements all claims for additional pay (e.g. overtime) and expenses must be submitted within 3 months or the Trust can decline payment.

## **18.2 Funded Establishment**

18.2.1 The workforce plans incorporated within the annual budget will form the funded establishment.

18.2.2 The funded establishment of any department may not be varied without the approval of the Divisional Director, operating within the overall Budget. Any increase in resources requires and business case approved at Executive Management Committee.

## **18.3 Staff Appointments**

18.3.1 No officer or Member of the Board or employee may engage, re-engage, or re grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

- (a) unless authorised to do so by the Chief Executive;
- (b) within the limit of their approved budget and funded establishment.

18.3.2 The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc., for employees.

18.3.3 Any change of grade or pay acceleration for an individual that has not been subject to a selection process must be approved by the Chief People Officer.

## **18.4 Processing Payroll**

18.4.1 The Director of Finance is responsible for:

- (a) specifying timetables for submission of properly authorised time records and other notifications;
- (b) the final determination of pay and allowances;
- (c) making payment on agreed dates;
- (d) agreeing method of payment.

18.4.2 The Director of Finance will issue instructions regarding:

- (a) verification and documentation of data;
- (b) the timetable for receipt and preparation of payroll data and the payment of employees and allowances;
- (c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;
- (d) security and confidentiality of payroll information;
- (e) checks to be applied to completed payroll before and after payment;
- (f) authority to release payroll data under the provisions of the Data Protection Act;
- (g) methods of payment available to various categories of employee and officers;
- (h) procedures for payment by cheque, bank credit, or cash to employees and officers;
- (i) procedures for the recall of cheques and bank credits;
- (j) pay advances and their recovery;
- (k) maintenance of regular and independent reconciliation of pay control accounts;
- (l) separation of duties of preparing records and handling cash;
- (m) a system to ensure the recovery from those leaving the employment of the Trust of sums of money and property due by them to the Trust.

- 18.4.3 Appropriately nominated managers have delegated responsibility for:
- (a) submitting time records, and other notifications in accordance with agreed timetables;
  - (b) completing time records and other notifications in accordance with the DOF's instructions and in the form prescribed by the DOF;
  - (c) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's or officer's resignation, termination or retirement. Where an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the DOF must be informed immediately.
- 18.4.4 Regardless of the arrangements for providing the payroll service, the Director of Finance shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and those suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.
- 18.4.5 It is the personal responsibility of each member of staff to monitor how much they are paid with each payment received. Staff must report any overpayment or underpayment as soon as it is noticed. All overpayments must be repaid in line with the requirements agreed with the Trust. Any underpayment must also be reported as soon as it is noticed, and any underpayments will be repaid by the Trust.

## **18.5 Expenses payable to staff**

- 18.5.1 Expenses are non-pay expenditure but should be paid with salary and only exceptionally by any other means. Trust procedures for expense claims must be followed by all staff and it is each individual's responsibility to submit claims on a regular basis, which enables the Trust to monitor and control expenditure and provide payment. The Trust will withhold the payment of expenses claimed 3 months or more after they were incurred. In exceptional circumstances appeals can go to the DOF, whose decision is final and not subject to any further appeal.

## **18.6 Contracts of Employment**

- 18.6.1 The Board shall delegate responsibility to an officer for:
- (a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation;
  - (b) dealing with variations to, or termination of, contracts of employment.

## **19. NON-PAY EXPENDITURE**

### **19.1 Delegation of Authority**

- 19.1.1 The Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers.
- 19.1.2 The Chief Executive will set out:
- (a) the list of managers who are authorised to place requisitions for the supply of goods and services;
  - (b) the maximum level of each requisition and the system for authorisation above that level.
- 19.1.3 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

### **19.2 Choice, Requisitioning, Ordering, Receipt and Payment for Goods**

## and Services (see overlap with SFI 17)

### 19.2.1 Requisitioning

19.2.1.1 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust.

### 19.2.2 Use of purchase orders

19.2.2.1 There is a trade-off between security, cost and the administration necessary to buy items for the Trust. The aim is to make things as simple as possible while keeping the right balance between these considerations.

19.2.2.2 Purchase orders for goods and services ordered via the Trust's electronic catalogue will be sent automatically to suppliers subject to the appropriate authorisation. Non catalogue goods or services will be ordered by the Trust's Procurement Team on the basis of a requisition raised by the requisitioner.

19.2.2.3 A single requisition may involve for example, the requisition of contract involving a number of annual payments; these payments are added together to determine the limit.

19.2.2.4 Requisitions may not be split or otherwise placed in a manner devised so as to avoid any Trust financial limits.

19.2.2.5 An order for goods or services may result in a contract or license to be signed by both the Trust and supplier. These documents may only be signed in accordance with delegated limits in the table below:

| Employee   | Limit   |
|--|---|
| Chief Executive or Director of Finance   | Up to £1,000,000  |
| Following approval by the Trust Board, any Executive Director on behalf of the Board | Greater than or equal to £1,000,000 (no limit on inter NHS contracts) |

19.2.2.6 Most invoices relating to goods requisitioned and purchased via a Purchase Order do not require authorisation. The Accounts Payable team matches the confirmation of receipt with the invoice and invoice value, and resolves any differences

19.2.2.7 Invoices not matched in the way described above require authorisation before payment.

19.2.2.8 The DOF is responsible for maintaining the lists of employees and their delegated limits. Managers are responsible for advising the Director of Finance of all changes.

19.2.2.9 Contracts for management consultancy over £50,000 will require approval from NHS Improvement

### 19.2.3 Procedures for obtaining Goods and Services

19.2.3.1 In choosing the item to be supplied (or the service to be performed) the advice of Procurement shall be sought where necessary in order to obtain value for money and as far as possible meet the sustainability obligations of the Trust.

19.2.3.2 Where the advice of Procurement is not acceptable, the Director of Finance (and/or the Chief Executive) shall be consulted and may approve procurement contrary to the advice received.

19.2.3.3 Goods may not be taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase.

19.2.3.4 No Order shall be issued for any item or items to any firm which has made an offer of gifts, rewards or benefit to directors or employees, other than isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars or conventional hospitality such as lunches in the course of working visits.

19.2.3.5 These SFIs apply equally to goods or services relating to charitable or pass-through expenditure.

19.2.3.6 Confirmation of the receipt of goods and services system will provide:

- a list of Trust employees authorised to certify invoices;
- certification that goods have been duly received, examined and are in accordance with specification and the prices are correct;
- certification that work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;
- where appropriate, that the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- the account is arithmetically correct; the account is in order for payment;
- instructions to employees regarding the handling and payment of accounts within the Finance Department.

#### **19.2.4 System of Payment and Payment Verification**

19.2.4.1 The DOF shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

19.2.4.2 All contracts for example; leases, tenancy agreements and other commitments which may result in a liability shall be notified to the Director of Finance.

19.2.4.3 The Director of Finance is responsible for designing and maintaining a system of verification, recording and payment of all amounts payable.

19.2.4.4 The Director of Finance is responsible for designing and maintaining procedures regarding the use and control of purchasing cards.

19.2.4.5 Prepayments are only permitted where exceptional circumstances apply.

### **19.3 Petty Cash**

19.3.1 Purchases from petty cash are restricted in value and by type of purchase as tabled below and must be supported by receipt(s) and certified by a budget holder within their delegated limit (see 8.1.7 above).

| <b>Description</b>  | <b>Amount</b>                                       |
|---|---|
| Return of Patients Cash   | Up to the amount of cash deposited for Safe-keeping |
| Payment of Patients Fares or Funeral expenses for which the Trust is liable | Up to the amount of fares paid or funeral expense   |
| All other petty cash payments   | £100  |

19.3.2 The Director of Finance will determine record keeping and other instructions relating to petty

cash.

## 19.4 Paying in advance – prepayments

19.4.1 The payment of goods/services in advance presents a **financial risk** for the Trust if the item being purchased is not delivered, or the company or organisation supplying the goods/services disappears or goes into liquidation or bankruptcy. As a result, the general rule is to **avoid paying for anything in advance of delivery.**

19.4.2 Prepayments are only permitted where exceptional circumstances apply. In such instances:

- the budget holder must provide: the budget holder must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet their commitments;
- the Director of Finance may approve the prepayment, permitting the prepayment arrangement to progress if:
  - the proposed arrangements take into account Public Contract Regulations (PCR) where the contract is above a stipulated financial threshold; and
  - the financial advantage outweighs the disadvantages.
- the budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately advise the appropriate Director or Chief Executive if problems are encountered.

## 19.5 Official orders

Official Orders must:

- (a) be consecutively numbered;
- (b) be in a form approved by the DOF;
- (c) state the Trust's terms and conditions of trade;
- (d) only be issued to, and used by, those duly authorised by the Chief Executive.

## 19.6 Duties of Managers and Officers

19.6.1 Managers and officers must ensure that they comply fully with the guidance and limits specified by the DOF and that:

- (a) all contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the DOF in advance of any commitment being made;
- (b) contracts above specified thresholds are advertised and awarded in accordance with UK rules on public procurement;
- (c) where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health and NHSI;
- (d) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:
  - (i) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;
  - (ii) conventional hospitality, such as lunches in the course of working visits;

(This provision needs to be read in conjunction with Standing Order No. 6 and the

principles outlined in the national guidance contained in HSG 93(5) "Standards of Business Conduct for NHS Staff" (the guidance contained within this document referring to the 'Prevention of Corruption Acts 1889 - 1916' has been superseded by the 'Bribery Act 2010');

- (e) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the DOF on behalf of the Chief Executive;
- (f) all goods, services, or works are ordered on an official order except works and services executed in accordance with a contract and purchases from petty cash. Internet purchases are ordered by Procurement and recorded separately.
- (g) verbal orders must only be issued very exceptionally - by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order".
- (h) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the DOF;
- (i) petty cash records are maintained in a form as determined by the DOF.

19.6.2 The Chief Executive, DOF and Commercial Director shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the relevant guidance contained. The technical audit of these contracts shall be the responsibility of the relevant Director.

## **19.7 Joint Finance Arrangements with Local Authorities and Voluntary Bodies (see overlap with Standing Order 9.1)**

19.7.1 Payments to local authorities and voluntary organisations made under the powers of section 28A of the NHS Act shall comply with procedures laid down by the DOF which shall be in accordance with these Acts. (See overlap with Standing Order 9.1).

## **20. TRUST COMMISSIONING OF HEALTHCARE SERVICES**

### **20.1 Role of the Chief Executive**

20.1.1 The Chief Executive as the Accountable Officer has responsibility for ensuring secondary services are commissioned in accordance with the priorities agreed in the Business Plan. This will involve ensuring Service Level Agreements (SLAs)/contracts are put in place with the relevant providers, based upon integrated care pathways.

20.1.2 SLAs/contracts are essential for different organisations to manage services provided between them. For healthcare they need to have a wide scope. The Chief Executive will need to ensure that all SLAs;

- Meet the standards of service quality expected;
- Fit the relevant national service framework (if any);
- Enable the provision of reliable information on cost and volume of services;
- Fit the NHS Operating Framework (and other relevant guidance);
- that SLAs build where appropriate on existing Joint Investment Plans;
- that SLAs are based upon cost-effective services;

20.1.3 The Chief Executive, as the Accountable Officer, will need to ensure that regular reports are provided (including as necessary to the Board) detailing actual and

forecast expenditure and activity for each SLA.

- 20.1.4 Where the Trust makes arrangements for the provision of services by non-NHS providers it is the Chief Executive, as the Accountable Officer, who is responsible for ensuring that the agreements put in place have due regard to the quality and cost-effectiveness of services provided. Before making any agreement with non- NHS providers, the Trust should explore fully the scope to make maximum cost- effective use of NHS facilities.

## **20.2 Role of Director of Finance**

- 20.2.1 The DOF has responsibility for advising the Chief Executive on all contracting aspects and for maintaining a system of financial monitoring to ensure the effective accounting of expenditure under the SLA. This should provide a suitable audit trail for all payments made under the agreements but maintains patient confidentiality.

## **21. EXTERNAL BORROWING**

- 21.1 The DOF will advise the Board concerning the Trust's ability to pay dividend on interest and repay Public Dividend Capital loans and any proposed new borrowing, within the limits set by the Department of Health and NHSI. The DOF is also responsible for reporting periodically to the Board concerning the PDC debt and all loans and overdrafts.
- 21.2 The Board will agree the list of employees (including specimens of their signatures) who are authorised to make short term borrowings on behalf of the Trust. This must contain the Chief Executive and the DOF.
- 21.3 The DOF must prepare detailed procedural instructions concerning applications for loans and overdrafts.
- 21.4 All short-term borrowings should be kept to the minimum period of time possible, consistent with the overall cashflow position, represent good value for money, and comply with the latest guidance from NHS Improvement.
- 21.5 Any short-term borrowing must be with the authority of two members of an authorised panel, one of which must be the Chief Executive or the DOF. The Board must be made aware of all short-term borrowings at the next Board meeting.
- 21.6 All long-term borrowing must be consistent with the plans outlined in the current Long-Term Financial Model (LTFM) and be approved by the Trust Board.

## **22. INVESTMENTS**

- 22.1 Temporary cash surpluses must be held only in such public or private sector investments as notified and approved by the Secretary of State and authorised by the Board.
- 22.2 The DOF is responsible for advising the Board on investments and shall report periodically to the Finance and Business Performance Committee concerning the performance of investments held.
- 22.3 The DOF will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

## **23. CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS**

### **23.1 Capital Investment**

- 23.1.1 The Chief Executive:

- (a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;
- (b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;
- (c) shall ensure that the capital investment is not undertaken without confirmation of purchaser(s) support and the availability of resources to finance all revenue consequences, including capital charges.

23.1.2 For every capital expenditure proposal the Chief Executive shall ensure:

- (a) that a business case is produced setting out:
  - (i) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;
  - (ii) the involvement of appropriate Trust personnel and external agencies;
  - (iii) appropriate project management and control arrangements;
- (b) that the DOF has certified professionally to the costs and revenue consequences detailed in the business case.

23.1.3 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management.

23.1.4 The DOF shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with Inland Revenue guidance.

23.1.5 The DOF shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

23.1.6 The approval of a capital programme shall not constitute approval for expenditure on any scheme.

The Chief Executive shall issue to the manager responsible for any scheme:

- (a) specific authority to commit expenditure;
- (b) authority to proceed to tender (see overlap with SFI No. 17.6);
- (c) approval to accept a successful tender (see overlap with SFI No. 17.6).

The Chief Executive will delegate capital investment management in accordance with the Trust's Standing Orders to allow the above to operate effectively – this will be through the Executive Team, Finance and Business Performance Committee, and the Capital Management Group.

23.1.7 Approval of capital projects and the purchase of capital items must be made within the budget and programme agreed by the Board within the delegated limits below:

- (a) Capital Management Group will approve up to £1m;
- (b) Board to approve over £1m
- (c) For revenue associated with capital business cases, Capital Management Group will approve revenue up to £0.1m; Executive Management Team will approve revenue over £0.1m and up to £1m; Finance and Business Performance Committee and Board will approve over £1m.

- 23.1.8 The DOF shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes. These procedures shall fully take into account the delegated limits for capital schemes issued by the Department of Health and NHSI (describing organisational delegated limits).

## **23.2 Private Finance (see overlap with SFI 17.10)**

- 23.2.1 The Trust should normally test for PFI when considering capital procurement. When the Trust proposes to use finance which is to be provided other than through its Allocations, the following procedures shall apply:
- (a) The DOF shall demonstrate that the use of private finance represents value for money and **genuinely** transfers significant risk to the private sector.
  - (b) Where the sum involved exceeds delegated limits, the business case must be referred to the Department of Health or in line with any current guidelines.
  - (c) The proposal must be specifically agreed by the Board.

## **23.3 Asset Registers**

- 23.3.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the DOF concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.
- 23.3.2 The Trust shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be as guided by the Capital Accounting Manual.
- 23.3.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:
- (a) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;
  - (b) stores, requisitions and wages records for own materials and labour including appropriate overheads;
  - (c) lease agreements in respect of assets held under a finance lease and capitalised.
- 23.3.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).
- 23.3.5 The DOF shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.
- 23.3.6 The value of each asset shall be indexed to current values in accordance with methods specified in the Capital Accounting Manual.
- 23.3.7 The value of each asset shall be depreciated using methods and rates as specified in the Capital Accounting Manual.
- 23.3.8 The DOF of the Trust shall calculate and pay capital charges as specified in the Capital Accounting Manual.

## **23.4 Security of Assets**

- 23.4.1 The overall control of fixed assets is the responsibility of the Chief Executive.
- 23.4.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the DOF. This procedure shall make provision for:

- (a) recording managerial responsibility for each asset;
- (b) identification of additions and disposals;
- (c) identification of all repairs and maintenance expenses;
- (d) physical security of assets;
- (e) periodic verification of the existence of, condition of, and title to, assets recorded;
- (f) identification and reporting of all costs associated with the retention of an asset;
- (g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

23.4.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the DOF.

23.4.4 Whilst each employee and officer has a responsibility for the security of property of the Trust, it is the responsibility of Board members and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with agreed procedures.

23.4.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Board members and employees in accordance with the procedure for reporting losses.

23.4.6 Where practical, assets should be marked as Trust property.

## **24. STORES AND RECEIPT OF GOODS**

### **24.1 General position**

24.1.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

- (a) kept to a minimum;
- (b) subjected to stock take at least annually
- (c) valued at the lower of cost and net realisable value.

### **24.2 Control of Stores, Stocktaking, condemnations and disposal**

24.2.1 Subject to the responsibility of the DOF for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated by him to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the DOF. The control of any Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of any fuel oil and coal of a designated estates manager.

24.2.2 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Officer. Wherever practicable, stocks should be marked as health service property.

24.2.3 The DOF shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

24.2.4 Stocktaking arrangements shall be agreed with the DOF and there shall be a physical check covering all items in store at least once a year.

24.2.5 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the DOF.

- 24.2.6 The designated Manager/Pharmaceutical Officer shall be responsible for a system approved by the DOF for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the DOF any evidence of significant overstocking and of any negligence or malpractice (see also overlap with SFI 25 Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

### **24.3 Goods supplied by NHS Supply Chain**

- 24.3.1 For goods supplied via the NHS Supply Chain central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note before forwarding this to the DOF who shall satisfy himself that the goods have been received before accepting the recharge.

## **25. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS**

### **25.1 Disposals and Condemnations**

#### **25.1.1 Procedures**

- 25.1.1.1 The DOF must prepare detailed procedures for the disposal of assets including condemnations and ensure that these are notified to managers.
- 25.1.1.2 When it is decided to dispose of a Trust asset, the Head of Department or authorised deputy will determine and advise the DOF of the estimated market value of the item, taking account of professional advice where appropriate.
- 25.1.1.3 All unserviceable articles shall be:
- (a) condemned or otherwise disposed of by an employee authorised for that purpose by the DOF;
  - (b) recorded by the Condemning Officer in a form approved by the DOF which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the DOF.
- 25.1.1.4 The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the DOF who will take the appropriate action.

### **25.2 Losses and Special Payments**

#### **25.2.1 Procedures**

- 25.2.1.1 The DOF must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.
- 25.2.1.2 Any employee or officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Chief Executive and the Director of Finance or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then appropriately inform the DOF and/or Chief Executive. Where a criminal offence is suspected, the DOF must immediately inform the police if theft or arson are involved. In cases of fraud, bribery or corruption the DOF must inform the relevant Local Counter Fraud Specialist (LCFS) and and/or the AAFS, in accordance with NHS Counter Fraud Authority's Standards for Providers.

- 25.2.1.3 The DOF must notify NHS Protect, the Audit and Assurance Committee and the External Auditor of all frauds.
- 25.2.1.4 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the DOF must immediately notify:
  - (a) the Board,
  - (b) the LSMS; and
  - (c) the External Auditor.
- 25.2.1.5 The DOF will inform the Board of losses written off and special payments authorised by officers.
- 25.2.1.6 The DOF shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.
- 25.2.1.7 For any loss, the DOF should consider whether any insurance claim can be made.
- 25.2.1.8 The DOF shall maintain a Losses and Special Payments Register in which write-off action is recorded.
- 25.2.1.9 Any novel, contentious or repercussive cases should be referred to Department of Health for approval. If any general losses emerge from a loss or special payment which would be of interest to others, then the Department of Health should be informed.
- 25.2.1.10 All losses and special payments must be reported to the Audit Committee (AC) periodically.

## **26. INFORMATION TECHNOLOGY**

### **26.1 Responsibilities and duties of the Director for Finance**

- 26.1.1 The DOF, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:
  - (a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which the Director is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 2018;
  - (b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;
  - (c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;
  - (d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as the Director may consider necessary are being carried out.
- 26.1.2 The DOF shall need to ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

### **26.2 Risk Assessment**

- 26.2.1 The DOF and the Director of Information and Facilities shall ensure that financial risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk.

### **26.3 Requirements for Computer Systems which have an impact on corporate financial systems**

- 26.3.1 Where computer systems have an impact on corporate financial systems the DOF shall need to be satisfied that:
- (a) systems acquisition, development and maintenance are in line with corporate policies such as an Information Communication and Technology Strategy;
  - (b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;
  - (c) Finance staff have access to such data;
  - (c) such computer audit reviews as are considered necessary are being carried out.

## **27. PATIENTS' PROPERTY**

- 27.1.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

- 27.1.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

- notices and information booklets; (*notices are subject to sensitivity guidance*)
- hospital admission documentation and property records;
- the oral advice of administrative and nursing staff responsible for admissions,

that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

- 27.1.3 The DOF must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

- 27.1.4 Where Department of Health instructions require the opening of separate accounts for patients' moneys, these shall be opened and operated under arrangements agreed by the DOF.

- 27.1.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

- 27.1.6 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

- 27.1.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose unless any variation is approved by the donor or patient in writing.

## **28. FUNDS HELD ON TRUST**

### **28.1 Corporate Trustee**

- 28.1.1 Standing Order 4.8.15 outlines the Trust's responsibilities as a corporate trustee for the management of funds it holds on trust, that defines the need for compliance with Charities Commission latest guidance and best practice. As corporate trustee of the Charitable funds, its responsibilities are governed by the law applicable to Trusts, principally the Trustee Act 2000 and the Charities Act 1993, 2006 and the Charities Act 2011 as amended by the Charities Act 2016.
- 28.1.2 The discharge of the Trust's corporate trustee responsibilities are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes.
- 28.1.3 The NHS Board has devolved responsibility for the on-going management of charitable funds to the Charitable Funds Committee, which administers the funds on behalf of the Corporate Trustee. As such the Committee acts independently of the Board. Members of the Committee are not individual trustees under charity law but act as agents on behalf of the Corporate Trustee.
- 28.1.4 The DOF shall ensure that each trust fund which the Trust is responsible for managing is managed appropriately with regard to its purpose and to its requirements.

