

Quality account 2018-2019



Safe &
compassionate
care,

every
time

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Introduction

The Quality Account is an annual account to the public about the quality of services that we provide and deliver and our plans for improvement. The requirement to produce a Quality Account is outlined in the NHS Act 2009 and in the terms set out in the collective Quality Accounts Regulations 2010 and the Amendments Regulations 2017.

The Quality Account incorporates all the requirements of the Quality Account Regulations and 2018/19 reporting requirements as set out by NHS Improvement. The Quality Account specifically aims to improve public accountability for the quality of care that is contained within the Trust's overall annual report.

Our quality improvements are reported in 3 categories:

- Implementing a culture of safety
- Listening to our patient voice
- Developing a learning organisation

This report also includes feedback from our stakeholders on how well they think we are doing. The publication of this document is one of the ways in which we are able to share our evidence on the quality of care we provide to our patients.

A guide to the structure of this report

This Quality Account summarises performance and improvements against the quality priorities and objectives which were set for 2018/19 and outlines the quality priorities and objectives which have been set for 2019/20.

- Part 1** Statement on quality from the Chair and Chief Executive Officer and speciality achievements for 2018/19
- Part 2** Priorities for improvement and statements of assurance from the Board
- Part 3** Further aspects on quality improvement

Your Feedback

If you have any comments or suggestions on this Quality Account, we would welcome your feedback. Please contact: Mrs Carolyn Morrice, Chief Nurse, through our Patient Experience Team's advice and liaison service on: email: bht.pals@nhs.net

Trust Profile

Buckinghamshire Healthcare NHS Trust is a major provider of integrated hospital and community services for people living in Buckinghamshire and surrounding counties, providing care to over half a million patients every year. In addition we provide specialist spinal services at our world renowned National Spinal Injuries Centre for patients across England and internationally. The Trust is also the regional centre for burns and plastics services.

Our aim is to provide safe and compassionate care, every time to our patients. Our highly trained doctors, nurses, midwives, health visitors, therapists, healthcare scientists and other support staff deliver this care.

We deliver our services from a network of facilities including:

- A range of community settings - health centres, schools and patients' own homes
- Three community hospitals in Amersham, Buckingham and Chalfont & Gerrard's Cross.
- Two community hubs at Thame and Marlow.
- Two acute hospitals located in the two most densely populated areas of Buckinghamshire – High Wycombe and Stoke Mandeville, Aylesbury.
- Florence Nightingale Hospice based on the Stoke Mandeville site, Aylesbury.

Over 6,000 members of staff provide care to approximately half a million people, including the dispersed population of Buckinghamshire and the surrounding areas of Thame (Oxfordshire), Tring (Hertfordshire) and Leighton Buzzard (Bedfordshire). We are recognised nationally for our spinal rehabilitation services, urology and skin cancer services. We are also a regional specialist centre for burns care, plastic surgery, stroke, cardiac services and dermatology.

The acute hospitals

- Stoke Mandeville Hospital, Mandeville Road, Aylesbury HP21 8AL
- Wycombe Hospital, Queen Alexandra Road, High Wycombe, HP11 2TT.

Our main community facilities

- Amersham Hospital, Whielden Street, Amersham HP7 0JD
- Buckingham Hospital, High Street, Buckingham MK18 1NU
- Chalfont & Gerrard's Cross Hospital, Hampden Road, Chalfont St Peter SL9 9SX
- Marlow Hospital, Victoria Road, Marlow SL8 5SX
- Thame Community Hospital, East Street, Thame OX9 3JT
- Florence Nightingale Hospice, Stoke Mandeville Hospital, Mandeville Road, Aylesbury HP21 8AL
- Rayners Hedge Rehabilitation Unit, Croft Road, Aylesbury, Buckinghamshire HP21 7RD.
- Camborne Centre, Jansel Square, Bedgrove, Aylesbury HP21 7ET

Our Trust headquarters are at Stoke Mandeville Hospital

Visit our website for more details on our services www.buckshealthcare.nhs.uk

PART ONE

Statement on Quality from the Chair and Chief Executive

We have continued make good progress during 2018/19 in spite of the ever-increasing demand on our services and continued financial pressure. We have a team of highly skilled professionals who deliver outstanding care in areas such as cancer and stroke, colorectal surgery (we are the highest performing Trust in the country by volume and outcomes) and spinal injuries and our family nurse partnership delivers the best outcomes supporting first time young mums and families across the county. We are particularly proud that the Trust is now seen as a national exemplar for the work being undertaken by our medical examiners, which is key in helping us to learn from deaths.