### **28.2 Accountability to Charity Commission and Secretary of State for Health**

- 28.2.1 The trustee responsibilities must be discharged separately, and full recognition given to the Trust's dual accountabilities to the Charity Commission for charitable funds held on trust and to the Secretary of State for all funds held on trust.
- 28.2.2 The Schedule of Matters Reserved to the Board and the Scheme of Delegation make clear where decisions regarding the exercise of discretion regarding the disposal and use of the funds are to be taken and by whom. All Board members and Trust officers must take account of that guidance before taking action.

### **28.3 Applicability of Standing Financial Instructions to funds held on Trust**

- 28.3.1 In so far as it is possible to do so, most of the sections of these Standing Financial Instructions will apply to the management of funds held on trust. (See overlap with SFI No 17.16).
- 28.3.2 The over-riding principle is that the integrity of each Trust must be maintained, and statutory and Trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

## **29. ACCEPTANCE OF GIFTS BY STAFF AND LINK TO STANDARDS OF BUSINESS CONDUCT (see overlap with SO 6.2 and SFI 19.2.3 & 19.6)**

- 29.1.1 The Director of Finance shall ensure that all staff are made aware of the Trust policy on the Standards of Business Conduct on the acceptance of gifts and other benefits in kind by staff. It is also deemed to be an integral part of these Standing Orders and

Standing Financial Instructions (see overlap with SO 6.2).

- 29.1.2 Staff should make themselves aware of, and comply with, the Bribery Act 2010, the Code of Conduct for NHS Managers 2002, and the ABPI 'The Code of Practice for the Pharmaceutical Industry Second 2012 Edition' relating to hospitality/gifts from pharmaceutical / external industry.

## **30. RETENTION OF RECORDS**

- 30.1.1 The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with Department of Health Records Management NHS Code of Practice Parts 1 and 2.
- 30.1.2 The records held in archives shall be capable of retrieval by authorised persons.
- 30.1.3 Records held in accordance with latest Department of Health guidance shall only be destroyed at the express instigation of the Chief Executive or delegated Information Asset Manager. Detail shall be maintained of records so destroyed.

## **31. RISK MANAGEMENT AND INSURANCE**

### **31.1 Programme of Risk Management**

- 31.1.1 The Chief Executive shall ensure that the Trust has a programme of risk management, in accordance with current Department of Health assurance framework requirements, which must be approved and monitored by the Board.
- 31.1.2 The programme of risk management shall include:
- a) a process for identifying and quantifying risks and potential liabilities;
  - b) engendering among all levels of staff a positive attitude towards the control of risk;
  - c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;
  - d) contingency plans to offset the impact of adverse events;
  - e) audit arrangements including; Internal Audit, clinical audit, health and safety review;
  - f) a clear indication of which risks shall be insured;
  - g) arrangements to review the Risk Management programme.
- 31.1.3 The existence, integration and evaluation of the above elements will assist in providing a basis to make an Annual Governance Statement within the Annual Report and Accounts as required by current Department of Health guidance.

### **31.2 Insurance: Risk Pooling Schemes administered by NHS Resolution**

- 31.2.1 The Board shall decide if the Trust will insure through the risk pooling schemes administered by the NHS Resolution or self-insure for some or all of the risks covered by the risk pooling schemes. If the Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

### **31.3 Insurance arrangements with commercial insurers**

- 31.3.1 There is a general prohibition on entering into insurance arrangements with commercial insurers. There are, however, three exceptions when Trust's may enter

into insurance arrangements with commercial insurers. The exceptions are:

- a) Trust's may enter commercial arrangements for insuring motor vehicles owned by the Trust including insuring third party liability arising from their use;
- b) where the Trust is involved with a consortium in a Private Finance Initiative contract and the other consortium members require that commercial insurance arrangements are entered into; and
- c) where income generation activities take place. Income generation activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the Trust for a NHS purpose the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from NHS Resolution. In any case of doubt concerning a Trust's powers to enter into commercial insurance arrangements the Finance Director should consult the Department of Health.

### **31.4 Arrangements to be followed by the Board in agreeing Insurance cover**

- 31.4.1 Where the Board decides to use the risk pooling schemes administered by NHS Resolution the DOF shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The DOF shall ensure that documented procedures cover these arrangements.
- 31.4.2 Where the Board decides not to use the risk pooling schemes administered by NHS Resolution for one or other of the risks covered by the schemes, the DOF shall ensure that the Board is informed of the nature and extent of the risks that are self-insured as a result of this decision. The DOF will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.
- 31.4.3 All the risk pooling schemes require Scheme members to make some contribution to the settlement of claims (the 'deductible'). The DOF should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

## SECTION D – SCHEME OF RESERVATION AND DELEGATION

### 32. Reservation of Matters to the Board

| REF | THE BOARD | DECISIONS RESERVED TO THE BOARD   |
|-----|-----------|---|
| NA  | THE BOARD | <p><b>General Enabling Provision</b></p> <p>The Board may determine any matter, for which it has delegated or statutory authority, it wishes in full session within its statutory powers.</p>   |
| NA  | THE BOARD | <p><b>Regulations and Control</b></p> <ol style="list-style-type: none"> <li>1. Approve Standing Orders (SOs), a schedule of matters reserved to the Board and Standing Financial Instructions for the regulation of its proceedings and business.</li> <li>2. Suspend Standing Orders.</li> <li>3. Vary or amend the Standing Orders.</li> <li>4. Ratify any urgent decisions taken by the Chair and Chief Executive in public session in accordance with SO 5.2</li> <li>5. Approve a scheme of delegation of powers from the Board to committees.</li> <li>6. Require and receive the declaration of Board members' interests that may conflict with those of the Trust and determining the extent to which that member may remain involved with the matter under consideration.</li> <li>7. Require and receive the declaration of officers' interests that may conflict with those of the Trust.</li> <li>8. Approve arrangements for dealing with complaints.</li> <li>9. Adopt the organisation structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications thereto.</li> <li>10. Receive reports from committees including those that the Trust is required by the Secretary of State or other regulation to establish and to take appropriate action on.</li> <li>11. Confirm the recommendations of the Trust's committees where the committees do not have executive powers.</li> <li>12. Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust.</li> <li>13. Establish terms of reference and reporting arrangements of all committees and sub-committees that are established by the Board.</li> <li>14. Approve arrangements relating to the discharge of the Trust's responsibilities as a bailer for patients' property.</li> <li>15. Authorise use of the seal.</li> <li>16. Ratify or otherwise instances of failure to comply with Standing Orders brought to the Chief Executive's attention in accordance with SO 5.6.</li> <li>17. Discipline members of the Board or employees who are in breach of statutory requirements or SOs.</li> </ol> |
| NA  | THE BOARD | <p><b>Appointments/Dismissal</b></p> <ol style="list-style-type: none"> <li>1. Appoint the Senior Independent Director of the Board.</li> <li>2. The appointment and dismissal of Associates of the Trust Board.</li> <li>3. Appoint and dismiss committees (and individual members) that are directly accountable to the Board.</li> <li>4. Appoint, appraise, discipline and dismiss Executive Directors (subject to SO 2.2).</li> <li>5. Confirm appointment of members of any committee of the Trust as representatives on outside bodies.</li> <li>6. Appoint, appraise, discipline and dismiss the Secretary (if the appointment of a Secretary is required under Standing Orders).</li> <li>7. Approve proposals of the Nominations and Remuneration Committee regarding directors and senior employees and those of the Chief Executive.</li> </ol>   |
| NA  | THE BOARD | <p><b>Strategy, Plans and Budgets</b></p> <ol style="list-style-type: none"> <li>1. Define the strategic aims and objectives of the Trust.</li> <li>2. Approve proposals for ensuring quality and developing clinical governance in services</li> </ol>   |

| REF | THE BOARD | DECISIONS RESERVED TO THE BOARD  |
|-----|-----------|--|
|     |           | <p>provided by the Trust, having regard to any guidance issued by the Secretary of State.</p> <ol style="list-style-type: none"> <li>3. Approve the Trust's policies and procedures for the management of risk.</li> <li>4. Approve Outline and Final Business Cases for Capital and Revenue Investment over £1m.</li> <li>5. Approve budgets.</li> <li>6. Approve annually Trust's proposed organisational development proposals.</li> <li>7. Ratify proposals for acquisition, disposal or change of use of land and/or buildings.</li> <li>8. Approve PFI proposals.</li> <li>9. Approve the opening of bank accounts.</li> <li>10. Approve proposals on individual contracts (other than NHS contracts) of a capital or revenue nature amounting to, or likely to amount to over £1,000,000 over a three-year period or the period of the contract if longer.</li> <li>11. Approve proposals in individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and Director of Finance (for losses and special payments) previously approved by the Board.</li> <li>12. Approve individual compensation payments.</li> <li>13. Approve proposals for action on litigation against or on behalf of the Trust.</li> <li>14. Review use of NHS Resolution risk pooling schemes (LPST/CNST/RPST).</li> </ol> |
|     | THE BOARD | <p><b>Policy Determination</b><br/>Approve management policies including personnel policies incorporating the arrangements for the appointment, removal and remuneration of staff.</p>   |
|     | THE BOARD | <p><b>Audit</b></p> <ol style="list-style-type: none"> <li>1. Approve the appointment (and where necessary dismissal) of External Auditors of funds held on trust, and the submission of reports to the Audit Committee meetings who will take appropriate action</li> <li>2. Receipt of the annual management letter received from the external auditor and agreement of proposed action, taking account of the advice, where appropriate, of the Audit Committee.</li> <li>3. Receive an annual report from the Internal Auditor and agree action on recommendations where appropriate of the Audit Committee.</li> </ol>  |
| NA  | THE BOARD | <p><b>Annual Reports and Accounts</b></p> <ol style="list-style-type: none"> <li>1. Receipt and approval of the Trust's Annual Report and Annual Accounts.</li> <li>2. Receipt and approval of the Annual Report and Accounts for funds held on trust.</li> </ol>  |
| NA  | THE BOARD | <p><b>Monitoring</b></p> <ol style="list-style-type: none"> <li>1. Receipt of such reports as the Board sees fit from committees in respect of their exercise of powers delegated.</li> <li>2. Continuous appraisal of the affairs of the Trust by means of the provision to the Board as the Board may require from directors, committees, and officers of the Trust as set out in management policy statements. All monitoring returns required by the Department of Health and the Charity Commission shall be reported, at least in summary, to the Board.</li> <li>3. Receive reports from Director of Finance on financial performance against budget Operational Plan and any Integrated Care System or Integrated Care Partnership plans.</li> <li>4. Receive reports from Chief Executive on actual and forecast income from SLA.</li> </ol>  |

### 33. DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES

| REF      | COMMITTEE                             | DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES   |
|----------|---------------------------------------|---|
| N/A      | <b>Executive Management Committee</b> | <p>The Committee will:</p> <ol style="list-style-type: none"> <li>1. Review updated versions of the Standing Financial Instructions and recommend them to the Board for approval.</li> <li>2. Approve Policies other than those formally delegated to other sub-Committees of the Board</li> <li>3. Approve operational and management procedures which affect the whole Trust or more than one division and keeping the effectiveness of procedures under review.</li> <li>4. Review Outline and Final Business Cases for Capital and Revenue Investment over £1m and recommend to Finance and Business Performance Committee and the Board.</li> <li>5. Approve Final Business Cases for Revenue Investment over £0.1m and up to £1m.</li> </ol>  |
| SFI 11.1 | <b>Audit Committee</b>                | <p><b>Governance, Risk Management and Internal Control</b></p> <p>The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), that supports the achievement of the Trust's objectives. In particular, the Committee will review the adequacy of:</p> <ul style="list-style-type: none"> <li>• All risk and control related disclosure statements (in particular the Annual Governance Statement and Quality Accounts), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board;</li> <li>• The underlying assurance processes that indicate the degree of the achievement of corporate objectives and assurance over quality of data in relation to performance reporting. This shall be through a review of the work of other relevant Committees which provide relevant assurances to support the Audit Committee's own scope of work;</li> <li>• The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements;</li> <li>• The Committee shall be notified of, and review, any decision to suspend Standing Orders;</li> <li>• The policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by NHS Protect; and</li> <li>• The policies and procedures for staff to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters, ensuring that arrangements are in place for independent investigation of such matters and for appropriate follow-up action audit</li> </ul> <p><b>1. Internal Audit</b></p> <p>The Committee shall ensure that there is an effective internal audit function established by management that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. This will be achieved by:</p> <ul style="list-style-type: none"> <li>• Considering and making recommendations for the provision of the internal audit service, the audit fee and any questions of resignation and dismissal;</li> </ul> |

| REF | COMMITTEE | DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES   |
|-----|-----------|---|
|     |           | <ul style="list-style-type: none"> <li>• Review and approval of the internal audit strategy and the detailed programme of internal audit work, ensuring that this is consistent with the audit needs of the Trust as identified by the Assurance Framework;</li> <li>• Consideration of the major findings of internal audit, together with management's response;</li> <li>▪ The Committee shall monitor the implementation of actions to address all recommendations arising from Internal Audit reports through the use of an overall audit and assurance outstanding recommendation tracker to be reported to each meeting;</li> <li>▪ Ensuring co-ordination between the internal and external auditors to optimise audit resources and avoid duplication;</li> <li>▪ Ensuring that the internal audit function is adequately resourced and has appropriate standing within the Trust through ongoing monitoring against core Internal Audit KPIs; and</li> <li>▪ Annual review of the effectiveness of internal audit.</li> </ul> <p><b>2. Local Counter Fraud Service</b><br/>The Committee shall review the work plan and periodic reviews of the local counter fraud service and consider actions necessary to combat fraud and corruption. This will be achieved by:</p> <ul style="list-style-type: none"> <li>• consider the appointment of the Local Counter Fraud Specialists (LCFS), the LCFS fee, the LCFS' scope and any question of resignation and dismissal;</li> <li>• consider and approve the counter fraud strategy and the annual work plan, ensuring that this is consistent with the needs of the Trust;</li> <li>• monitor the performance of the LCFS in the provision of both reactive and proactive fraud work in line with the requirements set out in the 'General Conditions' section of the NHS Standard Contract regarding fraud and corruption; and</li> <li>• review LCFS reports, consider the major findings of fraud investigations, and management's response, and ensure co-ordination between the LCFS, internal and external auditors.</li> </ul> <p><b>3. External Audit</b><br/>The Committee shall ensure a cost-efficient service, review the work and findings of the appointed external auditor and consider the implications and management's responses to their work. This will be achieved by:</p> <ul style="list-style-type: none"> <li>• Consideration of the appointment and performance of the external auditor;</li> <li>• Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the annual audit plan, and ensure coordination, as appropriate, with other external auditors in the local health economy;</li> <li>• Discussion with the External Auditor of their local evaluation of audit risks, their assessment of the Trust and the associated impact on the audit fee;</li> <li>• Review of all External Audit reports together with the management responses;</li> <li>• Agreement of the annual audit letter before submission to the Board and agreement to any work falling outside the</li> </ul> |

| REF | COMMITTEE | DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES  |
|-----|-----------|--|
|     |           | <p>annual audit plan; and</p> <ul style="list-style-type: none"> <li>The Committee will develop a policy, and monitor its implementation, on the engagement of the external auditor to supply any non-audit services to ensure the external auditor retains a high degree of independence from the Trust.</li> </ul> <p><b>4. Other Assurance Functions</b><br/> The Committee shall review the findings of other significant assurance functions, both internal and external to the Trust, and consider the implications to the governance of the Trust.</p> <p>Internally this will include the assurances provided through the Quality and Clinical Governance Committee. The Committee shall review the processes used by the Quality and Clinical Governance Committee to gain assurance. The Committee will wish to satisfy themselves on the assurance that the Quality and Clinical Governance Committee gain from the clinical audit function.</p> <p>Assurances will also be reviewed from information governance, workforce, health and safety, research governance and other functions.</p> <p>The Committee will ensure that the Assurance Framework records the level of assurance given by external reviews carried out by regulators such as the Care Quality Commission, NHS Resolution, Royal Colleges and other similar professional bodies. The Quality and Clinical Governance Committee will review the findings and the management response.</p> <p><b>5. Management</b><br/> The Committee shall request and review reports and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.</p> <p><b>6. Financial Reporting</b><br/> The Committee shall review the Annual Report and Financial Statements before submission to the Board, focusing particularly on:</p> <ul style="list-style-type: none"> <li>The wording in the Annual Governance Statement and other disclosures within the terms of reference of the Committee;</li> <li>Changes in, and compliance with, accounting policies and practices;</li> <li>Unadjusted misstatements in the financial statements;</li> <li>Significant judgements in the preparation of the financial statements;</li> <li>Significant adjustments resulting from the audit;</li> <li>Letter of representation; and</li> <li>Qualitative aspects of financial reporting.</li> </ul> <p>The Committee should also ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.</p> <p>The Committee shall review schedules of losses and compensations, making recommendations to the Board of Directors as appropriate, taking account of delegated limits;</p> <ul style="list-style-type: none"> <li>The Committee shall monitor compliance with the Trust's Standing Orders, including through notification and review</li> </ul> |

| REF      | COMMITTEE                                     | DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES   |
|----------|---|---|
|          |   | <p>of any decision to suspend them;</p> <ul style="list-style-type: none"> <li>• The Committee shall monitor compliance with Standing Financial Instructions through receipt of waivers for all variations; and</li> </ul>  |
| SFI 18.1 | <b>Nominations and Remuneration Committee</b> | <p>The Committee shall be responsible for the following duties:</p> <p><b>1. Nominations:</b></p> <ul style="list-style-type: none"> <li>• To regularly review the structure, size and composition (including skills, knowledge, experience and diversity) required of the Board and make recommendations with regard to changes;</li> <li>• To oversee and review the Trust’s talent management strategy ensuring this supports effective and robust succession planning including both internal identification and development of talent and external environment scanning;</li> <li>• To give full consideration to and make plans for succession planning for the Chief Executive, Executive Directors and specified Senior Officers, taking into account the challenges and opportunities facing the Trust and the skills and expertise needed, in particular on the Board in future;</li> <li>• Before advertising a position, to evaluate the balance of skills, knowledge, experience and diversity on the Board and in the light of this evaluation, prepare a description of the role and capabilities required for a particular appointment;</li> <li>• To oversee the Board recruitment process including the identification and nominating for appointment candidates to fill posts within its remit using open advertising or the use of external advisers to facilitate the search; consider candidates from a wide range of backgrounds and consider candidates on merit against objective criteria;</li> <li>• To consider any matter relating to the continuation in office of the Chief Executive, Executive Director or specified Senior Officers, including suspension or termination of service as an employee of the Trust; and</li> <li>• To consider the engagement or involvement of any suitably qualified third party or advisers to assist with any aspects of its responsibilities.</li> </ul> <p><b>2. Remuneration:</b></p> <ul style="list-style-type: none"> <li>• To decide and review the remuneration of the Chief Executive, Executive Directors and specified Senior Officers on locally determined pay. This advice will include all aspects of salary (including any performance-related elements/bonuses), provisions for other benefits including pensions and cars, as well as arrangements for termination of employment and other contractual terms.</li> <li>• to advise on and oversee appropriate contractual arrangements for the Chief Executive, Executive Directors including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate;</li> <li>• to ensure that the basis for employment of the Chief Executive, Executive Directors and specified Senior Officers is set out in properly constructed written contracts of employment</li> <li>• To ensure that Board of Directors emoluments are</li> </ul> |

| REF             | COMMITTEE   | DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES   |
|-----------------|---|---|
| HSC<br>1999/065 | <b>Quality and Clinical Governance Committee</b>  | <p>accurately reported in the Trust's Annual Report</p> <p>The Committee objectives will be:</p> <ol style="list-style-type: none"> <li>1. To provide leadership and assurance to the Board on the effectiveness of the structures, policies, systems and processes for quality assurance, clinical, information and quality governance , specifically in the areas of: <ul style="list-style-type: none"> <li>• Safety (Patient)</li> <li>• Effectiveness</li> <li>• Patient Experience</li> </ul> </li> <li>2. Review the Quality Strategy to ensure continuous improvement is delivered in quality and safety;</li> <li>3. Identify annual objectives of the Committee, produce an annual work plan in the agreed Trust format, measure performance at the end of the year and produce an annual report. This will also include an assessment of compliance with the Committee's terms of reference and a review of the effectiveness of the committee.</li> <li>4. Review reports about compliance with external assessment and reporting, e.g. Care Quality Commission's registration requirements set out in the essential standards of quality and safety, the NHS Resolution standards, assessments or reports from the Medicines and Healthcare Regulatory Authority (MHRA) or the Health and Safety Executive (HSE), the reporting framework for serious incidents and any others that may arise in relation to compliance;</li> <li>5. To examine in-depth key quality issues and thereby contribute to the development of a quality culture</li> <li>6. Oversee implementation of all elements of the quality strategy. In particular, obtaining assurance that the measures for success are implemented within the appropriate time scales;</li> <li>7. Gain assurance over the full range of quality performance via the quality report, quality dashboard, minutes and reports from relevant stakeholder groups and the provision of any other quality related information that the committee may request;</li> <li>8. To oversee the development of the Quality Accounts, ensuring they reflect the views of key stakeholders and advise the Audit Committee on publication; and</li> <li>9. Undertake any other responsibilities as delegated by the Trust board.</li> </ol> |
| N/A             | <b>Finance and Business Performance Committee</b> | <p>The Finance and Performance Committee shall be responsible for the following duties:</p> <ol style="list-style-type: none"> <li>1. <b>Financial Matters</b> <ul style="list-style-type: none"> <li>• To monitor, advise on and recommend to the Board matters relating to the Trust's financial strategy and policies;</li> <li>• Oversee and evaluate the Trust's financial strategy to deliver the integrated business plan;</li> <li>• To critically appraise the Trust's annual budgets for the Board's approval;</li> <li>• Undertake detailed scrutiny of monthly, quarterly and year to date financial information, including performance against the cost improvement programme;</li> <li>• Review the annual Trust Service and financial plans: revenue, capital, working capital and key performance targets;</li> <li>• Undertake detailed scrutiny of the financial forward projections;</li> <li>• Oversee the development, management and delivery of the</li> </ul> </li> </ol>   |

| REF | COMMITTEE                         | DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES  |
|-----|-----------------------------------|--|
|     |                                   | <p>Trust's annual capital programme;</p> <ul style="list-style-type: none"> <li>• Review and maintain an overview of financial and service delivery agreements and key contractual arrangements;</li> <li>• Oversee the delivery of the cost improvement programme and development of the Trust's efficiency and productivity processes;</li> <li>• Review the Trust's ICT and digital strategy and management and review of implementation of digital capabilities</li> <li>• Review the Trust's estates strategy, the Trust's asset strategy and management and review and propose future land and property transactions; and</li> <li>• Consider key financial policies e.g. investment policy, issues and developments to ensure that they are shaped, developed and implemented in the Trust appropriately.</li> </ul> <p><b>2. Business Cases</b><br/>Review Outline and Final Business Cases for Capital and Revenue Investment over £1m and recommend to the Board.</p> <p><b>3. Performance Management</b></p> <ul style="list-style-type: none"> <li>• Receive assurance from the Executive Management Committee in respect of divisional performance regarding key performance indicators;</li> <li>• Review the Trust's performance reporting and support the development of appropriate performance measures, including key performance indicators around the operating framework;</li> <li>• Oversee and evaluate the Trust's performance management strategy to ensure a framework is in place which allows the Trust to performance manage against its business plan.</li> </ul> |
| N/A | <b>Charitable Funds Committee</b> | <p>The Committee will:</p> <ul style="list-style-type: none"> <li>• Ensure the Charity complies with current legislation;</li> <li>• Determine the charitable fund's investment policy, including the selection of appropriate investment advisers and banking service provider;</li> <li>• Review the performance of the Charity's investments;</li> <li>• Set and review an expenditure policy, including the use of investment gains;</li> <li>• Approving expenditure over £50,000. This responsibility may be discharged by the Chair of the Committee and Director of Finance acting together. All approved expenditure of over £5,000 will be reported to the next meeting of the Committee. Fund managers have authority to approve expenditure up to £5,000, the Chief Executive and Director of Finance up to £50,000;</li> <li>• Review individual fund balances within the overall Charity on a regular basis;</li> <li>• Agree guidance and procedures for fundraising and expenditure;</li> <li>• Agree expenditure plans from individual fund holders;</li> <li>• Review and ensure audit recommendations are actioned;</li> <li>• To approve annual accounts for the Charity and ensure relevant information is disclosed;</li> <li>• Produce an annual report for the Charity in accordance with section 45 of the Charities Act 1993 and Charities Act 2006;</li> <li>• Encourage a culture of fundraising and raise the profile of the</li> </ul>   |

| REF | COMMITTEE | DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES   |
|-----|-----------|---|
|     |           | <p>Charity within the Trust and local population;</p> <ul style="list-style-type: none"> <li>• Develop and approve promotional material of the Charity on behalf of the Trustees to ensure that material used will not place the Charity's reputation at undue risk;</li> <li>• To ensure that all fund raising and expenditure is clinically and ethically appropriate;</li> <li>• To ensure funding decisions are appropriate and consistent with objectives, and to ensure said funding provides added value and benefit to patients and staff above those afforded by income for commissioned services;</li> <li>• To receive regular reports on the Charitable Trust fundraising activities;</li> <li>• To provide regular reports to the Audit Committee to enable it to provide assurance to the Board that the Charity is properly governed and well managed across the full range of activities; and</li> <li>• To implement appropriate policies and procedures to ensure that accounting systems are robust, donations received are acknowledged and that all expenditure is reasonable and in accordance with donors wishes.</li> </ul> |

#### 34. SCHEME OF DELEGATION DERIVED FROM THE ACCOUNTABLE OFFICER MEMORANDUM

| REF | DELEGATED TO                            | DUTIES DELEGATED   |
|-----|---|--|
| 1.  | CHIEF EXECUTIVE                         | Accountable through NHS Accounting Officer to Parliament for stewardship of Trust resources  |
| 2.  | CHIEF EXECUTIVE AND DIRECTOR OF FINANCE | <p>Ensure the accounts of the Trust are prepared under principles and in a format directed by the Secretary of State. Accounts must disclose a true and fair view of the Trust's income and expenditure and its state of affairs.</p> <p>Sign the accounts on behalf of the Board.</p>   |
| 3.  | CHIEF EXECUTIVE                         | <p>Sign a statement in the accounts outlining responsibilities as the Accountable Officer.</p> <p>Sign a statement in the accounts outlining responsibilities in respect of Internal Control.</p>  |
| 4.  | CHIEF EXECUTIVE                         | <p>Ensure effective management systems that safeguard public funds and assist the Trust Chair to implement requirements of corporate governance including ensuring managers:</p> <p>have a clear view of their objectives and the means to assess achievements in relation to those objectives be assigned well defined responsibilities for making best use of resources have the information, training and access to the expert advice they need to exercise their responsibilities effectively.</p> |
| 5.  | CHAIR                                   | Implement requirements of corporate governance.  |
| 6.  | CHIEF EXECUTIVE                         | Achieve value for money from the resources available to the Trust and avoid waste and extravagance in the organisation's activities.   |
| 7.  | DIRECTOR OF FINANCE                     | Operational responsibility for effective and sound financial management and information.   |
| 8.  | CHIEF EXECUTIVE                         | Primary duty to see that Director of Finance discharges this function.   |
| 9.  | CHIEF EXECUTIVE                         | Ensuring that expenditure by the Trust complies with Parliamentary requirements.   |

| REF | DELEGATED TO                            | DUTIES DELEGATED   |
|-----|---|--|
| 10. | CHIEF EXECUTIVE AND DIRECTOR OF FINANCE | Chief Executive, supported by Director of Finance, to ensure appropriate advice is given to the Board on all matters of probity, regularity, prudent and economical administration, efficiency and effectiveness.  |
| 11. | CHIEF EXECUTIVE                         | If Chief Executive considers the Board or Chair is doing something that might infringe probity or regularity, he should set this out in writing to the Chair and the Board. If the matter is unresolved, he/she should ask the Audit Committee to inquire and if necessary, the SHA and Department of Health.  |
| 12. | CHIEF EXECUTIVE                         | If the Board is contemplating a course of action that raises an issue not of formal propriety or regularity but affects the Chief Executive's responsibility for value for money, the Chief Executive should draw the relevant factors to the attention of the Board. If the outcome is that the Chief Executive is overruled, it is normally sufficient to ensure that the Chief Executive's advice and the overruling of it are clearly apparent from the papers. Exceptionally, the Chief Executive should inform the NHS Trust Authority and the Department of Health. In such cases, and in those described in section 35 row 23, the Chief Executive should as a member of the Board vote against the course of action rather than merely abstain from voting. |

### 35. SCHEME OF DELEGATION DERIVED FROM THE CODES OF CONDUCT AND ACCOUNTABILITY

| REF | DELEGATED TO                       | AUTHORITIES/DUTIES DELEGATED   |
|-----|------------------------------------|--|
| 13. | BOARD                              | Approve procedure for declaration of hospitality and sponsorship.  |
| 14. | BOARD                              | Ensure proper and widely publicised procedures for voicing complaints, concerns about misadministration, breaches of Code of Conduct, and other ethical concerns.  |
| 15. | ALL BOARD MEMBERS                  | Subscribe to Code of Conduct.  |
| 16. | BOARD                              | Board members share corporate responsibility for all decisions of the Board.   |
| 17. | CHAIR AND NON-EXECUTIVE/ DIRECTORS | Chair and Non-Executive Directors are responsible for monitoring the executive management of the organisation and are responsible to the Secretary of State for the discharge of those responsibilities.   |
| 18. | BOARD                              | The Board has six key functions for which it is held accountable by the Department of Health on behalf of the Secretary of State: <ol style="list-style-type: none"> <li>1 to ensure effective financial stewardship through value for money, financial control and financial planning and strategy;</li> <li>2 to ensure that high standards of corporate governance and personal behaviour are maintained in the conduct of the business of the whole organisation;</li> <li>3 to appoint, appraise and remunerate senior executives;</li> <li>4 to ratify the strategic direction of the organisation within the overall policies and priorities of the Government and the NHS, define its annual and longer-term objectives and agree plans to achieve them;</li> <li>5 to oversee the delivery of planned results by monitoring performance against objectives and ensuring corrective action is taken when necessary;</li> <li>6 to ensure effective dialogue between the organisation and the local community on its plans and performance and that these are responsive to the community's needs.</li> </ol> |
| 19. | CHAIR                              | It is the Chair's role to: <ol style="list-style-type: none"> <li>1 provide leadership to the Board;</li> <li>2 enable all Board members to make a full contribution to the Board's affairs and ensure that the Board acts as a team;</li> <li>3 ensure that key and appropriate issues are discussed by the Board in a timely manner,</li> <li>4 ensure the Board has adequate support and is provided efficiently with all the necessary data on which to base informed decisions;</li> </ol>  |

| REF | DELEGATED TO            | AUTHORITIES/DUTIES DELEGATED  |
|-----|-------------------------|---|
|     |                         | <p>5 lead Non-Executive Board members through a formally appointed Remuneration Committee of the main Board on the appointment, appraisal and remuneration of the Chief Executive and (with the latter) other Executive Board members;</p> <p>6 appoint Non-Executive Board members to an Audit Committee of the main Board;</p> <p>7 advise the Secretary of State on the performance of Non-Executive Board members.</p>  |
| 20. | CHIEF EXECUTIVE         | <p>The Chief Executive is accountable to the Chair and Non-Executive members of the Board for ensuring that its decisions are implemented, that the organisation works effectively, in accordance with Government policy and public service values and for the maintenance of proper financial stewardship. The Chief Executive should be allowed full scope, within clearly defined delegated powers, for action in fulfilling the decisions of the Board.</p> <p>The other duties of the Chief Executive as Accountable Officer are laid out in the Accountable Officer Memorandum.</p> |
| 21. | NON-EXECUTIVE DIRECTORS | Non-Executive Directors are appointed by NHS Improvement to bring independent judgement to bear on issues of strategy, performance, key appointments and accountability through the Department of Health to Ministers and to the local community.   |
| 22. | CHAIR AND DIRECTORS     | Declaration of conflict of interests.   |
| 23. | BOARD                   | NHS Boards must comply with legislation and guidance issued by the Department of Health on behalf of the Secretary of State, respect agreements entered into by themselves or in on their behalf and establish terms and conditions of service that are fair to the staff and represent good value for taxpayers' money.  |

### 36. SCHEME OF DELEGATION FROM STANDING ORDERS

| SO REF | DELEGATED TO            | AUTHORITIES/DUTIES DELEGATED   |
|--------|-------------------------|--|
| 0.1    | CHAIR                   | Final authority in interpretation of Standing Orders (SOs).  |
| 2.4    | BOARD                   | Appointment of Senior Independent Director   |
| 3.1    | CHAIR                   | Call meetings.   |
| 3.9    | CHAIR                   | Chair all Board meetings and associated responsibilities.  |
| 3.10   | CHAIR                   | Give final ruling in questions of order, relevancy and regularity of meetings.   |
| 3.12   | CHAIR                   | Having a second or casting vote  |
| 3.13   | BOARD                   | Suspension of Standing Orders  |
| 3.13   | AUDIT COMMITTEE         | Audit Committee to review every decision to suspend Standing Orders (power to suspend Standing Orders is reserved to the Board)  |
| 3.14   | BOARD                   | Variation or amendment of Standing Orders  |
| 5.3    | BOARD                   | Formal delegation of powers to sub committees or joint committees and approval of their constitution and terms of reference. (Constitution and terms of reference of sub committees may be approved by the Chief Executive.) |
| 5.2    | CHAIR & CHIEF EXECUTIVE | The powers which the Board has retained to itself within these Standing Orders may in emergency be exercised by the Chair and Chief Executive after having consulted at least two Non-Executive members.                     |
| 5.5    | CHIEF EXECUTIVE         | The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals that shall be considered and approved by the Board, subject to any amendment agreed during the discussion.                            |
| 5.6    | ALL                     | Disclosure of non-compliance with Standing Orders to the Chief Executive as soon as possible.  |
| 7.1    | THE BOARD               | Declare relevant and material interests.   |
| 7.2    | CHIEF EXECUTIVE         | Maintain Register(s) of Interests.   |
| 7.4    | ALL STAFF               | Comply with national guidance contained in HSG 1993/5 "Standards of Business Conduct for NHS Staff".   |

|     |  |  |
|-----|--|--|
| 7.4 | ALL                                    | Disclose relationship between self and candidate for staff appointment. (Chief Executive to report the disclosure to the Board.) |
| 8   | CHIEF EXECUTIVE                        | Keep seal in safe place and maintain a register of sealing.  |
| 8.4 | CHIEF EXECUTIVE/<br>EXECUTIVE DIRECTOR | Approve and sign all documents which will be necessary in legal proceedings.   |

### 37. SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

| SO or SFI REF   | DELEGATED TO                           | AUTHORITIES/DUTIES DELEGATED  |
|-----------------|--|---|
| 10.1.3          | DIRECTOR OF FINANCE                    | Approval of all financial procedures.   |
| 10.1.4          | DIRECTOR OF FINANCE                    | Advice on interpretation or application of SFIs.  |
| 10.1.6          | ALL MEMBERS OF THE BOARD AND EMPLOYEES | Have a duty to disclose any non-compliance with these Standing Financial Instructions to the Director of Finance as soon as possible.   |
| 10.2.2          | CHIEF EXECUTIVE                        | Responsible as the Accountable Officer to ensure financial targets and obligations are met and have overall responsibility for the System of Internal Control.  |
| 10.2.2          | CHIEF EXECUTIVE & DIRECTOR OF FINANCE  | Accountable for financial control but will, as far as possible, delegate their detailed responsibilities.   |
| 10.2.2          | CHIEF EXECUTIVE                        | To ensure all Board members, officers and employees, present and future, are notified of and understand Standing Financial Instructions.  |
| 10.2.3          | DIRECTOR OF FINANCE                    | Responsible for: <ul style="list-style-type: none"> <li>1 Implementing the Trust's financial policies and coordinating corrective action;</li> <li>2 Maintaining an effective system of financial control including ensuring detailed financial procedures and systems are prepared and documented;</li> <li>3 Ensuring that sufficient records are maintained to explain Trust's transactions and financial position;</li> <li>4 Providing financial advice to members of Board and staff;</li> <li>5 Maintaining such accounts, certificates etc. as are required for the Trust to carry out its statutory duties.</li> </ul> |
| 10.2.4          | ALL MEMBERS OF THE BOARD AND EMPLOYEES | Responsible for security of the Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming to Standing Orders, Financial Instructions and financial procedures.   |
| 10.2.5          | CHIEF EXECUTIVE                        | Ensure that any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income are made aware of these instructions and their requirement to comply.   |
| 11.1.1          | AUDIT COMMITTEE                        | Provide independent and objective view on internal control and probity.   |
| 11.1.2          | CHAIR                                  | Raise the matter at the Board meeting where Audit Committee considers there is evidence of ultra vires transactions or improper acts.   |
| 11.1.3 & 11.2.1 | DIRECTOR OF FINANCE                    | Ensure an adequate internal audit service, for which he/she is accountable, is provided (and involve the Audit Committee in the selection process when/if an internal audit service provider is changed.)   |
| 11.2.1          | DIRECTOR OF                            | Decide at what stage to involve police in cases of  |

| SO or SFI REF   | DELEGATED TO                          | AUTHORITIES/DUTIES DELEGATED  |
|-----------------|---------------------------------------|---|
|                 | FINANCE                               | misappropriation and other irregularities not involving fraud, bribery or corruption.   |
| 11.3            | HEAD OF INTERNAL AUDIT                | Review, appraise and report in accordance with NHS Internal Audit Manual and best practice.   |
| 11.4            | AUDIT COMMITTEE                       | Ensure cost-effective External Audit.   |
| 11.5            | CHIEF EXECUTIVE & DIRECTOR OF FINANCE | Monitor and ensure compliance with Secretary of State Directions on fraud, bribery and corruption including the appointment of the Local Counter Fraud Specialist.  |
| 11.6            | CHIEF EXECUTIVE                       | Monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS site security management including appointment of the Local Security Management Specialist.  |
| 16.1.1          | CHIEF EXECUTIVE                       | Compile and submit to the Board a Business Plan which takes into account financial targets and forecast limits of available resources. The Business Plan will contain: <ul style="list-style-type: none"> <li>1 a statement of the significant assumptions on which the plan is based;</li> <li>2 details of major changes in workload, delivery of services or resources required to achieve the plan.</li> </ul>  |
| 16.1.2 & 16.1.3 | DIRECTOR OF FINANCE                   | Submit budgets to the Board for approval. Monitor performance against budget; submit to the Board financial estimates and forecasts.  |
| 16.2.4          | DIRECTOR OF FINANCE                   | Ensure adequate training is delivered on an ongoing basis to budget holders.  |
| 16.3.1          | CHIEF EXECUTIVE                       | Delegate budget to budget holders.  |
| 16.3.2          | CHIEF EXECUTIVE & BUDGET HOLDERS      | Must not exceed the budgetary total or virement limits set by the Board.  |
| 16.4.1          | DIRECTOR OF FINANCE                   | Devise and maintain systems of budgetary control.   |
| 16.4.2          | BUDGET HOLDERS                        | Ensure that <ul style="list-style-type: none"> <li>a) no overspend or reduction of income that cannot be met from virement is incurred without prior consent of Board;</li> <li>b) approved budget is not used for any other than specified purpose subject to rules of virement;</li> <li>c) no permanent employees are appointed without the approval of the Chief Executive other than those provided for within available resources and workforce establishment.</li> </ul> |
| 16.4.3          | DIRECTOR OF FINANCE                   | Identify and implement cost improvements and income generation activities in line with the Business Plan.   |
| 16.6.1          | CHIEF EXECUTIVE                       | Submit monitoring returns   |
| 12.1            | DIRECTOR OF FINANCE                   | Preparation of annual accounts and reports.   |
| 13              | DIRECTOR OF FINANCE                   | Managing banking arrangements, including provision of banking services, operation of accounts, preparation of instructions and list of cheque signatories.<br><br>(Board approves arrangements.)  |
| 14              | DIRECTOR OF FINANCE                   | Income systems, including system design, prompt banking, review and approval of fees and charges, debt recovery arrangements, design and control of receipts, provision of adequate facilities and systems for employees whose duties include collecting or holding cash.   |
| 14.2.3          | ALL EMPLOYEES                         | Duty to inform Director of Finance of money due from transactions which they initiate/deal with.  |

| SO or SFI REF | DELEGATED TO                            | AUTHORITIES/DUTIES DELEGATED   |
|---------------|---|--|
| 17.           | CHIEF EXECUTIVE                         | Tendering and contract procedure.  |
| 17.5.3        | DIRECTOR OF FINANCE & CHIEF EXECUTIVE   | Waive formal tendering procedures.   |
| 17.5.3        | CHIEF EXECUTIVE                         | Report waivers of tendering procedures to the Board.   |
| 17.5.4        | DIRECTOR OF FINANCE                     | Where a supplier is chosen that is not on the approved list the reason shall be recorded in writing to the Chief Executive.  |
| 17.6.4        | CHIEF EXECUTIVE                         | Responsible for the receipt, endorsement and safe custody of tenders received.   |
| 17.6.5        | CHIEF EXECUTIVE                         | Shall maintain a register to show each set of competitive tender invitations dispatched.   |
| 17.6.6        | CHIEF EXECUTIVE AND DIRECTOR OF FINANCE | Where one tender is received will assess for value for money and fair price.   |
| 17.6.6        | CHIEF EXECUTIVE                         | No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.   |
| 17.6.9        | CHIEF EXECUTIVE                         | Will appoint a manager to maintain a list of approved firms.   |
| 17.6.9        | CHIEF EXECUTIVE                         | Shall ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.  |
| 17.7.2        | CHIEF EXECUTIVE                         | The Chief Executive or his/her nominated officer should evaluate the quotation and select the quote which gives the best value for money.  |
| 17.7.5        | CHIEF EXECUTIVE or DIRECTOR OF FINANCE  | No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.  |
| 17.10         | CHIEF EXECUTIVE                         | The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.   |
| 17.10         | BOARD                                   | All PFI proposals must be agreed by the Board.   |
| 17.11 & 17.12 | CHIEF EXECUTIVE                         | The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.   |
| 17.14         | CHIEF EXECUTIVE                         | The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.  |
| 17.17         | CHIEF EXECUTIVE                         | The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis.  |
| 17.17.5       | CHIEF EXECUTIVE                         | The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.   |
| 17.15         | CHIEF EXECUTIVE                         | Must ensure the Trust enters into suitable Service Level Agreements (SLAs) with service commissioners for the provision of NHS services  |
| 15.4.1        | CHIEF EXECUTIVE                         | As the Accountable Officer, ensure that regular reports are provided to the Board detailing actual and forecast income from the SLA  |
| 18.1.1        | BOARD                                   | Establish a Nominations & Remuneration Committee   |
| 18.1.2        | REMUNERATION COMMITTEE                  | <ul style="list-style-type: none"> <li>Advise the Board on and make recommendations on the remuneration and terms of service of the Chief Executive, other officer members and senior employees to ensure they are fairly rewarded having proper regard to the Trust's circumstances and any national agreements;</li> </ul> |