Over the next decade, the population of Buckinghamshire is predicted to grow by approximately 40,000. There will be a growth in children and older people but fewer people of working age. Whilst people are living for longer, they may not be in good health with more and more people being diagnosed with obesity, diabetes and dementia.

Working closely with our Integrated Care System partners (which include GPs, the Council, Ambulance Service, Commissioners and Mental Health services) we are committed to ensuring that we address these challenges supporting the people of Buckinghamshire to lead happy and health lives, receiving outstanding care when and where they need it.

To achieve this, we have set new corporate objectives for the next two years:

Improving our culture by:

- Listening to and involving our patients
- Making it easier to get things done
- Encouraging and supporting our staff to make small changes that make a big difference
- Using a systematic method to implement long-lasting improvements
- Learning from each other and our experiences

Introducing new models of care:

- Developing new models of care and staffing to make sure we have the right people, with the right skills working together to deliver outstanding patient care
- Making the Trust a great place to work
- Developing talent and ensuring we have inclusive workforce that celebrates equality and diversity

Addressing health inequalities and clinical variation by:

- Building community partnerships which help us to support hard to reach groups such as the homeless
- Getting it right first time to improve the experience for our patients
- Making the best use of our buildings and resources
- More effective use of digital technology

We would like to thank and praise all the staff, board members and volunteers who have worked so hard to support our patients and service users over the past year. We are very fortunate to have such a dedicated and skilled team and we are proud of everything they have achieved. Our thanks also go to our partners, key stakeholders and local communities for your continued support and encouragement.



Hattie Llewelyn-Davies, Chair



Neil Macdonald, Chief Executive

Divisional achievements for 2018/19

Division of Surgery and Critical Care

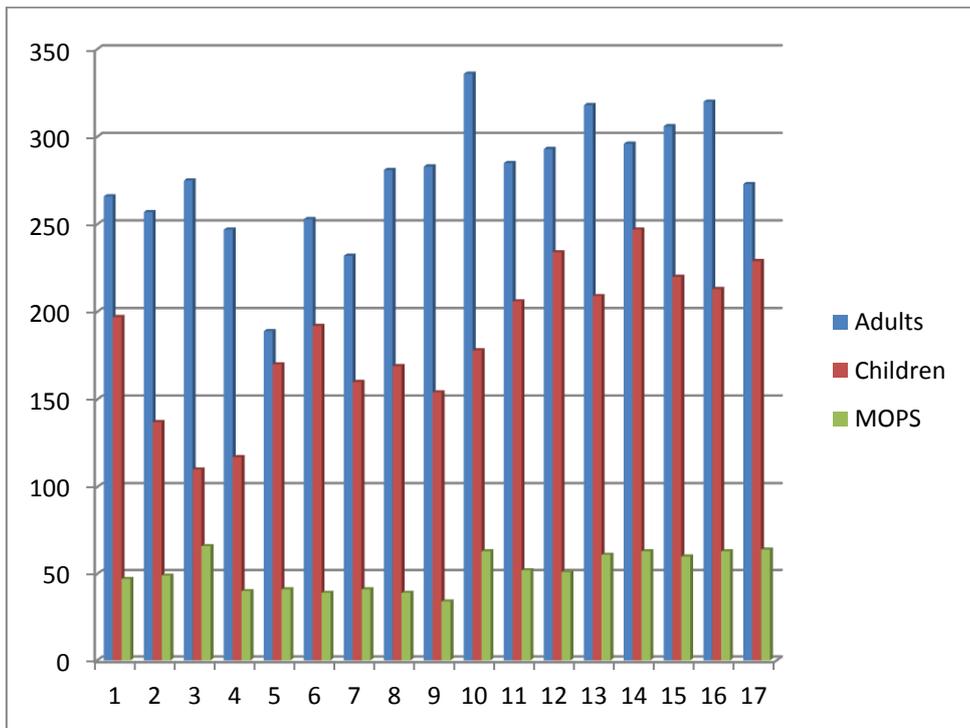
Improved patient experience in Surgical and Plastics Emergency Ambulatory Care (SPEAC)

SPEAC provides a consultant-led daily ambulatory emergency clinic for both plastic surgery and general surgery services. This allows for first class diagnostics and early treatment of emergencies in a safe and welcoming environment.

The new system has been running since October 2017, and the demand for the service continues to increase – reflecting population growth as well as the growing need for this service from the emergency department, Minor Injury Units and GPs.