| SO or SFI REF | DELEGATED TO   | AUTHORITIES/DUTIES DELEGATED   |
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|               |  | <ul style="list-style-type: none"> <li>Monitor and evaluate the performance of individual senior employees;</li> <li>Advise on and oversee appropriate contractual arrangements for such staff, including proper calculation and scrutiny of termination payments.</li> </ul>  |
| 18.1          | REMUNERATION COMMITTEE                                   | Report in writing to the Board its advice and its bases about remuneration and terms of service of directors and senior employees.   |
| 18.3          | BOARD  | Approve proposals presented by the Chief Executive for setting of remuneration and conditions of service for those employees and officers not covered by the Remuneration Committee.   |
| 18.2          | CHIEF EXECUTIVE  | Approval of variation to funded establishment of any department.   |
| 18.3          | CHIEF EXECUTIVE  | Staff, including agency staff, appointments and re-grading.  |
| 18.4          | DIRECTOR OF FINANCE                                      | Payroll: <ul style="list-style-type: none"> <li>specifying timetables for submission of properly authorised time records and other notifications;</li> <li>final determination of pay and allowances;</li> <li>making payments on agreed dates;</li> <li>agreeing method of payment;</li> <li>issuing instructions (as listed in SFI 10.2.2).</li> </ul> |
| 18.4.3        | NOMINATED MANAGERS AS PER AUTHORISED SIGNATORIES POLICY  | <ul style="list-style-type: none"> <li>Submit time records in line with timetable.</li> <li>Complete time records and other notifications in required form.</li> <li>Submitting termination forms in prescribed form and on time.</li> </ul>   |
| 18.4.4        | DIRECTOR OF FINANCE                                      | Ensure that the chosen method for payroll processing is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.  |
| 18.6          | CHIEF PEOPLE OFFICER                                     | Ensure that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and deal with variations to, or termination of, contracts of employment.  |
| 19            | CHIEF EXECUTIVE  | Determine, and set out, level of delegation of non-pay expenditure to budget managers, including a list of managers authorised to place requisitions, the maximum level of each requisition and the system for authorisation above that level. Such delegation is covered in the Limits of Delegation.   |
| 19.1.3        | CHIEF EXECUTIVE  | Set out procedures on the seeking of professional advice regarding the supply of goods and services.   |
| 19.2.3        | NOMINATED MANAGERS AS PER AUTHORISED SIGNATORIES LISTING | In choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's adviser on supply shall be sought.   |
| 19.2.4        | DIRECTOR OF FINANCE                                      | Shall be responsible for the prompt payment of accounts and claims.  |
| 17.6 & 17.7   | DIRECTOR OF FINANCE                                      | <ul style="list-style-type: none"> <li>Advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved,</li> </ul>   |

| SO or SFI REF | DELEGATED TO   | AUTHORITIES/DUTIES DELEGATED  |
|---------------|--|---|
|               |  | <p>the thresholds should be incorporated in standing orders and regularly reviewed;</p> <ul style="list-style-type: none"> <li>• Prepare procedural instructions [where not already provided in the Scheme of Delegation or procedure notes for budget holders] on the obtaining of goods, works and services incorporating the thresholds;</li> <li>• Be responsible for the prompt payment of all properly authorised accounts and claims;</li> <li>• Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable;</li> <li>• A timetable and system for submission to the Director of Finance of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment;</li> <li>• Instructions to employees regarding the handling and payment of accounts within the Finance Department;</li> <li>• Be responsible for ensuring that payment for goods and services is only made once the goods and services are received</li> </ul> |
| 19.4.2        | APPROPRIATE EXECUTIVE DIRECTOR                             | Make a written case to support the need for a prepayment.   |
| 19.4.2        | DIRECTOR OF FINANCE  | Approve proposed prepayment arrangements.   |
| 19.4.2        | BUDGET HOLDER  | Ensure that all items due under a prepayment contract are received (and immediately inform Director of Finance if problems are encountered).  |
| 19.5          | CHIEF EXECUTIVE  | Authorise who may use and be issued with official orders.   |
| 19.6.1        | MANAGERS AND OFFICERS                                      | Ensure that they comply fully with the guidance and limits specified by the Director of Finance.  |
| 19.6.2        | CHIEF EXECUTIVE, DIRECTOR OF FINANCE & COMMERCIAL DIRECTOR | Ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within CONCODE and ESTATECODE. The technical audit of these contracts shall be the responsibility of the relevant Director.   |
| 19.7          | DIRECTOR OF FINANCE  | Lay down procedures for payments to local authorities and voluntary organisations made under the powers of section 28A of the NHS Act.  |
| 21.1.1        | DIRECTOR OF FINANCE  | The Director of Finance will advise the Board on the Trust's ability to pay dividend on PBC and report, periodically, concerning the PDC debt and all loans and overdrafts.   |
| 21.2          | BOARD  | Approve a list of employees authorised to make short term borrowings on behalf of the Trust. (This must include the Chief Executive and Director of Finance.)   |
| 21.3          | DIRECTOR OF FINANCE  | Prepare detailed procedural instructions concerning applications for loans and overdrafts.  |
| 21.5          | CHIEF EXECUTIVE OR DIRECTOR OF FINANCE                     | Be on an authorising panel comprising one other member for short term borrowing approval.   |
| 22.2          | DIRECTOR OF FINANCE  | Will advise the Board on investments and report, periodically, on performance of same.  |
| 22.3          | DIRECTOR OF FINANCE  | Prepare detailed procedural instructions on the operation of investments held.  |
| 10.2.3        | DIRECTOR OF FINANCE  | Ensure that Board members are aware of the Financial Framework and ensure compliance  |

| SO or SFI REF   | DELEGATED TO                                  | AUTHORITIES/DUTIES DELEGATED  |
|-----------------|---|---|
| 23.1            | CHIEF EXECUTIVE                               | Capital investment programme: <ul style="list-style-type: none"> <li>ensure that there is adequate appraisal and approval process for determining capital expenditure priorities and the effect that each has on plans</li> <li>responsible for the management of capital schemes and for ensuring that they are delivered on time and within cost;</li> <li>ensure that capital investment is not undertaken without availability of resources to finance all revenue consequences;</li> <li>ensure that a business case is produced for each proposal.</li> </ul> |
| 23.1.2          | DIRECTOR OF FINANCE                           | Certify professionally the costs and revenue consequences detailed in the business case for capital investment.   |
| 23.1.3          | CHIEF EXECUTIVE                               | Issue procedures for management of contracts involving stage payments.  |
| 23.1.4          | DIRECTOR OF FINANCE                           | Assess the requirement for the operation of the construction industry taxation deduction scheme.  |
| 23.1.5          | DIRECTOR OF FINANCE                           | Issue procedures for the regular reporting of expenditure and commitment against authorised capital expenditure.  |
| 23.1.6          | CHIEF EXECUTIVE                               | <ul style="list-style-type: none"> <li>Issue manager responsible for any capital scheme with authority to commit expenditure, authority to proceed to tender and approval to accept a successful tender.</li> <li>Issue a scheme of delegation for capital investment management.</li> </ul>  |
| 23.1.8          | DIRECTOR OF FINANCE                           | Issue procedures governing financial management, including variation to contract, of capital investment projects and valuation for accounting purposes.   |
| 23.2.1          | DIRECTOR OF FINANCE                           | Demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.  |
| 23.2.1          | BOARD   | Proposal to use PFI must be specifically agreed by the Board.   |
| 23.3.1          | CHIEF EXECUTIVE                               | Maintenance of asset registers (on advice from Director of Finance).  |
| 23.3.5          | DIRECTOR OF FINANCE                           | Approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.  |
| 23.3.8          | DIRECTOR OF FINANCE                           | Calculate and pay capital charges in accordance with Department of Health requirements.   |
| 23.4.1          | CHIEF EXECUTIVE                               | Overall responsibility for fixed assets.  |
| 23.4.2          | DIRECTOR OF FINANCE                           | Approval of fixed asset control procedures.   |
| 23.4.4 & 23.4.5 | BOARD, EXECUTIVE MEMBERS AND ALL SENIOR STAFF | Responsibility for security of Trust assets including notifying discrepancies to Director of Finance, and reporting losses in accordance with Trust procedure.  |
| 24.2.1          | CHIEF EXECUTIVE                               | Delegate overall responsibility for control of stores (subject to Director of Finance responsibility for systems of control). Further delegation for day-to-day responsibility subject to such delegation being recorded.   |
| 24.2.1          | DIRECTOR OF FINANCE                           | Responsible for systems of control over stores and receipt of goods.  |
| 24.2.1          | DESIGNATED                                    | Responsible for controls of pharmaceutical stocks   |

| SO or SFI REF | DELEGATED TO                    | AUTHORITIES/DUTIES DELEGATED  |
|---------------|---------------------------------|---|
|               | PHARMACEUTICAL OFFICER          |   |
| 24.2.1        | DESIGNATED ESTATES OFFICER      | Responsible for control of stocks of fuel oil and coal.   |
| 24.2.2        | COMMERCIAL DIRECTOR             | Security arrangements and custody of keys   |
| 24.2.3        | DIRECTOR OF FINANCE             | Set out procedures and systems to regulate the stores.  |
| 24.2.4        | DIRECTOR OF FINANCE             | Agree stocktaking arrangements.   |
| 24.2.4        | DIRECTOR OF FINANCE             | Approve alternative arrangements where a complete system of stores control is not justified.  |
| 24.2.6        | DIRECTOR OF FINANCE             | Approve system for review of slow moving and obsolete items and for condemnation, disposal and replacement of all unserviceable items.  |
| 24.3.1        | CHIEF EXECUTIVE                 | Identify persons authorised to requisition and accept goods from NHS Supplies stores.   |
| 25.1.1        | DIRECTOR OF FINANCE             | Prepare detailed procedures for disposal of assets including condemnations and ensure that these are notified to managers. These procedures must be cross-referenced, where appropriate, to procedures put in place by the Commercial Director on the disposal of medical equipment.                      |
| 25.2.1        | DIRECTOR OF FINANCE             | Prepare procedures for recording and accounting for losses, special payments and informing police in cases of suspected arson or theft.   |
| 25.2.1        | ALL STAFF                       | Discovery or suspicion of loss of any kind must be reported immediately to either head of department or nominated officer. The head of department / nominated officer should then inform the Chief Executive and Director of Finance.   |
| 25.2.1        | DIRECTOR OF FINANCE             | Where a criminal offence is suspected, Director of Finance must inform the police if theft or arson is involved. In cases of fraud, bribery and corruption Director of Finance must inform the relevant LCFS in line with NHS Counter Fraud Authority's Standards for Providers.                          |
| 25.2.1        | DIRECTOR OF FINANCE             | Notify the LCFS, NHS counter Fraud Authority and External Audit of all frauds.  |
| 25.2.1        | DIRECTOR OF FINANCE             | Notify Board and External Auditor of losses caused theft, arson, neglect of duty or gross carelessness (unless trivial).  |
| 25.2.1        | BOARD                           | Approve write off of losses (within limits delegated by Department of Health).  |
| 25.2.1.7      | DIRECTOR OF FINANCE             | Consider whether any insurance claim can be made.   |
| 25.2.1        | DIRECTOR OF FINANCE             | Maintain losses and special payments register.  |
| 26.1.1        | DIRECTOR OF FINANCE             | Responsible for accuracy and security of computerised financial data.   |
| 26.1.2        | DIRECTOR OF FINANCE             | Satisfy him/herself that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation assurance of adequacy must be obtained from them prior to implementation. |
| 1.2.3         | SENIOR INFORMATION RISK OFFICER | Shall publish and maintain a Freedom of Information Scheme.   |
| 26.3          | RELEVANT OFFICERS               | Send proposals for general computer systems to Director of Finance  |
| 26.3          | DIRECTOR OF FINANCE             | Ensure that contracts with other bodies for the provision of computer services for financial applications clearly define  |

| SO or SFI REF | DELEGATED TO          | AUTHORITIES/DUTIES DELEGATED  |
|---------------|-----------------------|---|
|               |                       | responsibility of all parties for security, privacy, accuracy, completeness and timeliness of data during processing, transmission and storage, and allow for audit review.<br><br>Seek periodic assurances from the provider that adequate controls are in operation.  |
| 26.2          | DIRECTOR OF FINANCE   | Ensure that risks to the Trust from use of IT are identified and considered and that disaster recovery plans are in place.  |
| 26.3          | DIRECTOR OF FINANCE   | Where computer systems have an impact on corporate financial systems satisfy himself that: <ul style="list-style-type: none"> <li>• systems acquisition, development and maintenance are in line with corporate policies;</li> <li>• data assembled for processing by financial systems is adequate, accurate, complete and timely, and that a management trail exists;</li> <li>• Director of Finance and staff have access to such data;</li> <li>• Such computer audit reviews are being carried out as are considered necessary.</li> </ul>   |
| 27.1.2        | CHIEF EXECUTIVE       | Responsible for ensuring patients and guardians are informed about patients' money and property procedures on admission.  |
| 27.1.3        | DIRECTOR OF FINANCE   | Provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of.  |
| 27.1.6        | DEPARTMENTAL MANAGERS | Inform staff of their responsibilities and duties for the administration of the property of patients.   |
| 28.1.4        | DIRECTOR OF FINANCE   | Shall ensure that each trust fund which the Trust is responsible for managing is managed appropriately.   |
| 29.1.1        | DIRECTOR OF FINANCE   | Ensure all staff are made aware of the Trust policy on the acceptance of gifts and other benefits in kind   |
| 30            | CHIEF EXECUTIVE       | Retention of document procedures in accordance with HSC 1999/053.   |
| 31.1          | CHIEF EXECUTIVE       | Risk management programme.  |
| 31.1          | BOARD                 | Approve and monitor risk management programme.  |
| 31.2.1        | BOARD                 | Decide whether the Trust will use the risk pooling schemes administered by NHS Resolution or self-insure for some or all of the risks (where discretion is allowed). Decisions to self-insure should be reviewed annually.  |
| 31.4          | DIRECTOR OF FINANCE   | Where the Board decides to use the risk pooling schemes administered by NHS Resolution the Director of Finance shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Director of Finance shall ensure that documented procedures cover these arrangements.<br>Where the Board decides not to use the risk pooling schemes administered by the NHS Litigation Authority for any one or other of the risks covered by the schemes, the Director of Finance shall ensure that the Board is informed of the nature and extent of the risks that are self-insured as a result of this decision. The Director of Finance will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses that will not be reimbursed. |

| SO or SFI REF | DELEGATED TO        | AUTHORITIES/DUTIES DELEGATED   |
|---------------|---------------------|--|
| 31.4.3        | DIRECTOR OF FINANCE | Ensure documented procedures cover management of claims and payments below the deductible. |

## Schedule 1:

### Authority to commit or spend Trust money - delegated limits

#### Responsibilities set out in Standing Financial Instructions

The Trust's Standing Financial Instructions are very clear about staff requiring formal authority to commit or spend Trust money.

Staff who commit or spend Trust money must read the Standing Financial Instructions - specific areas to be aware of (this is not an exhaustive list) are as follows:

- Section 15.5 covers **staff making decisions about healthcare procedures**, and states that staff should not commit resources to do work not covered, or restricted by, Commissioners Contracts.
- Section 16 covers **budget holders** and states that Trust resources should be spent according to what the budget has been allocated for;
- Section 18 covers **pay** expenditure (revenue);
- Section 19 covers **non pay** expenditure (revenue)
- Section 23 covers **capital**.

It is each individual's responsibility to make themselves aware of their responsibilities as stated in the Standing Financial Instructions.

#### Formal authorisation

This schedule provides the limits to be applied. Not every person at each level will have delegated authority - specific authority is provided by an individual signing, and an (authorised) senior signing to confirm, an authorised signatory pro-forma.

If you do not have a signed authorised signatory form saying so you do not have delegated authority to commit or spend Trust money.

#### Automated Trust financial and purchasing processes

The Trust uses NHS an electronic purchasing system (E-Procurement). The system is highly automated. Staff must ensure they are:

- (a) trained to use it,
- (b) use it properly and
- (c) do not let the system emails generated build up, they must be dealt with promptly

Within the system authority levels for posts are set such that:

- Post holders who requisition goods and services are unable to approve those purchases, the requisition moves electronically to the next line manager level for approval.
- If that requisition is above the next levels approval limit it moves electronically to the next level.
- This is repeated until the requisition is approved or it gets to the Chief Executive.
- The purpose of the detailed bandings is to facilitate a smooth progression upwards and avoid significant 'limit' bottlenecks.
- The process operates similarly for approval of non-purchase order expenditure where invoicing is sent electronically through the same approvals hierarchy.

# Delegated limits

## 1. Introduction

1.1 The Code of Accountability requires that Boards draw up a schedule of decisions reserved to the Board and ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives (a scheme of delegation).

### 1.2 Delegation of Powers

The Trust has powers to delegate and make arrangements for delegation. The Standing Orders set out the detail of these arrangements. Under the Standing Order relating to the Arrangements for the Exercise of Functions (SO 5) the Trust is given powers to "make arrangements for the exercise, on behalf of the Trust of any of their functions by a committee, sub-committee or joint committee appointed by virtue of Standing Order 4 or by an officer of the Trust, in each case subject to such restrictions and conditions as the Trust thinks fit or as the Secretary of State may direct". Delegated Powers are covered in Section 2.9 and section D (also known as the Scheme of Delegation) of Standing Orders and Appendix 2 of the Corporate Governance Framework Manual. This document has effect as if incorporated into the Standing Orders and Standing Financial Instructions.

1.3 Approval for Revenue Expenditure and Business Cases assumes that sufficient budget is, or will be made, available. Approval cannot be made where the expenditure or business cases cannot, or will not, be met by budget.

Committees or individuals only have delegated authority for specific items up to the limits delegated to them. Circumvention of these limits by breaking requisitions or clearly linked items into smaller units is specifically banned.

## 2 Limits Conditions of Use

- Limits are always subject to sufficient budget being available unless agreed by the Director of Finance.
- Only a single limit only can be applied to transaction Individuals limits cannot be combined with another individuals limit.
- Limits maybe withdrawal or amendment in-year as part of an Expenditure management plan.
- Individuals limits will be suspended in the case of continued non-compliance to the SO's and SFI's or where non-compliance with SFI's is considered to be material enough to warrant this action.
- Unless otherwise stated individual Limits cannot be combined with another individuals limit, Any exception to this is detailed in the limits schedule in section 3.
- It is a breach of SFI 17.5.3.4 and 17.5.6.1 to segment an order so that the cost taken into account against a signatory limit is lower. Purchase orders must be raised for the entire contract period to the full value or estimated value of the contract, see table below. The value of contracts is calculated as the cost or forecast cost over the duration of the contract eg if a contract value is £100,000 and the duration of the contract is 5 years then the value to be taken into account against a signatory limit is £500,000 (5 x £100,000).
- Where the procurement falls above the Trusts tendering limit (see below) the Head of Procurement/deputy head of procurement may need to provide assurance that the procurement was conducted in-line with SFI's and where necessary Public Contract Regulations. Where this is not possible a breach of SFI's must be reported to the Trusts Audit Committee.
- Where tendering has appropriately and correctly taken place over and above £100,000 the signatory may raise/authorise the purchase order.

### 3 Limits of Authority

#### **3.1(a) Authority to approve Revenue expenditure**

##### **Exceptions to the limits below:**

Authority to approve Payroll Positive Returns, excluding individual's own return, will be indicated on the Authorised Signatory Schedule provided to the Payroll provider.

|  |                  |   |
|--|------------------|---|
| Board Approval   | ≥ £1,000,000     | Items exceeding £1,000,000 must go to the Board for approval, following review by Finance and Business Performance Committee and the Executive Management Committee. In respect of any Leases or contracts, the value should be determined by the whole life value. |
| Chief Executive  | Up to £1,000,000 | Business cases for schemes up to this value and ≥ £100,000 will be approved by the Executive Management Committee.  |
| Director of Finance  | Up to £750,000   | As above re business case approval.   |
| Deputy Director of Finance   | Up to £500,000   | As above re business case approval.   |
| Executive Director   | Up to £250,000   | As above re business case approval. All other voting and non-voting   |
| Divisional Directors and Divisional Chairs<br>Head of Midwifery<br>Corporate Deputy Directors<br>Corporate Assistant Directors | Up to £100,000   | As above re business case approval.   |
| General Managers, Heads of Nursing or equivalent   | Up to £10,000    |   |
| Service Managers, Matrons or equivalent  | Up to £5,000     | .   |
| Ward sisters or equivalent   | Up to £500       |   |

In some circumstances the Executive Director responsible may seek authorisation from the Director of Finance to raise delegated limits of certain named managers, not to a level greater than the Director of Finance.

#### **3.1(b) Authority for Pharmacy to approve expenditure on Drugs**

These limits apply only to Drugs expenditure while the Trust is a participant in the Commercial Medicines Unit (CMU)

|  |                               |   |
|--|-------------------------------|---|
| Chief Pharmacist<br>Associate Director | Non-binding credit agreements | CMU negotiated contracts non-binding credit agreements only |
| Chief Pharmacist                       | ≥ £250,000                    |   |
| Associate Director                     | Up to £250,000                | Homecare only   |
|  | Up to £150,000                | Other drugs   |
| Senior Pharmacy Staff (8a)             | £70,000                       | Two signatures  |
| Senior Pharmacy Staff (8a)             | £10,000                       | Single signature  |

In Exceptional Circumstances where it is felt that patient safety may be compromised the above limits may be delegated as necessary by the Chief Pharmacist, Chief Executive, Chief Operating Officer, Medical and Nursing Directors

#### **3.2 List of approved exceptions from the delegated limits shown above: Invoices for Supplies and Services**

| <b>Description of Expenditure</b>                | <b>Revised Limit</b> | <b>Signatory</b>  |
|--|----------------------|---|
| Statutory Payments of Tax and National Insurance | Up to £7,500,000     | Any two from the following list:<br>Director of Finance<br>Deputy Director of Finance |

| <b>3.2 List of approved exceptions from the delegated limits shown above:<br/>Invoices for Supplies and Services</b>  |                   |   |
|---|-------------------|---|
|   |                   | Head of Finance Department  |
| Payments of contributions to the Pensions Agency  | Up to £5,000,000  | Any two from the list above   |
| Authorisation to process the Payroll BACS file  | Up to £12,000,000 | Any one of the following list:<br>Director of Finance,<br>Deputy Director of Finance<br>Heads of Finance Department,<br>Deputy Financial Controller<br>Payroll Manager,<br>Treasury Manager |
| In a single month where pay arrears are included the limit is temporarily increased by:                               | Up to £1,000,000. |   |
| Authorisation to Process Creditors BACS Payment File  | Up to £3,000,000  | Any One of the following list:<br>Director of Finance,<br>Deputy Director of Finance<br>Heads of Finance Department,<br>Deputy Financial Controller<br>Payroll Manager,<br>Treasury Manager |
| General Practice Vocational Training Scheme (GPVTS) salary payments   | Up to £3,000,000  | Chief People Officer and Director of Finance  |
| Monthly service charge invoices from United Healthcare South Bucks or Enterprise Healthcare                           | Up to £3,000,000  | Any two from the following list:<br>Chief Executive<br>Chief Operating Officer<br>Director of Finance<br>Commercial Director  |
| Weekly invoices payments to NHS Professionals re Agency & Bank Staff  | Up to £2,000,000  | Any two from the following list:<br>Director of Finance<br>Deputy Director of Finance<br>Head of Finance Department   |
| Monthly materials management invoices payments to NHS Supply Chain  | Up to £1,000,000  | Any two from the following list:<br>Director of Finance<br>Deputy Director of Finance<br>Head of Finance Department   |
| Monthly invoices for Clinical Negligence Scheme for Trusts premiums   | Up to £1,250,000  | Deputy Director of Finance, or two Heads of Finance Department  |
| Monthly invoice payments to FedBukcs  | Up to £600,000    | Deputy Director of Finance, or two Heads of Finance Department  |
| Monthly invoice payment to Practice Plus (Formerly Care UK)   | Up to £500,000    | Deputy Director of Finance, or two Heads of Finance Department  |
| Monthly invoices to NHS Blood and Transplant (subject to Board approval of contract) and Abbott Laboratories contract | Up to £150,000    | Laboratory Services Manager   |
| Utility invoices  | Up to £100,000    | Associate Director Property Services  |
| Rates invoices  | Up to £250,000    | Associate Director Property Services  |
| Monthly ambulance service / patient transport service invoices (subject to Board approval of the contract)            | Up to £200,000    | Director of Property Services   |
| Monthly invoices to Oxford University Hospital re Pathology Testing Services  | Up to £150,000    | Head of Pathology   |

Heads of Finance Departments are:  
Head of Financial Control  
Head of Costing  
Head of Management Accounts  
Head of Contracts  
Head of Financial Planning

The Head of Procurement is not included above due to the requirement for the segregation of duties.

| <b>3.3 List of approved exceptions from the delegated limits shown above:<br/>Mandated Supplies</b> |                      |   |
|---|----------------------|---|
| <b>Description of Expenditure</b>   | <b>Revised Limit</b> | <b>Signatory</b>  |
| Blood Products  | Up to £5,000,000     | Any two from the following list:<br>Director of Finance<br>Deputy Director of Finance<br>Head of Finance Department |
| CNST  | Up to £3,000,000     | Any two from the list above   |

Heads of Finance Departments are:

- Head of Financial Control
- Head of Costing
- Head of Management Accounts
- Head of Contracts
- Head of Financial Planning
- Head of Financial Systems

| <b>3.4 Authority to approve Waiver of Competitive Tender/Quotation<br/>(subject to compliance with Procurement legislation)<br/>(request for approval form can be found in Annex 3)</b> |                  |  |
|---|------------------|--|
| Board Approval  | ≥ £1,000,000     | Items exceeding £1,000,000 must go to the Board for approval. In respect of any Leases or contracts, the value should be determined by the whole life value. Request form at annex 3. In each case a supporting paper setting out the reasons for the request should be produced and all requests should initially be sent to the Assistant Director of Finance (Financial Control). |
| Chief Executive   | Up to £1,000,000 | Items exceeding £1,000,000 must go to the Board for approval.  |
| Director of Finance   | Up to £100,000   |  |

| <b>3.5 Tender Limits</b>   |                |  |
|--|----------------|--|
| (see section 17 of Standing Financial Instructions)  |                |  |
| Competitive Quotations are required for all expenditure in excess of:  | ≥ £20,000      | Normally at least 3 quotations should be sought. |
| Competitive Tenders are required for all expenditure in excess of:   | Up to £50,000  | Normally at least 3 tenders should be sought.    |
| A Member of the Trust Board will be required to be one of the two approved persons present for the opening of tenders estimated above: | Up to £750,000 |  |

| <b>3.7 Authority to approve Capital expenditure (inc VAT)</b> |              |  |
|---|--------------|--|
| Board Approval  | ≥ £1,000,000 | The Board will approve the headline Capital Programme and total budget for |

| <b>3.7 Authority to approve Capital expenditure (inc VAT)</b> |                  |   |
|---|------------------|---|
|   |                  | the year. Amendments to the Programme require Board approval, even if the total budget remains unchanged. Business Cases and contracts for individual schemes within this budget that exceed this limit must go to the Board for approval. In respect of any Leases or contracts, the value should be determined by the whole life value. |
| Director of Finance   | Up to £1,000,000 | Business cases for schemes up to this value will be approved by CMG.  |

| <b>3.8 Authority to approve losses for write-off</b>  |                  |   |
|---|------------------|---|
| All losses and special payments must go to the Audit Committee meetings for review. Annually a schedule of to the Board as part of the annual accounts process. |                  |   |
| <b>(a) Losses due to theft, fraud or arson</b>  |                  |   |
| Trust Board   | No Delegation    | All losses and special payments involving theft, fraud or arson must go to the Board for approval.  |
| <b>(b) Bad Debts and Claims Abandoned Only</b>  |                  |   |
| Board Approval  | ≥ £100,000       |   |
| Chief Executive and Director of Finance   | Up to £100,000   |   |
| Deputy Director of Finance  | Up to £50,000    |   |
| Head of Financial Control   | Up to £10,000    |   |
| <b>(c) Pay and Remuneration Special Payments</b>  |                  |   |
| Remuneration Committee  | Unlimited        | Only the Remuneration Committee can approve pay and remuneration special payments outside of the employee's terms and conditions or statutory payments. |
| <b>(d) Approval of settlement of a claim through NHS Resolution</b>   |                  |   |
| Board   | ≥ £5,000,000     | Based on the advice of NHS Resolution and experts involved on the likelihood of the claim being successful.   |
| Chief Executive   | Up to £5,000,000 |   |
| Medical Director  | Up to £1,000,000 | For clinical negligence cases   |
| Commercial Director   | Up to £1,000,000 | For estates related claims  |
| Director of Finance   | Up to £1,000,000 | For any other claims  |
| Any other Executive Director  | Up to £1,000,000 | In the absence of the above where there is a time limit imposed on acceptance of the settlement.  |
| <b>(e) All other Losses – Non NHS</b>   |                  |   |
| Board Approval  | ≥ £75,000        |   |
| Director of Finance   | Up to £25,000    |   |
| <b>(f) All other Losses – NHS</b>   |                  |   |
| Board   | ≥ £1,000,000     |   |
| Chief Executive   | Up to £1,000,000 |   |
| Director of Finance   | Up to £750,000   |   |
| Head of Contracts and Income  | Up to £100,000   |   |

| <b>3.9 Authority to dispose of surplus assets</b><br>(limits based on anticipated sale proceeds, request form can be found in Annex 1). |  |  |
|---|--|--|
|---|--|--|

|  |                |  |
|--|----------------|--|
| The process surrounding the actual disposal will be specific to the type of asset e.g. medical equipment and this is separately available. |                |  |
| Board Approval   | ≥ £200,000     |  |
| Chief Executive  | Up to £200,000 |  |
| Director of Finance  | Up to £100,000 |  |
| Deputy Director of Finance   | Up to £40,000  |  |

|   |                |   |
|---|----------------|---|
| <b>3.10 Authority to accept or expend Charitable Funds</b><br>(subject to funds being available and compliance with Trust deed) |                |   |
| Board of Trustees (Trust Board)   | ≥ £100,000     | Items exceeding £100,000 must go to the Trustee (Board) for approval.   |
| Charitable Funds Committee  | Up to £100,000 |   |
| Chief Executive   | Up to £50,000  | Summary of items approved to be reported to Charitable Funds Committee. |
| Director of Finance   | Up to £50,000  | Summary of items approved to be reported to Charitable Funds Committee. |
| Fund Manager  | Up to £5,000   | Summary of items approved to be reported to Charitable Funds Committee. |

|   |                |   |
|---|----------------|---|
| <b>3.11 In-House Bids in respect of Competitive Tendering</b>   |                |   |
| (see section 17.15 of Standing Financial Instructions)          |                |   |
| Board   | ≥ £100,000     |   |
| For services having a likely annual expenditure exceeding: - £0 | Up To £100,000 | A non - executive member should be a member of the evaluation team. |

|   |     |  |
|---|-----|--|
| <b>3.12 Changing Banking Arrangements</b><br>(including setting up and closing Bank Accounts) |     |  |
| The Board   | All | All proposed change of Banking Arrangements must be authorised by the Trusts Board |

|   |           |  |
|---|-----------|--|
| <b>3.13 Setting Up Commercial ventures</b><br>(including Joint Ventures and Subsidiary Companies, Private Patients) |           |  |
| All Business case   | Any Value | A non-executive member should be a member of the evaluation team.  |
| Board   | Unlimited | Only the Board can establish a joint venture or commercial company |

|  |                    |   |
|--|--------------------|---|
| <b>3.14 Authority to approve Income Contracts for Patient Related Activity</b> |                    |   |
| Board  | ≥ £300,000,000     |   |
| Chief Executive  | Up to £300,000,000 | Annual Patient SLA Income Contract and invoices including In-Year variations. |

#### 4. Monitoring Arrangements

The entering into contracts or incurring expenditure by Trust staff and managers that does not follow this Policy will be treated as a disciplinary matter. For this reason, it is the responsibility of Trust managers to ensure that full records showing compliance with Standing Financial Instructions are retained. It is particularly important that the Trust's procurement activities are open and transparent. Full records should

be kept on competitive quotations or tenders, reasons that contracts were awarded and/or any waiver of Standing Financial Instructions. Before orders are approved copies of Waivers must be provided to the Procurement Department. If such records cannot be produced for senior management or audit it will be deemed that the correct procedures have not been followed.

E-procurement will be used to assign authorisation limits for orders. On set-up requests for limits other than those listed will be refused except where a specific exemption is listed in annex 4. Attempts to circumvent these limits by ordering outside the e-procurement process or by splitting orders into smaller parts will be taken extremely seriously and are likely to result in disciplinary action. Please note that limits are only applicable to approval of the orders. As the raising of a requisition does not commit the Trust to expenditure until that requisition is approved and converted to an official order, different limits will be set for requisitioners. The requisitions will be forwarded to others who have the appropriate approval levels for approval.

Any repeated instances of noncompliance from the same source will be initially referred to the originator's manager. This may lead to repeated non-compliance being treated as a disciplinary issue and followed up accordingly. In respect of those transactions covered by **annex 1**, they will be reported to the Trust Board as they arise. In respect of transactions covered by **annex 2**, they will be reported to the Trust Procurement Group on a quarterly basis and in respect of those transactions covered by **annex 3**, they will be reported to the next scheduled Audit Committee.



## Annex 2 – Asset Register: notification of change



### ASSET REGISTER – NOTIFICATION OF CHANGE

You are required to use this form and notify change when:

1. You receive goods into your Department that have been purchased, donated or transferred with a value of £5000 or more (including VAT).
2. When you dispose of goods by any means.

Should you require further information please contact: Capital Accountant, Amersham - Ext 4773.

|  |                                  |
|--|----------------------------------|
| <b>From:</b>   |                                  |
| <b>Department:</b>   |                                  |
| <b>Location (Floor, Room and Hospital):</b>                                |                                  |
| <b>The following goods have been PURCHASED / DONATED / TRANSFERRED in:</b> |                                  |
| Item:  |                                  |
| Make and Model:  |                                  |
| Serial No:   | Finance Code:    - - - - - - - - |
| Date of Purchase:  | Purchase Order No:               |
| Supplier:  | Invoice No:                      |
| Cost £ (inclusive of VAT)<br>(This must be the exact invoiced value)       | Maintenance contract arranged?   |
| <b>GOODS REPLACED / TRANSFERRED OUT / DISPOSED:</b>                        |                                  |
| Asset No:  | If transferred, new location:    |
| Description:   |                                  |
| Date:  |                                  |
| Proceeds: £  | Finance Code:    - - - - - - - - |

**Manager's Signature .....** **Date.....**

FILE ONE COPY & FORWARD ONE COPY TO:  
Capital Accountant, Finance Department, Trust HQ  
Amersham Hospital  
Whielden Street  
Amersham  
HP7 0JD

For Finance Use Only

|          |                     |      |
|----------|---------------------|------|
| Initials | Entered on Register | Date |
|----------|---------------------|------|

## Annex 3 – Request for Waiver of Trust’s Standing Orders / Standing Financial Instructions requiring Competitive Tenders or Quotations



20200210 Waiver of  
standing financial insti

## **SECTION E – CODES OF ACCOUNTABILITY AND CONDUCT FOR NHS BOARDS**

As published by the Department of Health and the Appointments Commission

### **CODE OF CONDUCT**

Public Service Values General Principles

Openness and Public Responsibilities

Public Service Values in Management

Public Business and Private Gain

Hospitality and Other Expenditure

Relations with Suppliers

Staff Compliance

Appendix 1 – The Nolan Principles

### **CODE OF ACCOUNTABILITY**

Status

Code of Conduct

Statutory Accountability

The Board of Directors

The Role of the Chair

Non-Executive Directors

Reporting and Controls

Declaration of Interests

Employee Relations

## 38. CODE OF CONDUCT FOR NHS BOARDS

Public service values must be at the heart of the National Health Service. High standards of corporate and personal conduct based on a recognition that patients come first, have been a requirement throughout the NHS since its inception. Moreover, since the NHS is publicly funded, it must be accountable to Parliament for the services it provides and for the effective and economical use of taxpayers' money.

There are three crucial public service values which must underpin the work of the health service.

- **Accountability** – everything done by those who work in the NHS must be able to stand the test of parliamentary scrutiny, public judgements on propriety and professional codes of conduct.
- **Probity** – there should be an absolute standard of honesty in dealing with the assets of the NHS: integrity should be the hallmark of all personal conduct in decisions affecting patients, staff and suppliers, and in the use of information acquired in the course of NHS duties.
- **Openness** – there should be sufficient transparency about NHS activities to promote confidence between the NHS organisation and its staff, patients and the public.

### General Principles

Public service values matter in the NHS and those who work in it have a duty to conduct NHS business with probity. They have a responsibility to respond to staff, patients and suppliers impartially, to achieve value for money from the public funds with which they are entrusted and to demonstrate high ethical standards of personal conduct.

The success of this Code depends on a vigorous and visible example from boards and the consequential influence on the behaviour of all those who work within the organisation. Boards have a clear responsibility for corporate standards of conduct and acceptance of the Code should inform and govern the decisions and conduct of all board directors.

### Openness and Public Responsibilities

Health needs and patterns of provision of health care do not stand still. There should be a willingness to be open with the public, patients and with staff as the need for change emerges. It is a requirement that major changes are consulted upon before decisions are reached. Information supporting those decisions should be made available, in a way that is understandable, and positive responses should be given to reasonable requests for information and in accordance with the Freedom of Information Act 2000.

NHS business should be conducted in a way that is socially responsible. As a large employer in the local community, NHS organisations should forge an open and positive relationship with the local community and should work with staff and partners to set out a vision for the organisation in line with the expectations of patients and the public. NHS organisations should demonstrate to the public that they are concerned with the wider health of the population including the impact of the organisation's activities on the environment.

The confidentiality of personal and individual patient information must, of course, be respected at all times.

### Public Service Values in Management

It is unacceptable for the board of any NHS organisation, or any individual within the organisation for which the board is responsible, to ignore public service values in achieving results. Chairs and board directors have a duty to ensure that public funds are properly safeguarded and that at all times the board conducts its business as efficiently and effectively as possible. Proper stewardship of public monies requires value for money to be high on the agenda of all NHS boards.

Accounting, tendering and employment practices within the NHS must reflect the highest professional standards. Public statements and reports issued by the board should be clear, comprehensive and balanced, and should fully represent the facts. Annual and other key reports should be issued in good time to all individuals and groups in the community who have a legitimate interest in health issues to allow full consideration by those wishing to attend public meetings on local health issues.

### Public Business and Private Gain

Chairs and board directors should act impartially and should not be influenced by social or business relationships. No one should use their public position to further their private interests. Where there is a potential for private interests to be material and relevant to NHS business, the relevant interests should be declared and recorded in the board minutes and entered into a register which is available to the public. When a conflict of interest is established, the board director should withdraw and play no part in the relevant discussion or decision.

### Hospitality and Other Expenditure

Board directors should set an example to their organisation in the use of public funds and the need for good value in incurring public expenditure. **The use of NHS monies for hospitality and entertainment, including hospitality at conferences or seminars, should be carefully considered.** All expenditure on these items should be capable of justification as reasonable in the light of the general practice in the public sector. NHS boards should be aware that expenditure on hospitality or entertainment is the responsibility of management and is open to be challenged by the internal and external auditors and that ill-considered action can damage respect for the NHS in the eyes of the community.

### Relations with Suppliers

NHS boards should have an explicit procedure for the declaration of hospitality and sponsorship offered by, for example, suppliers. Their authorisation should be carefully considered and the decision should be recorded. NHS boards should be aware of the risks in incurring obligations to suppliers at any stage of a contracting relationship. Suppliers should be selected on the basis of quality, suitability, reliability and value for money. The Department of Health has issued guidance to NHS organisations about standards of business conduct (ref: HSG(93)5).

### Staff

NHS boards should ensure that staff have a proper and widely publicised procedure for voicing complaints or concerns about maladministration, malpractice, breaches of this code and other concerns of an ethical nature. The board must establish a climate:

- that enables staff who have concerns to raise these reasonably and responsibly with the right parties;
- that gives a clear commitment that staff concerns will be taken seriously and investigated; and
- where there is an unequivocal guarantee that staff who raise concerns responsibly and reasonably will be protected against victimisation.

(Ref: Whistleblowing in the NHS, letter dated 25 July 2003 from the Director of Organisational Development and People in the NHS)

### Compliance

Board directors should satisfy themselves that the actions of the board and its directors in conducting board business fully reflect the values in this Code and, as far as is reasonably practicable, that concerns expressed by staff or others are fully investigated and acted upon. All board directors of NHS organisations are required, on appointment, to subscribe to the Code of Conduct.

### 39. CODE OF ACCOUNTABILITY FOR NHS BOARDS

This Code of Practice is the basis on which NHS organisations should seek to fulfil the duties and responsibilities conferred upon them by the Secretary of State for Health.

#### Status

NHS organisations, such as NHS Trusts, Clinical Commissioning Groups, National Commissioning Board, NHSI and special health authorities, are established under statute as corporate bodies so ensuring that they have separate legal personality. Statutes and regulations prescribe the structure, functions and responsibilities of the boards of these bodies and prescribe the way chairs and directors of boards are to be appointed.

#### Code of Conduct

All board directors of NHS organisations are required, on appointment, to subscribe to the Code of Conduct. Breaches of this Code of Conduct by the chair or a non-executive director of the board should be drawn to the attention of the appropriate Regional Commissioner of the NHS Appointments Commission.

NHS managers are required to take all reasonable steps to comply with the requirements set out in the Code of Conduct for NHS Managers. Chairs and non-executive directors of NHS boards are responsible for taking firm, prompt and fair disciplinary action against any executive director in breach of the Code of Conduct for NHS Managers.

#### Statutory Accountability

The Secretary of State for Health has statutory responsibility for the health of the population of England and uses statutory powers to delegate functions to NHS organisations who are thus accountable to the Secretary of State and to Parliament. The Department of Health is responsible for directing the NHS, ensuring national policies are implemented and for the effective stewardship of NHS resources.

NHS trusts provide services to patients (these may be acute services, ambulance services, mental health or other special services, e.g. for children). Other main functions are to:

- ensure services are of high quality and accessible;
- lead the development of new ways of working to fully engage patients and ensure a patient-centred service;

Clinical Commissioning Groups are expected to identify the health needs of the population, to work to improve the health of the community and to secure the provision of a full range of services. Other main functions are to:

- maintain an effective public health function;
- lead local planning;
- manage and develop primary healthcare services;
- develop and improve local services;
- lead the integration of health and social care; and
- Deliver services within their remit.

NHSI provide strategic leadership to ensure the maintenance of provision and the delivery of improvements in local health and health services by primary care trusts and NHS Trusts and FTs, within the national framework of developing a patient-centred NHS and supported by effective controls and clinical governance systems. Other main functions for which NHSI is responsible are to:

- lead the development and empowerment of uniformly excellent frontline NHS organisations committed to innovation and improvement;
- consider the overall needs of the health economy across primary, community, secondary and tertiary care, and working with primary care trusts and NHS trusts to deliver a programme to meet these needs;
- performance manage and ensure accountability of local primary care trusts and NHS trusts;

- lead on the creation and development of clinical and public health networks;
- create capacity through the preparation and delivery of strategies for capital investment, information management and workforce development;
- ensure effective networks and joint working exists between NHS organisations for the provision of health and social care; and
- ensure the development and training of an adequate workforce of competent clinical personnel.

NHS Trust, Commissioners and NHSI finances are subject to external audit and, for the value for money element, by the Care Quality Commission.

NHS boards must co-operate fully with the Department of Health, External Audit and the Care Quality Commission when required to account for the use they have made of public funds, the delivery of patient care and other services, and compliance with statutes, directions, guidance and policies of the Secretary of State. The Chief Executive/ Permanent Secretary of the Department of Health, as Accounting Officer for the NHS, is accountable to Parliament. The work of the Department of Health and its associated bodies is examined by the House of Commons Health Committee. Its remit is to examine the expenditure, administration and policy of the Department of Health. Two other Parliamentary Committees, the Public Accounts Committee and the Public Administration Select Committee, scrutinise the work of the Department of Health and the health service.

### The Board of Directors

NHS boards comprise executive directors together with non-executive directors and a chair who are appointed by the NHSI on behalf of the Secretary of State. Together they share corporate responsibility for all decisions of the board. There is a clear division of responsibility between the chair and the chief executive; the chair's role and board functions are set out below; the chief executive is directly accountable to the board for meeting their objectives, and as Accountable Officer, to the Chief Executive of the NHS for the performance of the organisation. Boards are required to meet regularly and to retain full and effective control over the organisation; the chair and non-executive directors are responsible for monitoring the executive management of the organisation and are responsible to the Secretary of State for the discharge of these responsibilities. NHSI generally provide the line of accountability from local NHS organisations to the Secretary of State for the performance of the organisation the NHSI will always be available to chairs and non-executive directors on matters of concern to them relating to the personal effectiveness of individual chairs and non-executives.

The duty of an NHS board is to add value to the organisation, enabling it to deliver healthcare and health improvement within the law and without causing harm. It does this by providing a framework of good governance within which the organisation can thrive and grow. Good governance is not restrictive but an enabling ingredient to underpin change and modernisation.

The role of an NHS board is to:

- be collectively responsible for adding value to the organisation, for promoting the success of the organisation by directing and supervising the organisation's affairs
- provide active leadership of the organisation within a framework of prudent and effective controls which enable risk to be assessed and managed
- set the organisation's strategic aims, ensure that the necessary financial and human resources are in place for the organisation to meet its objectives, and review management performance
- set the organisation's values and standards and ensure that its obligations to patients, the local community and the Secretary of State are understood and met.

Further details may be obtained from *Governing the NHS: A Guide for NHS Boards* at [www.dh.gov.uk](http://www.dh.gov.uk)

### The Role of the Chair

The overall role of the chair is one of enabling and leading so that the attributes and specific roles of the executive team and the non-executives are brought together in a constructive partnership to take forward the business of the organisation.