Below is a table demonstrating the work-load for plastic surgery trauma in the last 17 months for both adults and children alongside (Major) the minor case operating procedures undertaken (MOPs).

In the last three years, we have seen an increase from 400 patients per month to 580 patients per month, not including the adult burns which account for an additional 60 patients per month.



Ophthalmology Vanguard mobile theatre

The Trust has installed temporary operating theatres at Stoke Mandeville to help its ophthalmology team tackle a backlog of patients requiring cataract surgery.

Phacoemulsification with Intraocular Lens (IOL) Implantation (commonly known as cataract surgery) is the most common procedure carried out within the NHS. With a growing and ageing population there is a national backlog of patients waiting for treatment and the Royal College of Ophthalmologists predict numbers will increase by 25% in the next 10 years. The Trust recorded a 24% increase in the number of procedures carried out from April 2017- March 2018 in comparison with the same period the previous year.

This initiative, led by consultant ophthalmologists, with support from Buckinghamshire Clinical Commissioning Group, allowed the Trust to rent a Vanguard theatre service (temporary theatre) for a three month period to help clear the backlog of patients requiring cataract surgery. Uniquely, the surgery was provided by the Trust's own consultant ophthalmologists, who agreed to provide extra operating sessions in what would normally be non-clinical time.



Patient feedback (16 January 2019):

“Stoke Mandeville Ophthalmology Department are to be congratulated for their can do/proactive initiative in the provision of the mobile Vanguard unit to tackle the cataract surgery backlog. I attended on 16 January and found the whole process was well organised, efficient and above all, very sympathetic and patient orientated. Particular praise is due to Dorcia who coordinated the process in a wonderfully efficient and friendly manner. She put

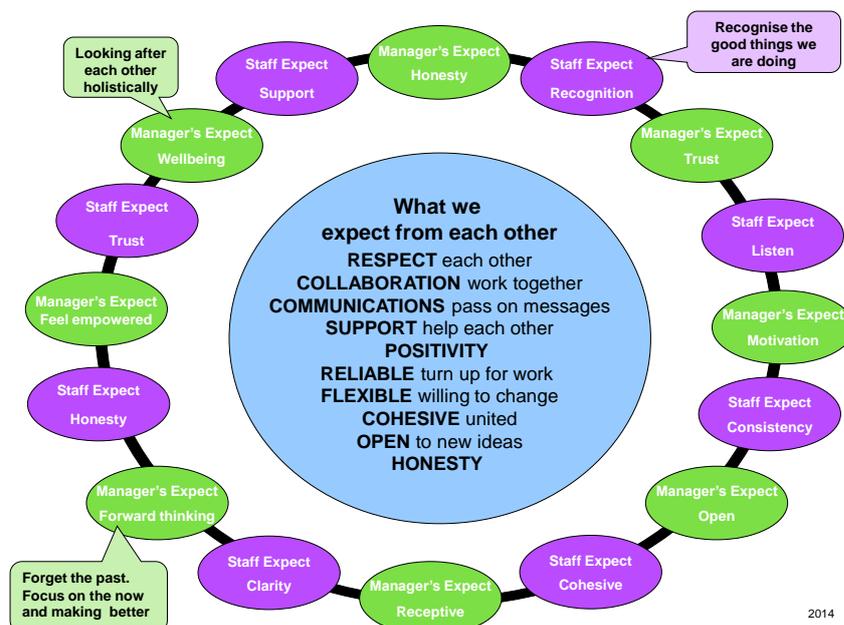
patients at their ease - instantly endearing her to all of us. She is a star and a shining example of what patient care can and should be.”

Theatres cultural improvement programme



We have successfully undertaken a focused piece of work within theatres to proactively address safety standards and change a fragile low trust, low morale culture into a sustainable high trust, high morale, solution-focused culture.

A theatre leadership team has been created with a shared voice and vision alongside a theatre values and behaviour charter which has been collectively agreed and implemented. Motivated and empowered team leaders are now more willing to courageously challenge and uphold performance standards and there is an upsurge of accountability, respect and pride.



Staff now report feeling heard, understood and valued. Feedback revealed that mid-level leaders are now working closely with staff to find solutions to long standing problems.

Anaesthesia Clinical Services Accreditation (ACSA)

Anaesthesia Clinical Services Accreditation (ACSA) is a voluntary scheme run by the Royal College of Anaesthetists for the NHS and independent sector organisations, offering quality improvement through peer review.