The key responsibilities of the chair are:

- leadership of the board, ensuring its effectiveness on all aspects of its role and setting its agenda;

- ensuring the provision of accurate, timely and clear information to directors;
- ensuring effective communication with staff, patients and the public;
- arranging the regular evaluation of the performance of the board, its committees and individual directors; and
- facilitating the effective contribution of non-executive directors and ensuring constructive relations between executive and non-executive directors.

A complementary relationship between the chair and chief executive is important. The chief executive is accountable to the chair and non-executive directors of the board for ensuring that the board is empowered to govern the organisation and that the objectives it sets are accomplished through effective and properly controlled executive action. The chief executive should be allowed full scope, within clearly defined delegated powers, for action in fulfilling the decisions of the board.

Further details may be obtained from *Governing the NHS: A Guide for NHS Boards* at [www.dh.gov.uk](http://www.dh.gov.uk).

### Non-Executive Directors

Non-executive directors are appointed by the NHS NHI on behalf of the Secretary of State to bring an independent judgement to bear on issues of strategy, performance, key appointments and accountability through the Department of Health to Ministers and to the local community.

The duties of non-executive directors are to:

- constructively challenge and contribute to the development of strategy;
- scrutinise the performance of management in meeting agreed goals and objectives and monitor the reporting of performance;
- satisfy themselves that financial information is accurate and that financial controls and systems of risk management are robust and defensible;
- determine appropriate levels of remuneration of executive directors and have a prime role in appointing, and where necessary, removing senior management and in succession planning; and
- ensure the board acts in the best interests of the public and is fully accountable to the public for the services provided by the organisation and the public funds it uses.

Non-executive directors also have a key role in a small number of permanent board committees such as the Audit Committee, Remuneration Committee, Quality and Clinical Governance Committee and Finance and Business Performance Committee.

Further details may be obtained from *Governing the NHS: A Guide for NHS Boards* at [www.dh.gov.uk](http://www.dh.gov.uk).

### Reporting and Controls

It is the board's duty to present through the timely publication of an annual report, annual accounts and other means, a balanced and readily understood assessment of the organisation's performance to:

- the Department of Health, on behalf of the Secretary of State
- the Audit Commission and its appointed auditors, and
- the local community.

Detailed financial guidance, including the role of internal and external auditors, issued by the Department of Health must be observed. (Ref: the *NHS Finance Manual* at [www.info.doh.gov.uk/doh/finman](http://www.info.doh.gov.uk/doh/finman)). The Standing Orders of boards should prescribe the terms on which committees and sub-committees of the board may be delegated functions, and should include the schedule of decisions reserved for the board.

### Declaration of Interests

It is a requirement that chairs, and all board directors should declare any conflict of interest that arises in the course of conducting NHS business. All NHS organisations maintain a register of member's interests to avoid any danger of board directors being influenced, or appearing to be influenced, by their private interests in the exercise of their public duties. All board members are therefore expected to declare any personal or business interest which may influence, or may be *perceived* to influence, their judgement. This should include, as a minimum, personal direct and indirect financial interests, and should normally

also include such interests of close family members. Indirect financial interests arise from connections with bodies which have a direct financial interest, or from being a business partner of, or being employed by, a person with such an interest.

#### Employee Relations

NHS boards must comply with legislation and guidance from the Department of Health on behalf of the Secretary of State, respect agreements entered into by themselves or on their behalf and establish terms and conditions of service that are fair to the staff and represent good value for taxpayers' money. Fair and open competition should be the basis for appointment to posts in the NHS.

The terms and conditions agreed by the board for senior staff should take full account of the need to obtain maximum value for money for the funds available for patient care. The board should ensure through the appointment of a remuneration and terms of service committee that executive board directors' remuneration can be justified as reasonable. Board directors' remuneration for the NHS organisation should be published in its annual report.

## SECTION E APPENDIX 1

The Trust places high importance on appropriate accountability and openness in its working practices and endorses the recommended seven principles of conduct that underpin the work of public authorities

### NOLAN PRINCIPLES – SEVEN PRINCIPLES OF PUBLIC LIFE

**‘Seven Principles of Public Life’** which should apply to all in the public service are:

#### **Selflessness**

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

#### **Integrity**

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

#### **Objectivity**

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

#### **Accountability**

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

#### **Openness**

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

#### **Honesty**

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

#### **Leadership**

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

In addition to this, members of NHS boards and governing bodies in England are expected to adhere to the New standards for NHS leaders. They put respect, compassion and care for patients at the centre of leadership and good governance. These standards are published by the Professional Authority for Health and Social Care. Copies of the standards are available at <http://www.chre.org.uk/media/18/502/>

## Annex 4 Equality Impact Assessment

| Questions   | Answers   |
|---|---|
| 1. Brief summary of the project/ policy including the main aims and proposed outcomes.  | Trust Governance Manual policy containing the Standing Orders, Standing Financial Instructions and Scheme and Limits of Delegation.   |
| 2. Could the proposed strategy, policy, service change, or function have a direct or indirect affect on patients, service users, staff or local community?<br><br>Please explain your answer  | The policy sets out the responsibilities of the Board and all members of staff regarding sound corporate and financial governance, therefore directly affecting staff and indirectly patients, service users and the local community.   |
| 3. Could the proposal have a positive or negative effect on patients, service users, staff or local community by the protected characteristics (age, disability, gender, gender re-assignment, marriage & civil partnership, pregnancy & maternity, race religion or belief, sexual orientation?<br><br>Briefly explain your answer by consider each characteristic and state what is the impact on each group. | The policy applies to all members of staff and should not have any negative effect on anyone with protected characteristics. The policy sets out the responsibilities of the Director of Finance for ensuring training and support is available where required for understanding and interpreting the information.<br><br>The proper implementation of the requirements set out in the policy should have a positive impact on staff and patients through best practice corporate and financial governance. |
| 4. Is there any indication or evidence (including from engagement/consultation with relevant groups) that different groups have or will have different needs, experiences, issues, and priorities in relation to the proposals? Or do you need more information?  | No indication or evidence that different groups will have different needs, although the training and support made available by the Director of Finance to ensure sound interpretation of the enclosed information should be designed to allow for this.   |
| 5. What measures are you proposing to take to mitigate/reduce the impact of your proposal for any of the protected characteristics, within patients, service users or staff?  | Our policies for Equality Diversity and Inclusion ensure that the protected characteristics for patients service users and staff are taken into consideration and there is a requirement for all Trust policies to consider any impact on Equality, Diversity and Inclusion.  |
| 6. Are there any measures that you can take to produce a positive impact for any of the protected characteristics, within patients, service users or staff?   | The training and support offer made available by the Director of Finance should be designed to be inclusive for all so that all colleagues can be confident in their responsibilities with regard to the Trust's Standing Orders, Standing Financial Instructions, and Scheme and Limits of Delegation  |
| 7. As a result of the screening is a full EQIA necessary?   | A full EQIA is not considered necessary as the screening has not identified any potential significant impacts on individuals with protected characteristics.  |
| <b>Signed off by</b>  |   |
| <b>Project Lead (name)</b>  | Chloe Powell, CEO Business Manager  |
| <b>Signature &amp; date:</b>  | CPowell, 22 April 2021  |
| <b>EQIA Lead (name)</b>   | Neil Macdonald, CEO   |
| <b>Signature &amp; date:</b>  | NMacdonald, 23 April 2021   |

**Meeting:** Trust Board Meeting in Public

**26 May 2021**

|                              |  |
|------------------------------|--|
| <b>Agenda item</b>           | Corporate Risk Register (CRR)                                    |
| <b>Board Lead</b>            | Karen Bonner Chief Nurse   |
| <b>Name of author</b>        | Karen Bonner Chief Nurse   |
| <b>Attachments</b>           | Corporate Risk Register  |
| <b>Purpose</b>               | Assurance  |
| <b>Previously considered</b> | EMC 21 <sup>st</sup> April 2021<br>Quality Committee 11 May 2021 |

**Executive Summary**

This report provides outlines the top 3 risks for the Trust which with a risk score of 20.

- 1) CRR10 – Shortage of qualified nursing staff (added 11/2014- post mitigation score 15)
- 2) CRR126 – impact on staff physical and psychological health and well-being during covid-19 (added 04/2020- post mitigation score 15)
- 3) CRR139 There is a risk to the delivery and sustainability of the national standard for Referral to Treatment Time (RTT) as per the 20/21 NHS Guidance (added 18/02/21- post mitigation score 12)

The Committee is requested to note the report and more work is required to provides assurance of the risk management process to the board. The corporate risk register will be transitioning to a new, bespoke, digital platform in quarter 2 2021/22

|   |  |                |  |
|---|--|----------------|--|
| <b>Decision</b>   | The Committee is requested to note the updated actions to the CRR  |                |  |
| <b>Relevant strategic priority</b>                                      |  |                |  |
| <b>Quality</b> ☒  | <b>People</b> ☒  | <b>Money</b> ☒ |  |
| <b>Implications / Impact</b>  |  |                |  |
| <b>Patient Safety</b>   | Identifies any potential patient safety concerns   |                |  |
| <b>Risk: link to Board Assurance Framework (BAF)/Risk Register</b>      | Risks articulated in the CRR   |                |  |
| <b>Financial</b>  | Risks articulated in the CRR   |                |  |
| <b>Compliance</b> <small>Select an item.</small> <b>Good Governance</b> | Risks articulated in the CRR   |                |  |
| <b>Partnership: consultation / communication</b>                        | Consultation and Communication identified in updated actions   |                |  |
| <b>Equality</b>   | The trust is committed to the fair treatment of all patients and service users, regardless of age, colour, disability, ethnicity, gender, gender reassignment, |                |  |

|   |  |
|---|--|
|   | nationality, race, religion or belief, responsibility for dependents, sexual orientation, or any other personal characteristics. |
| <b>Quality Impact Assessment [QIA] completion required?</b> | Not Applicable   |

## 1. Purpose

This report provides the Committee with assurance the risk management process is complied with in the management and mitigation of the risks on the Corporate Risk Register (CRR) See Appendix 1.

## 2. Background

The CRR has been reviewed by each Director responsible for the risks. Many of the actions to mitigate the risks are being reviewed in the light of the impact of COVID 19 on the level of risk, mitigating actions, target dates and outcomes.

## 3. Top 3 risks for the Trust with a risk score of 20.

- 1) **CRR10** – Shortage of qualified nursing staff (added 11/2014- post mitigation score 15)
- 2) **CRR126** – impact on staff physical and psychological health and well-being during covid-19 (added 04/2020- post mitigation score 15)
- 3) **CRR139** There is a risk to the delivery and sustainability of the national standard for Referral to Treatment Time (RTT) as per the 20/21 NHS Guidance (added 18/02/21- post mitigation score 12)

## 4. Updates:

The following Risks have been updated:

**CRR137** Increased risk of pressure ulcer incidents due to increased skin vulnerability of those affected by Covid and staff pressures with the inability to provide best practice around pressure ulcer prevention: Monthly reporting to Quality committee, development of quality improvement and use of innovation such as SEM scanner.

**CRR116** Aged Datix version: owner moved to Chief Nurse, deadline 30/05/21.

**CRR115/PS118** Medical Gas Pipework Due to Covid experience, additional / upgraded pipework is being requested by the Trust to the PFI to improve O2 flow rates (project dates to be agreed). Clinical requirements for WH are currently being reviewed in terms of number of patients/ delivery methods that could be supported. Manifold installed at Wycombe. The target date has been extended from 30/11/2020 to 31/03/2021 and a further extension to 31/07/21.

**CRR45/S199** Increase in Ophthalmology Referrals: the risk has been revised with more robust actions including target dates and the risk score has increased from 5x3 to 4x4. The overall target

date has been extended from 31/12/2020 to 31/03/2021. The risk has been completely reviewed in light of Covid and so this risk has been archived and a new risk created CRR136.

**CRR10/ HR4/14** - Shortage of qualified Nursing, Midwifery and AHP staff: Actions and Key controls have been updated with current recruitment activity – there is no change to the score or target date.

**CRR88** – Patient tracking: The team are due to start work on 26<sup>th</sup> April and this is expected to be a lengthy project therefore the target date has been extended to 31/07/2021.

**CRR126/ Covid-19 RR ref 11** - Increased impact on staff physical and psychological health and wellbeing from working during COVID-19: The vaccination uptake has improved in response to actions put in place including specific communications, an advice line, and face to face appointments to discuss concerns. The BAME uptake has also improved. The target date has been extended to March 2022.

**CRR127/ Covid-19 RR ref 12** - Increase risk of adverse impact on staff from BAME backgrounds if they become positive with COVID19: Further follow ups co-ordinated weekly with HR Business Partners and Occupational Health supporting individuals and managers. Work is underway to centralise aspects of Risk Assessments, e.g. for CEV colleagues returning to work. The target date has been extended to March 2022

**CRR130/PS177** - Spalling concrete on the tower block at Wycombe Hospital: A further risk of larger concrete panels falling was identified following an in depth investigation and the existing scaffolding has had to be replaced with a stronger and higher scaffold whilst the repairs to the building are undertaken. This has extended the target completion from May to 30<sup>th</sup> September 2021.

**CRR135/FINT02** - The Trust does not deliver its operating plan (or Forecast Out-Turn): Ongoing annual risk - the actions have been updated to reflect the current mitigations in place and the target date extended to April 2022 to cover this financial year.

## 5. Expired Risks which require urgent review

There are currently no expired risks.

## 6. New Risks

CRR136/previously CRR45/S199: Backlog in Ophthalmology - completely reviewed and re-written to reflect current situation with Covid - old risk archived. Risk rating 16 revised following control rated 8.

As a result of the Covid 19 pandemic the ophthalmology service has a significant backlog of new and follow up appointments the glaucoma and medical retinal service being the most affected.

- The glaucoma service is at risk due to the large volume of patients requiring an appointment and the length of time that they are having to wait for this.
- The retinal service is at risk due to the large volume of patients combined with the social distancing restrictions in outpatients.
- There is likely to be an increase in number of patients remaining 'On Hold' - waiting to be seen due to the lack of capacity.

## 7. Risks for removal

**CRR119** - Covid 19 presents a potential risk to service delivery and sustainability: The risk score has been reduced from 16 to 12 following review by the Chief Operating Officer. The likelihood is reduced due to demand.

**CRR95** - Decontamination is not compliant with dirty/clean separation of scopes: The risk score has been reduced from 16 to 12 following review by the Chief Operating Officer. The likelihood is reduced due to the SoPs now in place.

**8. Review of the Risk register**

The risk register and process are currently under review with a plan to move to an electronic system which will enable robust tracking and auditing.

**9. Recommendation**

The Committee is requested to note the report and more work is required to provides assurance of the risk management process to the board.

**10. Appendices**

Appendix 1

|  | Consequence Score (severity levels) and examples of descriptors                        |   |  |  |   |
|--|--|---|--|--|---|
|  | 1  | 2   | 3  | 4  | 5   |
| <b>Domains</b>   | <b>Negligible</b>  | <b>Minor</b>  | <b>Moderate</b>  | <b>Major</b>   | <b>Catastrophic</b>   |
| <b>Impact on the safety of patients, staff or public (physical / psychological harm)</b> | Minimal injury requiring no/minimal intervention or treatment.<br><br>No time off work | Minor injury or illness, requiring minor intervention<br><br>Requiring time off work for >3 days<br><br>Increase in length of hospital stay by 1-3 days | Moderate <u>injury requiring professional intervention</u><br><br>Requiring time off work for 4-14 days<br><br>Increase in length of hospital stay by 4-15 days<br><br>RIDDOR/agency reportable incident<br><br>An event which impacts on a small number of patients | Major injury leading to long-term incapacity/disability<br><br>Requiring time off work for >14 days<br><br>Increase in length of hospital stay by >15 days<br><br>Mismanagement of patient care with long-term effects | Incident <u>leading to death</u><br><br>Multiple permanent injuries or irreversible health effects<br><br>An event which impacts on a <u>large number of patients</u> |
| <b>Likelihood score</b>  | <b>1</b>   | <b>2</b>  | <b>3</b>   | <b>4</b>   | <b>5</b>  |
| <b>Descriptor</b>  | <b>Rare</b>  | <b>Unlikely</b>   | <b>Possible</b>  | <b>Likely</b>  | <b>Almost certain</b>   |
| <b>Frequency</b><br>How often might it/does it happen                                    | This will probably never happen/recur<br><br><0.1 %                                    | Do not expect it to happen/recur but it is possible it may do so<br><br><0.1 – 1%   | Might happen or recur occasionally<br><br>1 – 10%  | Will probably happen/recur but it is not a persisting issue<br><br>10 – 50%  | Will undoubtedly happen/recur <u>possibly frequently</u><br><br>>50%  |

Appendix 2 CRR

| Corporate Risk Register | Divisional Risk Register | Division          | Date added to CRR | Trust Objective                | Description of risk   | Unmitigated risk | Key controls   | Risk Score |   |       | Gaps in controls   | Actions to address risk, including target completion dates (bold) for each action.  | Target overall completion date | Executive 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, Midwifery 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<br>(5x5)      | <ul style="list-style-type: none"> <li>Performance management of Recruitment Service - People Committee.</li> <li>Performance management of Divisions and Corporate Services</li> <li>Performance management of NHSP to ensure quality of temporary staff and high proportion of bank rather than agency staff. <ul style="list-style-type: none"> <li>Daily safe staffing huddles.</li> </ul> </li> <li>Weekly safe staffing meeting to identify and review hot spots. <ul style="list-style-type: none"> <li>Monthly vacancy heat map by cost centre.</li> </ul> </li> <li>Detailed recruitment plan under three strands - grow your own, UK candidate, International</li> <li>Continuation of Phase 4 NHSi retention strategy that focuses on three strands (recruit well / mid-career / 50+ programme). <ul style="list-style-type: none"> <li>Monitored through Strategic Workforce Committee.</li> </ul> </li> <li>31 individuals recruited onto Nursing associate apprenticeship and Nurse degree programmes for 2020-21;</li> <li>UK based online nurse recruitment campaign launched Winter 2020 directing candidates to the new microsite - includes Facebook, mobile web banners, and RCN website.</li> </ul> | 5          | 4 | 20    | <ul style="list-style-type: none"> <li>National shortage of registered nurses.</li> <li>Drop in numbers recruiting to nurse degree programmes - Y3 qualifiers September 2020 was our lowest number ever - this is the first cohort following the removal of the nurse bursary.</li> <li>Delays in conversion of overseas recruits due to the requirements of the IELTS/OET and the time it takes to register with the NMC and changes in immigration rules due to COVID</li> <li>Uncertainty around impact BREXIT will have on EU recruitment. This position may be exacerbated by COVID-19</li> <li>reduction in overseas nurse recruitment due to COVID-19. Of 15 recruits in the May cohort, 6 are unable to travel due to Covid-19 restrictions.</li> <li>possible increase in individuals leaving the profession</li> </ul> | <ul style="list-style-type: none"> <li>Trust-wide recruitment plans in place - this includes, local, national and international recruitment of nurses</li> <li>Longer term plans: UK recruitment supported by work of Bucks Health and Social Care Academy - including use of apprenticeships</li> <li>Local plans for hotspot areas and recruitment to a wider range of roles.</li> <li>Recruitment of international nurses - target to recruit and relocate 222 nurses over 12 to 18 months. Three cohorts (36 individuals) have arrived to date across March and April: five recruits from India scheduled to join in April unable to travel due to Covid-19 restrictions. There are 70+ individuals in the candidate pipeline and interviews are being conducted across May and June. Partner agencies have been asked to attract candidates from a number of countries to counter on-going Covid-19 restrictions in India.</li> <li>Contact with EU Universities maintained - meeting held with Portuguese partners during February 2021 with invite to online job fair in May 2021.</li> <li>OET (Overseas English Test) training continues in house and with support from NHSP for new international recruits - focus on reducing timelines to achieve OET pass.</li> <li>Retention plan - continuation of activity from NHSi Cohort 4.</li> </ul> | 30/03/2022                     | Chief People Officer | 5                        | 3 | 15    |
| CRR 27B                 | PS153                    | Property Services | 20/10/2017        | Estate strategy                | <p>The SMH main HV/LV electrical supply is insufficient for the current needs of the Estate and is not resilient.</p> <p>In addition, due to the discovery of corrosion on the existing equipment, the installation of a new joint box and replacement switch gear and cables is also required.</p> <p>If external supplies fail the internal back up support generators will only support the power needs of the site for 4 hours.</p> <p>This will affect all clinical and non clinical services.</p> | 25<br>(5x5)      | <p>We have a generator supply system which will provide emergency power to all of the site.</p> <p>This project will re-structure the power supply systems to provide secure services.</p> <p>Initial 4 hour back up will require extra fuel deliveries to allow continuation of generator support and Clinical services. Contract in place.</p> <p>Individual medical equipment has limited battery back up for approximately 30 minutes.</p>   | 5          | 4 | 20    | <p>Insufficient power supply</p> <p>Only one electrical supply cable, 2nd needed for resilience</p>  | <p>HV/LV upgrade project now 65% complete. Expected completion date has now been extended by 3 months from 31/03/2021 to 30/06/2021 due to the discovery of corroded cables and switchgear which now needs to be replaced.</p> <p>New cabling and switch gear now on order to be installed.</p> <p>Transformers and distribution panel to be installed.</p>   | 30/06/2021                     | Commercial Director  | 5                        | 1 | 5     |

| Corporate Risk Register | Divisional Risk Register | Division | Date added to CRR | Trust Objective                | Description of risk  | Unmitigated risk | Key controls   | Risk Score |   |       | Gaps in controls   | Actions to address risk, including target completion dates (bold) for each action.  | Target overall completion date | Executive Lead          | Predicted residual score |   |       |
|-------------------------|--------------------------|----------|-------------------|--------------------------------|--|------------------|--|------------|---|-------|--|---|--------------------------------|-------------------------|--------------------------|---|-------|
|                         |                          |          |                   |                                |  |                  |  | C          | L | C x L |  |   |                                |                         | C                        | L | C x L |
| CRR 95                  |                          | 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<br>(4x5)      | <ul style="list-style-type: none"> <li>Existing staff asked if they would like to work extra shifts.</li> <li>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.</li> <li>Resident Medical Officer (RMO) service in place in National Spinal-cord Injuries Centre to offer additional cover.</li> <li>RMO post incorporated into night rota for acute surgery at Wycombe and Stoke Mandeville Hospitals.</li> <li>Revised middle grade rotas in order to make them more resilient.</li> <li>Controls around leave booking is held at local level.</li> <li>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.</li> <li>E-rostering for medical staff - in place</li> <li>Annual Leave policy - in place</li> </ul> | 5          | 3 | 15    | <p>National shortage of doctors from key groups.</p> <p>There are identified gaps in rotas in medicine at registrar and consultant level. These gaps have increased with the expansion of the medical bed base due to Covid-19</p>   | <ul style="list-style-type: none"> <li>Active recruitment to vacant posts. Medical director to work with Finance to ensure approved posts are authorised in a timely manner.</li> <li>Action plan to address findings of review against new Royal College of Physicians guidance - needs to be reviewed following Covid-19.</li> <li>Continued development of new roles to support medical rotas e.g. associate physicians, extended nurse practitioners. (Divisional Chair and Director, Integrated Medicine.)</li> </ul> <p>Project reviewed March 2020 - COVID-19 issues will delay this moving forward. Target completion date moved to 30th September 2021.</p>  | 30/09/2021                     | Medical Director        | 5                        | 1 | 5     |
| CRR 88                  | S220, IM138 and IM 139   | Trust    | 19/02/2018        | Digital strategy               | <p>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:</p> <ul style="list-style-type: none"> <li>-Monitoring of hospital initiated cancellations</li> <li>-Tracking follow up appointments</li> <li>-oversight of patients put 'on hold'</li> <li>-incomplete clinic outcome forms</li> </ul> <p>This has become increasingly visible through new reporting via Medway</p> | 25<br>(5x5)      | <p>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.</p>   | 4          | 4 | 16    | <ul style="list-style-type: none"> <li>'On hold' project and data validation exercise expanded to include cancellations due to COVID-19.</li> <li>Ability to be able to track non compliance with agreed standard operating procedures.</li> <li>Recovery plans and Outpatient capacity.</li> <li>Non compliance with cancellation process</li> <li>Outpatient modernisation project.</li> </ul> | <ul style="list-style-type: none"> <li>Additional resource agreed to commence on hold project: validation 'on hold' entries by reason, review of patients in progress, COVID-19 cancellations. Start 26/4/21. <ul style="list-style-type: none"> <li>Establishing a single follow up PTL</li> </ul> </li> <li>COVID-19 recovery plans and non face to face contacts to include appropriate 'on hold' patients. <ul style="list-style-type: none"> <li>Follow up dashboard to facilitate recovery plans by SDU</li> <li>Cashing up of clinics to be completed within 7 days</li> </ul> </li> <li>Secretaries review all 'On Hold' entries when typing up patient letters</li> </ul>  | 31/07/2021                     | Chief Operating Officer | 5                        | 2 | 10    |
| CRR 100                 |                          | Trust    | 07/09/2018        |                                | <p>There is a risk that Brexit could have an adverse impact on workforce supply and procurement of essential clinical supplies.</p>  | 20<br>(4x5)      | <ul style="list-style-type: none"> <li>Monitoring of leavers from EU.</li> <li>Review re-introduction of regular EU Exit meetings [announced end of October] by the Emergency Planning Lead.</li> </ul>  | 5          | 3 | 15    | <p>There is a high level of uncertainty about the impact of Brexit although the transition period ended on 31 December 2020.</p> <p>The deadline for EEA nationals to apply for settled or pre-settled status is 30th June 2021.</p>   | <ul style="list-style-type: none"> <li>Attention to communication from the Department of Health and Social Care and any resulting action. <ul style="list-style-type: none"> <li>Senior HRBP - Lead</li> <li>Action plan drawn up.</li> </ul> </li> <li>All business continuity plans are up to date.</li> <li>All EU colleagues (c500) written to on the 1st Dec – as part of the letter colleagues were advised of the process for EU settled status scheme open until end of June 2021.</li> <li>All EU colleagues will be written to again in Mid – June 2021. Asking for evidence of their immigration status to be provided by 1st July 2021. Recruitment processes have been reviewed to reflect the new points based sponsorship process which comes into effect from 1st Jan 2021.</li> <li>A designated Brexit e-mail address for any queries is in place.</li> </ul> | 30/06/2021                     | Chief People Officer    | 5                        | 2 | 10    |

| Corporate Risk Register | Divisional Risk Register | Division          | Date added to CRR | Trust Objective | Description of risk  | Unmitigated risk | Key controls  | Risk Score |   |       | Gaps in controls  | Actions to address risk, including target completion dates (bold) for each action.   | Target overall completion date | Executive Lead      | Predicted residual score |   |       |
|-------------------------|--------------------------|-------------------|-------------------|-----------------|--|------------------|---|------------|---|-------|---|--|--------------------------------|---------------------|--------------------------|---|-------|
|                         |                          |                   |                   |                 |  |                  |   | C          | L | C x L |   |  |                                |                     | C                        | L | C x L |
| CRR115                  | PS118                    | Property Services | 12/11/2019        | Estate strategy | The existing medical gas pipe work is not sufficient for current clinical needs.<br><br>In the event of an increased medical demand for oxygen such as a surge in Covid, there is insufficient infrastructure in place to deliver required supply. | 20<br>(5x4)      | Additional Vacuum Insulated Evaporator (VIE for bulk storage of Oxygen) installed<br>Pipework upgraded from the oxygen tanks to the main site at SMH<br>Upgraded deliveries from BOC to ensure tank levels are greater than 50%<br>Evaporators placed to support tank oxygen delivery (to assist with oxygen flow)<br>Oxygen concentrators (60) obtained to provide ward supplies to individual patients<br>Manifold provided with 20 cylinders to augment supply at front door (ED)<br>Improvement of information flows using vitals and development of a live dashboard | 5          | 3 | 15    | The current infrastructure is not designed to support the oxygen demand during a Covid surge  | SMH new VIE supply from BOC has been pushed back to July due to manufacturing difficulties, awaiting confirmed date for installation. Site for installation identified near carpark B.<br><br>Due to Covid experience, additional / upgraded pipework is being requested by the Trust to the PFI to improve O2 flow rates ( project dates to be agreed).<br><br>Clinical requirements for WH are currently being reviewed in terms of number of patients/ delivery methods that could be supported. S/B Manifold installed at Wycombe. | 31/07/2021                     | Commercial Director | 5                        | 1 | 5     |
| CRR116                  |                          | Trust             | 12/11/2019        |                 | The Datix system fails to function appropriately due to its age and unsupported infrastructure. It is not compatible with Windows 10.  | 20<br>(4x5)      | Monitoring and vigilance and Workarounds<br>Regular meetings and checks within the Patient Safety Team  | 4          | 4 | 16    | <ul style="list-style-type: none"> <li>System performance discourages staff from reporting and managing incidents in a timely manner.</li> <li>The Trust reporting and ability to learn from incidents is affected due to the difficulty in obtaining information in a clear and timely manner.</li> <li>Datix cannot provide standard Technical back room support, and workarounds on the system to support functions are required and may introduce some unintended or unknown risk into the system.</li> <li>Risk of Business Continuity impact as the system may fail unexpectedly because the current version of Datix cannot be sustained or supported in the long term by the suppliers.</li> <li>There is an increasing 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.</li> <li>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.</li> </ul> | The patient safety team monitor the system on a regular basis supported by IT.<br>IT Project Manager now in place and task and finish group set up<br>Business case to be developed for upgrade to DCIQ cloud version in co-operation with Procurement, IT and the QI team<br>Task groups to be set up to manage system configurations for each DATIX module required by the Trust ( <b>March 2021</b> )   | 30/05/2021                     | Chief Nurse         | 2                        | 1 | 2     |

| Corporate Risk Register | Divisional Risk Register | Division | Date added to CRR | Trust Objective                            | Description of risk   | Unmitigated risk | Key controls   | Risk Score |   |       | Gaps in controls  | Actions to address risk, including target completion dates (bold) for each action.  | Target overall completion date | Executive Lead       | Predicted residual score |   |       |
|-------------------------|--------------------------|----------|-------------------|--|---|------------------|--|------------|---|-------|---|---|--------------------------------|----------------------|--------------------------|---|-------|
|                         |                          |          |                   |  |   |                  |  | C          | L | C x L |   |   |                                |                      | C                        | L | C x L |
| CRR 126                 | Covid-19 RR ref 11       | Trust    | 01/04/2020        | People are safe, supported and listened to | Increased impact on staff physical and psychological health and wellbeing from working during COVID-19 pandemic. Specific risks include: increased pressure in work environment- wearing of PPE for prolonged periods, increased end of life patients, caring for colleagues, working in new environments | 25               | <ol style="list-style-type: none"> <li>1. Comprehensive staff occupational health &amp; wellbeing offer - psychological and physical - in house and access to national programmes</li> <li>2. Weekly debriefs with CEO and regular communications</li> <li>3. Staff networks</li> <li>4. Strengthened collaboration with Clinical Psychology, Chaplaincy and OD Teams. Additional mental health specialist support in place.</li> <li>5. Implementation of Employee Assistance Programme (Vivup) w/b 06/07/2020 ongoing.</li> <li>6. Strong wellbeing Comms plan in place providing information and links to a range of external support and psycho-educational material.</li> <li>7. Continued promotion of the 'Just Ask' campaign</li> <li>8. Developing return to work packs to support staff and managers with the transition of coming back to the workplace.</li> <li>9. BHT Winter CARE pack issued from the Chief Executive on 29 September - by email. Includes details of the following support: Roll out of #@HAY (How Are You) regional guidance - key actions include TRIM (Trauma Risk Injury Management) and identification of inside and outside hubs for staff Wrap around support offer from OH, Wellbeing, Chaplaincy and psychologists in place and being regularly advertised Psychologist identified to support high risk areas Inline with social distancing rule develop COVID19 Schwartz round; After Event Reflections</li> <li>10. Vaccination uptake - improved in response to actions in place to increase uptake including specific communications, an advice line and face to face appointments to discuss concerns. BAME uptake also improved.</li> <li>11. Support for ICU colleagues has commenced with sessions at Lindengate. First group to attend on Friday 14th May ; this will also help to inform the level of support required for colleagues and this will gradually be extended to other priority groups eg respiratory.</li> </ol> | 5          | 3 | 15    | <p>Impact of sustained pressure of managing COVID-19 is not yet known.</p> <p>Specific impact on some staff groups in particular those from a BAME background.</p> <p>Lower uptake of COVID-19 vaccination from colleagues from some BAME backgrounds.</p>  | <p>Developing additional communication channels to get service information out to staff.</p> <p>Using all existing services (training, 1:1's, team support) to share what's available for staff.</p> <p>Disseminating information through Wellbeing Champions, Trust Networks, Junior Doctors Forum.</p> <p>People recovery plan covering next two years launched</p> <p>Actions in place to increase uptake including specific communications, an advice line and face to face appointments to discuss concerns</p>  | 31/03/2022                     | Chief People Officer | 5                        | 2 | 10    |
| CRR 127                 | Covid-19 RR ref 12       | Trust    | 01/04/2020        | People are safe, supported and listened to | National data shows an Increase risk of adverse impact on staff from BAME backgrounds if they become positive with COVID19; 24 % of the Trust's staff are from a BAME background. There is therefore a higher risk to both physical and psychological health and wellbeing to these staff.                | 20               | <ol style="list-style-type: none"> <li>1. Risk Assessments for all high risk staff</li> <li>2. Access to appropriate PPE</li> <li>3. Information cascade on guidance</li> <li>4. Active staff networks</li> <li>5. Regular formal and informal communication between Directors and staff from a BAME background</li> <li>6. Chief People Officer and Chief Nurse attend national and regional meetings to ensure Trust receives most up to date guidance</li> </ol>  | 5          | 3 | 15    | <p>Reasons for disproportionate impact for individuals from a BAME background are not fully identified</p> <p>Monthly reporting shows overall risk assessment compliance has dropped 2% from earlier full compliance levels</p> <p>Difference in uptake in vaccine levels between White and BAME colleagues</p> | <p>CEO letter to all BAME staff</p> <p>Development of COVID 19 risk assessment</p> <p>Ongoing review of all emerging evidence</p> <p>Link with local public health team to understand if there are any specific local risks</p> <p>Plans in place for all new starters to undergo a risk assessment with line manager when commencing with the Trust - new starters should not start employment without an RA being in place</p> <p>Follow up of all new recent starters/SDU leads starting w/c 9 November 2020.</p> <p>Ongoing monitoring of Risk Assessment completion (new starters, those returning from maternity leave, long term sick).</p> <p>Further follow ups co-ordinated weekly - with HR Business Partners and Occupational Health supporting individuals and managers. Work underway to centralize aspects of Risk Assessments - for example for CEV colleagues returning to work.</p> | 31/03/2022                     | Chief People Officer | 4                        | 2 | 8     |

| Corporate Risk Register | Divisional Risk Register | Division                                   | Date added to CRR | Trust Objective | Description of risk   | Unmitigated risk | Key controls  | Risk Score |   |       | Gaps in controls  | Actions to address risk, including target completion dates (bold) for each action. | Target overall completion date | Executive Lead | Predicted residual score |   |       |
|-------------------------|--------------------------|--|-------------------|-----------------|---|------------------|---|------------|---|-------|---|--|--------------------------------|----------------|--------------------------|---|-------|
|                         |                          |  |                   |                 |   |                  |   | C          | L | C x L |   |  |                                |                | C                        | L | C x L |
| CRR130                  | PS177                    | Property Services                          | 20/10/2020        | Estate strategy | Wycombe Hospital. The concrete panels installed on the exterior of the tower block are at risk of falling away from the main building to the ground due to deterioration of the cast iron clips installed when the tower was constructed. | 20               | Scaffolding is currently erected with boarding to protect persons from smaller spalling concrete. Larger concrete panels which have been identified as concerns have been removed.  | 5          | 3 | 15    | Further scaffolding and boarding needed to protect from larger pieces of falling concrete.  | 30/09/2022   | Commercial Director            | 5              | 1                        | 5 |       |
| CRR131                  | Gynae3                   | Women, Children and Sexual Health Services | 19/10/2020        |                 | Risk of delayed diagnostics and treatments (including cancers) as outpatient hysteroscopy demand exceeds service capacity, due to unexpected enforced temporary relocation of hysteroscopy suite reducing number of sessions provided     | 20               | 1) temporary relocation of outpatient hysteroscopy to urodynamic suite<br>2) Weekly operational meeting to review waiting times<br>3) prioritisation of 2 ww cancer patients  | 4          | 4 | 16    | 1) urodynamic suite shared with spinal department, therefore only limited availability to perform hysteroscopy.<br>urodynamic suite environment not appropriate for hysteroscopy procedures<br><br>2) currently 355 patients awaiting appointments. This is likely to increase if suitable alternative location is not identified | 31/08/2021   | Chief Operating Officer        | 4              | 1                        | 4 |       |
| CRR135                  | FINT02                   | Finance                                    | 26/11/2020        |                 | The Trust does not deliver its operating plan (or Forecast Out-Turn), meaning that statutory break-even is not delivered.   | 25               | Timely close and reporting to Senior Management, EMC and F&BPC. Monthly report includes a clear messages and summary of Forecast Out-Turn. Detailed monthly budget reports and meetings to discuss variances. EMC Review<br>Monthly finance review in place with all divisions and corporate areas. | 5          | 3 | 15    | Operational pressures<br>Continued reliance on agency staffing<br>Non-delivery of Workstreams   | 31/03/2022   | Director of Finance            | 3              | 3                        | 9 |       |

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|-------------------------|--------------------------|-------------------|-------------------|-------------------|---|------------------|---|------------|---|-------|---|--|--------------------------------|-------------------------|--------------------------|---|-------|
|                         |                          |                   |                   |                   |   |                  |   | C          | L | C x L |   |  |                                |                         | C                        | L | C x L |
| CRR136                  | Previously S199 (CRR45)  | Surgery           | 28/01/2021        | Clinical Strategy | <p>As a result of the Covid 19 pandemic the ophthalmology service has a significant backlog of new and follow up appointments the glaucoma and medical retinal service being the most affected.</p> <p>The glaucoma service is at risk due to the large volume of patients requiring an appointment and the length of time that they are having to wait for this.</p> <p>The retinal service is at risk due to the large volume of patients combined with the social distancing restrictions in outpatients.</p> <p>There is likely to be an increase in number of patients remaining 'On Hold' - waiting to be seen due to the lack of capacity.</p> | 20<br>(5x4)      | <p>A plan for additional weekend clinics and additional Glaucoma Fellows has been submitted to address the follow up backlog.</p> <p>A Failsafe officer was appointed in December 19, key POC for glaucoma patients who have concerns</p> <p>2 Consultants joined the Retinal team Dec 20/Jan 21. These posts also bolster the team for covering the AMD suite at Amersham, which is working at maximum capacity throughout the pandemic.</p> <p>The daily safety huddles and flow within this clinic, is being used to model future plans for our outpatient services. AMD coordinator and Retinal failsafe officers in post to monitor and track and prioritise these patients and escalate capacity concerns.</p> <p>Backlogs also occur in the cataract service, approx. 700 referrals. We now have 2 Fellows and a third due to join mid Feb 21. Between them they will be able to see 80 new referrals per week and cover all 10 operating lists in the Vanguard unit.</p> <p>A proposal for funding to increase the vanguard to three session days and 7-day working is being submitted through business planning.</p> <p>All routine post op cataract appointments are over the telephone and nurse delivered. Two F2F clinics per week with Fellows have been set up for any complications coming through Eye casualty with the increase in cataract surgery.</p> <p>Cataract-athon took place in November where c480 patients all had cataract surgery in a dedicated 2-week programme.</p> | 4          | 4 | 16    | <p>Space for booking teams to be housed in one central location</p> <p>Availability of physical space in the Mandeville Wing to accommodate the required activity</p> <p>Challenge to recruit high quality Fellows.</p> | <p>Reconfiguration of Amersham or Stoke Mandeville space (replicating the efficient clinic set – up currently used for AMD) to create an enhanced ophthalmic service with increased workflow and capacity. This would future proof the service for the next ten years. Business case to be submitted to EMC in February 2021. Awaiting Space Committee outcome.</p> <p>Implement virtual glaucoma outpatient clinics at WH and SMH utilising AHPs and nursing staff to support. Pending recruitment of staff into posts (<b>February 21</b>). This will increase the number of patients reviewed (c90 patients per week on each site).</p> <p>Consider insourcing of new glaucoma patients at the weekends with an external company to reduce wait times (<b>February 21</b>).</p> <p>Working with NHSE national GIRFT South East of England programme - high volume glaucoma new clinics (<b>March 21</b>).</p> | 31/05/2021                     | Chief Operating Officer | 4                        | 2 | 8     |
| CRR137                  |                          | Trust             | 04/02/2021        |                   | <p>Increased risk of pressure ulcer incidents due to increased skin vulnerability of those affected by Covid and staff pressures with the inability to provide best practice around pressure ulcer prevention</p>   | 16               | <p>Tissue Viability (TV) team to visit all wards &amp; community teams weekly and support with pressure ulcer prevention</p> <p>Provide extra training as needed</p> <p>Mini training videos on prevention on intranet</p>  | 3          | 5 | 15    | <p>Minimal TV support to ICU due to access</p> <p>Source products for protection under medical devices when patients are prone</p> <p>Staff pressures meaning less mobilisation of patients</p>                         | <p>Email sent to ICU matron asking how we can support them 04/02/2021</p> <p>TV team to undertake further review if newer products on market 12/02/2021</p> <p>Audit assessments, care plans to be in place, patients have correct equipment</p> <p>TVN team to assist during weekly reviews</p> <p>Monthly reporting to Quality committee, development of quality improvement and use of innovation such as SEM scanner (8/04/21)</p>   | 30/07/2021                     | Chief Nurse             | 3                        | 3 | 9     |
| CRR138                  | PS180                    | Property Services | 18/02/2021        |                   | <p>SMH. Improved ventilation required in clinical / ward areas. Patients / Staff / Visitors / Contractors have an Increased risk of infection, particularly Covid 19. Potential regulatory enforcement leading to legal action, fines, or Trust reputational damage</p>   | 20               | <ul style="list-style-type: none"> <li>• IQ EA air units in each ward (Standard Operating Procedure being written) <ul style="list-style-type: none"> <li>• Air monitoring of area</li> <li>• Windows left open when appropriate inspections.</li> <li>• Limiting the number of patients / visitors in bays <ul style="list-style-type: none"> <li>• Air conditioning turned on where installed</li> </ul> </li> <li>• Compliance with PPE procedures and hand hygiene</li> <li>• Staff Communication Strategy – Staff awareness / training</li> <li>• Standard Operating Procedure for IQ EA air units now issued</li> </ul> </li> </ul>   | 4          | 4 | 16    | <p>SOP for IQ EA units required</p> <p>Trust ventilation policy required</p>  | <ul style="list-style-type: none"> <li>• Ventilation Policy being drafted</li> <li>• Ventilation survey to be completed and improvement plan produced to ensure current standards are being achieved. <ul style="list-style-type: none"> <li>• Application to regional and national funding streams.</li> </ul> </li> <li>• Business Plan to be produced to secure funding for identified improvement works <ul style="list-style-type: none"> <li>• Funding to be approved</li> </ul> </li> <li>• Tender document to be produced and process initiated</li> <li>• Works to install improved ventilation to commence</li> </ul>  | 30/06/2021                     | Commercial Director     | 4                        | 2 | 8     |