The ACSA standards are considered 'above and beyond' the Guidelines for Provision of Anaesthetic Services (GPAS) that the Quality Care Commission (CQC) uses as its benchmark. The overall aim is to improve and standardise the provision of anaesthetic services across the UK.

The scheme is recognised by the Care Quality Commission (CQC) and the Healthcare Quality Improvement Partnership (HQIP) and there are some 27 accredited anaesthetic departments in the UK though none, so far, in the Thames Valley area.

The ACSA standards cover the whole of anaesthesia throughout the peri-operative period including pre-operative assessment, peri-operative care, post-operative care and discharge and follow-up, where appropriate, for all surgical specialities provided by Buckinghamshire Healthcare NHS Trust (BHT).

We signed up for the ACSA scheme in 2016 and received our review visit by ACSA committee representatives September 2018. We have received informal feedback from the review team, as well as a draft report, and await the final formal report and accreditation.

Informal feedback highlighted some minor work to be done on policies and infrastructure, 80% of which has already been completed. It also highlighted areas of outstanding performance, some of which will be presented to the ACSA Committee for inclusion in future ACSA standards (medical examiners, excellence reporting, speak-up boards and theatre quality and safety meetings).

The reviewers also praised the overall culture of safety and quality across the whole Trust, the level of managerial support, the involvement of and support of specialty and associate specialist (SAS) anaesthetists and the pre-operative assessment service.

Medical Support Workers (MSW) – their role in venous thromboembolism (VTE) prevention

The newly created Medical Support Worker (MSW) role was generated within General Surgery to assist in supporting the junior doctors with the increasing burden of administrative, non-clinical tasks. For example:

- Updating patient location details
- Looking up blood test results and scans
- Checking antibiotic review dates
- Checking VTE compliance
- Checking sepsis and MRSA stickers
- Entering blood & scan results into handover notes
- Performing and helping senior surgeons with their audits
- Collecting and checking data
- Working on the comorbidity coding forms and discharge summaries

Since the introduction of the MSW role on the surgical floor, there have been no serious incidents declared in general surgery patients since April 2018 for VTE. The compliance with VTE prophylaxis clinical guidelines has been greatly improved with the support of the MSWs.

The role has been very well received by the trainees and the consultants and there are now eight MSWs across all of Surgery, Plastics, T & O and Urology.

Integrated Elderly and Community Care (IECC)

CIRCLE (Correlate Intelligence Responsibly, Circulate Learning Effectively)



This year the division has designed and is embedding a unique shared governance model, to support staff across specialities to be involved in improving the care they deliver.

Each month a CIRCLE report is circulated to every member of staff. The report contains key information on all aspects of clinical governance and learning from incidents, complaints, excellence reporting, learning from deaths, clinical audits completed and outstanding, good news stories and key performance indicators relating to quality that are aligned with Trust and divisional objectives and what is important to staff.

It is expected that each team will review where they are and choose a topic to focus on for that month. The most important part of this is all team members are involved in reviewing relevant data to them, planning how they could make improvements and understand the infrastructure in place to support them to make decisions and improvements that matter to them and their patients.

CIRCLE is about leading from the frontline through shared governance, having access to a comprehensive report on a monthly basis where the information is clear and data is presented in a way staff can relate to daily clinical practice, enabling staff to feel involved, informed and engaged with the Trust quality agenda.

Community Hubs and Community Assessment and Treatment Service

Development of Thame and Marlow Community Hubs has continued through 2018/19 with the following achievements:

- Provided the Community Assessment and Treatment Service (CATS) including a frailty assessment service where geriatricians, nurses, therapists and GPs provide expert

assessment, undertake tests and agree a treatment plan to help frail older people to stay at home and avoid an A&E visit or hospital admission.

- Introduced a pathway for the ambulance service to consider CATS as an alternative to taking an older person to A&E
- Provided additional diagnostic facilities such as 'one-stop' blood tests and x-rays
- Following the success of the 'Cancer Care Closer to Home' outreach site at Marlow Community Hub, where over 250 patients received line care, pre-chemotherapy assessments and certain oral and subcutaneous cancer treatments during the first year, the service is now also running out of Thame Community Hub.
- Falls specialist led clinics have been run out of both Hubs and a 'Better Balance' strength and balance class out of Marlow Community Hub
- Developed links with Specialist Nurses such as Nutrition Specialist Nurse

Provision of outpatient clinics continues to grow.

The Community Assessment and Treatment Service (CATS) operates from 9am to 5pm at Marlow on Mondays, Wednesdays and Fridays and Thame on Tuesdays and Thursdays. There is a Geriatrician on site in the mornings and a GP in the afternoon.