| Corporate Risk Register | Divisional Risk Register | Division                                   | Date added to CRR | Trust Objective | Description of risk   | Unmitigated risk | Key controls   | Risk Score |   |       | Gaps in controls  | Actions to address risk, including target completion dates (bold) for each action.  | Target overall completion date | Executive Lead          | Predicted residual score |   |       |
|-------------------------|--------------------------|--|-------------------|-----------------|---|------------------|--|------------|---|-------|---|---|--------------------------------|-------------------------|--------------------------|---|-------|
|                         |                          |  |                   |                 |   |                  |  | C          | L | C x L |   |   |                                |                         | C                        | L | C x L |
| CRR139                  | Previously CRR68/ S228   | Trust                                      | 18/02/2021        |                 | <p>There is a risk to the delivery and sustainability of the national standard for Referral to Treatment Time (RTT) as per the 20/21 NHS Guidance:</p> <ul style="list-style-type: none"> <li>•Half number of 52 week breaches in 20/21 compared to 19/20</li> <li>•waiting list size in March 21 must be less than that submitted in January 20</li> </ul> <p>The main factor contributing to this is reduction in capacity which increases waiting times.</p> <p>The possible adverse outcomes for this risk are:</p> <ul style="list-style-type: none"> <li>•poor patient experience if their waiting times are extended;</li> <li>•possible clinical harm to patients if there are delays.</li> </ul> <p>There is an increased likelihood of 52-week breaches occurring in all surgical specialities waiting for treatment due to the second surge of the COVID-19 pandemic, and longer waiting times for first appointments across all specialities.</p> | 20               | <p>RTT performance is monitored through:</p> <ul style="list-style-type: none"> <li>Weekly Patient Tracking List (PTL) meetings.</li> <li>Weekly Access Performance Management Group (APMG) meetings.</li> <li>Monthly Divisional Performance Meetings</li> </ul> <ul style="list-style-type: none"> <li>•Training programme established for IFR funding process and adherence to CCG criteria</li> <li>•Evidence Based Intervention Monitoring <ul style="list-style-type: none"> <li>•Recover capacity post COVID</li> <li>•Additional Waiting List Initiatives</li> <li>•Continuation of Vanguard facilities</li> </ul> </li> <li>•Performance trajectories in line with National targets</li> <li>•Retaining elective activity in safe facilities</li> <li>•Eull demand and capacity review of all specialities to be repeated by October 2021.</li> <li>•All appropriate appointments moved to virtual</li> <li>•Referrals of all surgical specialities to be vetted</li> <li>Priority post COVID-19 elective recovery planning in place <ul style="list-style-type: none"> <li>•Maximise use of the Independent Sector</li> <li>•Outsource work via the ICS as appropriate</li> </ul> </li> <li>•Business planning commenced to increase capacity in 21/22 <ul style="list-style-type: none"> <li>•Patient communication: <ul style="list-style-type: none"> <li>•20,000 letters to patients waiting first appointment</li> </ul> </li> <li>•Refresh of prioritisation letters to patients on elective waiting list</li> </ul> </li> </ul> | 4          | 5 | 20    | <p>Outpatient Clinic capacity is lower than 19/20.</p> <p>Elective capacity is lower than 19/20</p> <p>Capacity restrictions due to IPC Capacity does not meet backlog demand.</p> <p>Inability to recruit to nursing and medical vacancies across the Trust.</p> <p>Patient choice to defer treatment</p> <p>NHSE expectation to reduce elective operating in times of pressure in the system.</p> | <p>Increasing the amount of day case and elective surgery in line with IPC recommendations</p> <p>Maximise use of IS facilities</p> <p>Implement partial booking and Patient Initiated follow up which will support the teams to proactively plan the ambulatory pathways</p> <p>Harm assessment completed for each patient on the waiting list</p> <p>Individual clinical harm reviews for any 52-week breaching patient.</p> <p>Management plan for all patients over 104 weeks</p> <p>Prioritise capacity for highest clinical harm risk</p> <p>Trust wide RTT training programme completed.</p> <p>Recovery trajectory monitored through APMG and oversight provided at the elective care recovery group in line with NHSE Phase 3 requirements</p> | 31/10/2021                     | Chief Operating Officer | 4                        | 3 | 12    |
| CRR140                  | OG11                     | Women, Children and Sexual Health Services | 18/02/2021        |                 | <p>The environment in which outpatient services are provided at SMH is leading to infection control risks, health and safety risk for staff and patients due to generalised ageing and disrepair of temporary building structure</p>  | 20               | <p>Daily focus on maintaining cleanliness and safety and reporting of cleanliness and maintenance issues via helpdesk.</p> <p>Regular IPC audits to identify and manage infection control risks</p> <p>Reporting of building defects and identified repairs required to maintain health and safety of patients and staff.</p> <p>temporary relocation of gynae clinics to other departments whilst repairs / permanent relocation considered</p>   | 4          | 5 | 20    | <p>temporary building has been in place since 2007 therefore the efficacy of essential repairs is limited and not cost-effective</p> <p>IPC audit results &amp; environmental failures</p>  | <p>Creation of new bespoke Paediatric Emergency Department supported with funding provided by NHS Improvement, programme is underway and scheduled for completion <b>31/12/2021</b></p>   | 31/12/2021                     | Chief Operating Officer | 1                        | 2 | 2     |

| Corporate Risk Register | Divisional Risk Register | Division                                   | Date added to CRR | Trust Objective | Description of risk   | Unmitigated risk | Key controls  | Risk Score |   |       | Gaps in controls  | Actions to address risk, including target completion dates (bold) for each action.   | Target overall completion date | Executive Lead          | Predicted residual score |   |       |
|-------------------------|--------------------------|--|-------------------|-----------------|---|------------------|---|------------|---|-------|---|--|--------------------------------|-------------------------|--------------------------|---|-------|
|                         |                          |  |                   |                 |   |                  |   | C          | L | C x L |   |  |                                |                         | C                        | L | C x L |
| CRR141                  | Paeds 32                 | Women, Children and Sexual Health Services | 18/02/2021        |                 | <p>Insufficient capacity within the Paediatric Decisions Unit footprint for ongoing treatment of children and young children leading to periods of overcrowding.</p> <p>Triage Process through Paediatric Decisions Unit inability to rapidly assess children who may be unwell</p> | 20               | <ol style="list-style-type: none"> <li>Weekly review of datix documenting the escalation into the outpatient area 5a and 5b.</li> <li>Review of complaints related to the PDU environment and waiting times.</li> <li>Daily review of patient attendance within PDU.</li> <li>BHT Guideline 279.1 Paediatric Decisions Unit (PDU) Triage Guideline. Contains overcrowding tool for escalation.</li> <li>Specific training for all nursing staff involved in triage as part of mandatory training.</li> <li>G.P. streaming of minor illnesses to support urgent care pathway.</li> <li>Use of outpatient area 5a and 5b to support early assessment of children and young people.</li> <li>Identification of those children and young people who can remain in waiting area awaiting review by medical staff</li> <li>Additional staffing for PDU overnight to support activity</li> <li>Paediatric Senior Nurse support out of normal working hours</li> <li>Emergency Department to support paediatric minor injuries flow to reduce triage times for children and young people who are acutely unwell.</li> <li>Additional temporary staffing for PDU overnight to support increase in overall activity enabling the ability to increase the number of triaging staff.</li> <li>Appointment of additional Matron to support the development of paediatric urgent care pathways</li> </ol> | 5          | 4 | 20    | <ol style="list-style-type: none"> <li>Continued review of triage pathways including minor illness and minor injuries exploring alternative pathways for triage of these patients.</li> <li>Escalate to divisional board to support the physical expansion of PDU.</li> <li>provision of appropriate space</li> </ol> | <p>Creation of new bespoke Paediatric Emergency Department supported with funding provided by NHS Improvement, programme is underway and scheduled for completion <b>31/12/2021</b></p> <p>Work currently underway to mitigate against potential further risk due to a forecasted increase in paediatric respiratory demand from Aug 2021.</p> | 31/12/2021                     | Chief Operating Officer | 5                        | 2 | 10    |

Board Attendance Record: March 2021 to May 2021

|  | Strategic Workforce Committee |        | Finance and Business Performance Committee |        |        | Quality & Clinical Governance Committee |                           |       | Organ & Tissue Donation Committee | Charitable Funds Committee | Audit Committee |       |       | Trust Board |        |
|--|-------------------------------|--------|--|--------|--------|---|---------------------------|-------|-----------------------------------|----------------------------|-----------------|-------|-------|-------------|--------|
|  | 8 Mar                         | 10 May | 23 Mar                                     | 20 Apr | 19 May | 9 Mar                                   | 21 Apr                    | 5 May | 5 May                             | No meeting in this period  | 4 Mar           | 4 May | 6 May | 31 Mar      | 28 Apr |
| Hattie Llewelyn-Davies<br>Trust Chair *      | ✓                             | ✓      | ✓  | ✓      | x      | ✓                                       | X (due to change of date) | ✓     |                                   |                            |                 |       |       | ✓           | ✓      |
| Neil Macdonald,<br>Chief Executive Officer * | x                             | x      | ✓  | ✓      | ✓      | ✓                                       | x                         | ✓     |                                   |                            |                 |       | ✓     | ✓           | ✓      |
| Dipti Amin<br>NED*                           |                               |        |  |        |        | ✓                                       | ✓                         | ✓     | ✓                                 |                            | ✓               | ✓     | ✓     | ✓           | ✓      |
| Karen Bonner<br>Chief Nurse *                | ✓                             | ✓      |  |        |        | ✓                                       | ✓                         | ✓     |                                   |                            |                 |       |       | ✓           | ✓      |
| Dan Gibbs<br>Chief Operating Officer*        |                               |        | ✓  | ✓      | ✓      | ✓                                       | ✓                         | ✓     |                                   |                            |                 |       |       | ✓           | ✓      |
| Nicola Gilham<br>NED*                        | ✓                             |        | ✓  | ✓      | ✓      |   |                           |       |                                   |                            | ✓               | ✓     | ✓     | ✓           | ✓      |
| Mo Girach<br>Associate NED                   |                               |        |  |        |        | ✓                                       | ✓                         | ✓     |                                   |                            |                 |       |       | ✓           | ✓      |
| Adrian Hayter<br>Associate NED               |                               |        |  |        |        |   | ✓                         | ✓     |                                   |                            |                 |       |       | ✓           | ✓      |
| Rajiv Jaitly<br>NED *                        |                               |        | ✓  | ✓      | ✓      |   |                           |       |                                   |                            | ✓               | ✓     | ✓     | ✓           | ✓      |

|   | Strategic Workforce Committee |        | Finance and Business Performance Committee |        |        | Quality & Clinical Governance Committee |        |       | Organ & Tissue Donation Committee | Charitable Funds Committee | Audit Committee |       |       | Trust Board |        |
|---|-------------------------------|--------|--|--------|--------|---|--------|-------|-----------------------------------|----------------------------|-----------------|-------|-------|-------------|--------|
|   | 8 Mar                         | 10 May | 23 Mar                                     | 20 Apr | 19 May | 9 Mar                                   | 21 Apr | 5 May | 5 May                             | No meeting in this period  | 4 Mar           | 4 May | 6 May | 31 Mar      | 28 Apr |
| Barry Jenkins<br>Director of Finance*                       |                               |        | ✓  | ✓      | ✓      |   |        |       |                                   |                            | ✓               | ✓     | ✓     | ✓           | ✓      |
| Graeme Johnston<br>NED * (SID)                              |                               |        | ✓  |        |        |   |        |       |                                   |                            | ✓               |       |       | ✓           |        |
| Tina Kenny<br>Medical Director *                            |                               |        | ✓  |        |        | ✓                                       |        |       |                                   |                            | ✓               |       |       | ✓           |        |
| John Lisle NED<br>* (from 1 April 2021)                     |                               |        |  | ✓      | ✓      |   |        |       |                                   |                            |                 | ✓     |       |             | ✓      |
| Andrew McLaren<br>Medical Director<br>* (from 1 April 2021) |                               |        |  | ✓      | ✓      |   | ✓      | x     | x                                 |                            |                 |       |       |             | ✓      |
| Bridget O'Kelly<br>Chief People Officer                     | ✓                             | ✓      |  |        |        |   |        |       |                                   |                            |                 |       |       | ✓           | ✓      |
| Tom Roche<br>NED*   | ✓                             | ✓      | ✓  | ✓      | ✓      |   |        |       |                                   |                            | ✓               | ✓     | ✓     | ✓           | ✓      |
| David Sines<br>Associate NED                                | ✓                             |        |  |        |        | ✓                                       |        |       |                                   |                            |                 |       |       | ✓           |        |
| Sandra Silva<br>Board Affiliate                             |                               | ✓      |  |        |        | ✓                                       |        | ✓     |                                   |                            |                 |       |       | ✓           | ✓      |

|   | Strategic Workforce Committee |        | Finance and Business Performance Committee |        |        | Quality & Clinical Governance Committee |        |       | Organ & Tissue Donation Committee | Charitable Funds Committee | Audit Committee |       |       | Trust Board |        |
|---|-------------------------------|--------|--|--------|--------|---|--------|-------|-----------------------------------|----------------------------|-----------------|-------|-------|-------------|--------|
|   | 8 Mar                         | 10 May | 23 Mar                                     | 20 Apr | 19 May | 9 Mar                                   | 21 Apr | 5 May | 5 May                             | No meeting in this period  | 4 Mar           | 4 May | 6 May | 31 Mar      | 28 Apr |
| David Williams<br>Director of Strategy & Business Development |                               | ✓      | x  | x      | ✓      |   |        |       |                                   |                            | ✓               |       |       | ✓           | ✓      |
| Ali Williams<br>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

**Meeting:** Trust Board Meeting in Public

**26 May 2021**

|                              |                            |  |
|------------------------------|----------------------------|--|
| <b>Agenda item</b>           | Board Attendance Record    |  |
| <b>Board Lead</b>            | Chief Executive Officer    |  |
| <b>Type name of Author</b>   | Senior Board Administrator |  |
| <b>Attachments</b>           | None                       |  |
| <b>Purpose</b>               | Information                |  |
| <b>Previously considered</b> | N/A                        |  |

### Executive Summary

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

|                 |  |
|-----------------|--|
| <b>Decision</b> | The Board is requested to note the contents of the report. |
|-----------------|--|

### Relevant Strategic Priority

|  |   |  |
|--|---|--|
| <b>Quality</b> <input checked="" type="checkbox"/> | <b>People</b> <input checked="" type="checkbox"/> | <b>Money</b> <input checked="" type="checkbox"/> |
|--|---|--|

### Implications / Impact

|  |   |
|--|---|
| <b>Patient Safety</b>  | Patient safety concerns are discussed by all members of the Board   |
| <b>Risk: link to Board Assurance Framework (BAF)/Risk Register</b> | Board risks are discussed by all members of the Board   |
| <b>Financial</b>   | Financial information is presented and discussed by all Board members   |
| <b>Compliance</b> Select an item. Select CQC standard from list.   | Compliance information and concerns are presented when appropriate and discussed by all Board members                                 |
| <b>Partnership: consultation / communication</b>                   | Not Required  |
| <b>Equality</b>  | Equality, Diversity and Inclusion information and compliance is identified in all Board reports and discussed by members of the Board |
| <b>Quality Impact Assessment [QIA] completion required?</b>        | Not Required  |

**Meeting:** Trust Board Meeting in Public

**26 May 2021**

|                              |   |  |
|------------------------------|---|--|
| <b>Agenda item</b>           | Private Board Summary 31 March 2021 & 28 April 2021 |  |
| <b>Board Lead</b>            | Chief Executive Officer                             |  |
| <b>Type name of Author</b>   | Senior Board Administrator                          |  |
| <b>Attachments</b>           | None  |  |
| <b>Purpose</b>               | Information   |  |
| <b>Previously considered</b> | N/A   |  |

### Executive Summary

The purpose of this report is to provide a summary of matters discussed at the Board in private on the 31 March 2021 and 28 April 2021. The matters considered at these sessions of the Board were as follows:

- Procurement Processes
- Business case for Carbon Energy Fund
- Patient Safety and Safeguarding / Vulnerable Patients Surveillance Report
- Excluded Practitioners
- Buckinghamshire Healthcare Projects Limited
- Capital Programme
- Finance Report
- Board Workplan
- 2021/2011 Financial Plan
- Operational Plan
- Integrated performance report and recovery
- Return on investment: Digital Strategy

|                 |  |
|-----------------|--|
| <b>Decision</b> | The Board is requested to note the contents of the report. |
|-----------------|--|

### Relevant Strategic Priority

|  |  |
|--|--|
|  |  |
|--|--|

|  |   |  |
|--|---|--|
| <b>Quality</b> <input checked="" type="checkbox"/> | <b>People</b> <input checked="" type="checkbox"/> | <b>Money</b> <input checked="" type="checkbox"/> |
|--|---|--|

### Implications / Impact

|   |  |
|---|--|
| <b>Patient Safety</b>   | Aspects of patient safety were considered at relevant points in the meeting              |
| <b>Risk: link to Board Assurance Framework (BAF)/Risk Register</b>              | Any relevant risk were highlighted within the reports and during the discussion          |
| <b>Financial</b>  | Where finance had an impact it was highlighted and discussed as appropriate              |
| <b>Compliance</b> <small>Select an item. Select CQC standard from list.</small> | Compliance with legislation and CQC standards were highlighted when required or relevant |
| <b>Partnership: consultation / communication</b>                                | N/A  |
| <b>Equality</b>   | Any equality issues were highlighted and   |

|   |                        |
|---|------------------------|
|   | discussed as required. |
| <b>Quality Impact Assessment [QIA] completion required?</b> | N/A                    |

## Acronym 'Buster'

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

## **B**

- BBE - Bare Below Elbow
- BHT – Buckinghamshire Healthcare Trust
- BME - Black and Minority Ethnic
- BMA - British Medical Association
- BMI - Body Mass Index
- BOB – Buckinghamshire, Oxfordshire, Berkshire West
- BPPC – Better Payment Practice Code

## **C**

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

## **D**

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

## **E**

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

## **F**

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

## **G**

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

## **H**

- HAI - Hospital Acquired Infection
- HASU - Hyper Acute Stroke Unit
- HCA - Health Care Assistant
- HCAI - Healthcare-Associated Infection
- HDU - High Dependency Unit
- HEE – Health Education England
- HETV - Health Education Thames Valley
- HMRC – Her Majesty’s Revenue and Customs

- HSE - Health and Safety Executive
- HSLI – Health System Led Investment
- HSMR – Hospital-level Standardised Mortality Ratio
- HWB - Health and Wellbeing Board

## I

- ICS – Integrated Care System

## M

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

## J

- JAG - Joint Advisory Group

## K

- KPI - Key Performance Indicator

## L

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

## M

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

## N

- NBOCAP - National Bowel Cancer Audit Programme
- NCASP - National Clinical Audit Support Programme
- NED - Non-Executive Director

- NHS – National Health Service
- NHSE – National Health Service England
- NHSE/I – National Health Service England & Improvement
- NHSI – National Health Service Improvement
- NHSLA - NHS Litigation Authority
- NICE - National Institute for Health and Care Excellence
- NICU - Neonatal Intensive Care Unit
- NMC - Nursing and Midwifery Council
- NNU - Neonatal Unit
- NOGCA - National Oesophago-Gastric Cancer Audit
- NRLS - National Reporting and Learning System / Service

## O

- O&G - Obstetrics and Gynaecology
- OBC - Outline Business Case
- ODP - Operating Department Practitioner
- OHD - Occupational Health Department
- OOH - Out of Hours
- OP - Outpatient
- OPD - Outpatient Department
- OT - Occupational Therapist/Therapy
- OUH - Oxford University Hospital

## P

- PACS - Picture Archiving and Communications System / Primary and Acute Care System
- PALS - Patient Advice and Liaison Service
- PAS - Patient Administration System
- PBR - Payment by Results
- PBR Excluded – Items not covered under the PBR tariff
- PDC - Public Dividend Capital
- PDD - Predicted Date of Discharge
- PE - Pulmonary Embolism
- PFI - Private Finance Initiative
- PHE - Public Health England
- PICC - Peripherally Inserted Central Catheters
- PID - Patient / Person Identifiable Data
- PID - Project Initiation Document
- PLACE - Patient-Led Assessments of the Care Environment
- PMO - Programme Management Office
- PPE - Personal Protective Equipment
- PP – Private Patients
- PPI - Patient and Public Involvement
- PSED - Public Sector Equality Duty

## Q

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

## R

- RAG - Red Amber Green
- RCA - Root Cause Analysis

- RCN - Royal College of Nursing
- RCP - Royal College of Physicians
- RCS - Royal College of Surgeons
- RIDDOR - Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
- RTT - Referral to Treatment

## **S**

- SAU - Surgical Assessment Unit
- SCAS / SCAmb - South Central Ambulance Service
- SHMI - Summary Hospital-level Mortality Indicator
- SI - Serious Incident
- SIRI - Serious Incident Requiring Investigation
- SIRO – Senior Information Risk Owner
- SID - Senior Independent Director
- SLA - Service Level Agreement
- SLR - Service-Line Reporting
- SLT / SaLT - Speech and Language Therapy
- SMR - Standardised Mortality Ratio
- SoS - Secretary of State
- SSI(S) - Surgical Site Infections (Surveillance)
- SNAP - Sentinel Stroke National Audit Programme
- STF – Strategic Transformation Fund
- STP - Sustainability and Transformation Plan
- SUI - Serious Untoward Incident

## **T**

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

## **U**

- UGI - Upper Gastrointestinal
- UTI - Urinary Tract Infection

## **V**

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

## **W**

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

## **Y**

- YTD - Year to Date

# Performance: April 2021 in numbers



**A&E attendances**

7,393  
April 2021

Number of people arriving in March: 6,763



**Emergency admissions**

3,497  
April 2021

The number of patients admitted to a hospital bed March 2021: 3,475



**Planned procedures**

3,268  
April 2021  
(3,324 - March 2021)

The number of elective day case and elective inpatient procedures carried out



**Outpatients contacts**

35,497  
April 2021

The number of patients receiving treatment in an outpatient clinic vs March 2021 33,911



**87**

The number of deaths during April 2021 vs 114 March 2021

Crude mortality: 1.5%  
- deaths expressed as % of the number of admissions (1.6% March 2020)



**A&E patients seen within 4 hour target**  
**82 %**

Percentage of A&E patients seen within 4 hour national target in April 2021 (82.% in March 2021)



**Friends & family test approval**  
**27%**

Percentage of patients who would be likely or extremely likely to recommend our services to their friends & family in April 2021 (39.4% in March 2021)



**Referral to treatment**

**52.6%**  
52.6% (Feb 2021)

National target for patients receiving treatment within 18 weeks of being referred in Apr 2021



**Total Falls**

53 - Apr 2021  
0 causing severe harm

(59 - March 2021, 0 severe)

We monitor the number of patient falls and grade the severity of harm each month



**Cancer 2 week wait for referral**

**99.1%**  
(98.3% March 2021)

Percentage of cancer patients referred receiving first appointment within 2 weeks March 2021 (reported 1 month in arrears)



**Cardiac arrests**

**1** - Apr 2021  
(2 - Feb 2021)

We are committed to achieving the elimination of all avoidable cardiac arrests



**Pressure ulcers**

**4** grade 3&4 Apr 2021  
(3 grade 3&4 - March 2021)

We monitor the number of pressure ulcers acquired each month and grade the severity

**Joiners total: 174**  
Nursing: 27  
Clinicians: 26  
Health care assistants: 31  
Administrative: 35 Support: 43  
Allied health professional: 12

Number of staff who joined/left in March & April 2021

**Leavers total: 175**



**Training modules delivered**

**9684**

9724 (March 2021)

Number of staff training modules delivered by our learning and education team in Apr 2021