Quality of service is measured through a Patient Experience Questionnaire. 99.6% of patients who complete the surveys rate the service as good or excellent. 95.9% are likely or extremely likely to recommend the service to friends and family.

97.8% of patients seen in CATS return to their usual place of residence with 2.2% requiring transfer to either the Cardiac and Stroke Receiving Unit or A&E.

A 6 month audit showed that just 3% of patients assessed in CATS present to A&E within 28 days of attendance.

Community Hubs have been shortlisted as finalists for a Health Service Journal (HSJ) award in the category of Improving Value in the Care of Older Patients

Following on from the success of the 'Café' type forums in 2018 we have consulted with a number of people using inpatient facilities and decided to launch monthly forums called 'Big Conversation Cafes' from April 2019. These will be advertised within Thame and Marlow and we will be inviting people to come and talk about 'big stuff' like nutrition, falls worries, power of attorney and stress levels. Feedback will be collected at each session. If we identify someone who needs a clinical assessment we can refer to CATS.

The Dementia Specialist Nurse

The Dementia Specialist Nurse demonstrates a high level of expertise and skill in understanding the needs of people living with memory problems and/or dementia, their families and carers.

The service is visible within acute hospital services and provides much-needed support to frontline clinicians to enable them to better support the patients in their care.

The key areas of focus in the work of the Dementia Specialist Nurse are:

- To ensure BHT services are meeting the needs of people living with memory problems and/or dementia.
- To help patients access to acute healthcare services for people living with memory problems and/or dementia.
- To help obtain reasonable adjustments to support the often complex care needs of this group of patients and to avoid preventable harm or untimely deaths within this vulnerable group.
- To adopt a consultative and advocacy role to facilitate inter-agency and inter-professional communication in primary care and mainstream services.
- To provide opportunities for learning to all hospital staff. This takes the form of regular monthly dementia awareness sessions and ad-hoc on-demand sessions tailored to specific clinical areas and professional groups.

BHT aims to screen every patient over the age of 75 years to allow early recognition of potential cognitive problems; enabling timely treatment and/or sign-posting to appropriate agencies.

Some of the comments received over the last year:

- “A familiar face makes all the difference! But, please pass my thanks on to the rest of the team.”
- “Thank you so much for all your support & good wishes.”
- “Thank you for all your help and support.”
- “Thank you so much for all your help and, in particular, your support over the last ten weeks; it has been invaluable. Once again we are indebted to you!”

Podiatry integrated service

Podiatry is an integrated countywide service delivering care in various locations such as, in-patient wards, outpatient clinics, GP surgeries, health centres and patient homes. The Booking Hub at Brookside Clinic, Aylesbury is the single point of access for the county where all referrals are received, registered and triaged. The team is made up of 26 podiatrists and 6 podiatry assistants who treat a case load of 13,300 patients with approximately 575 new referrals and 2,840 attended treatments each month.

The service objectives are:

- Provide optimal healing times for foot wounds to minimise foot and lower leg amputation and avoid hospital admission.
- Improve quality of life through pain relief & optimal foot function via prescription of insole/ orthotics/ footwear.
- Prevent further deterioration of chronic foot deformities & maintain mobility/ independence.
- Prevent infection and pain by performing partial/ total nail operations, 440 operations annually.
- Risk-rate all our patients to predict their likelihood of ulceration/ amputation.

Quality and outcomes are measured by the use of:

- Manchester Oxford Foot questionnaire implemented in Musculoskeletal (MSK) and Rheumatology clinics.
- Submission to the National Diabetes Foot Audit to benchmark BHT Podiatry Service against national outcomes for non-elective amputation rates.
- Root Cause Analysis techniques are used to identify gaps in service operating procedures and to provide safer patient care.
- The 'Putting Feet First' inpatient diabetic screening team managed to screen and risk-rate an impressive 1,691 patients in 2018 of which 232 patient had active wound.

Photo on following page is of some members of the Amersham team who provide High-Risk and Rheumatology care.



In 2018, 537 questionnaires were sent out for a patient engagement event in the south of Buckinghamshire with 41% completed questionnaires returned. The overwhelming majority of respondents felt the podiatry service provides a good or excellent service (95%).

Therapy and Nurse Led Unit (TNLU)

The Therapy and Nurse Led Unit was established in December 2018. It is based at Stoke Mandeville Hospital and sees patients aged 18 and over. However, the majority of the patients are over 65 years of age.

The Friends and Family Test (FFT) will continue to be used to monitor patient experience, alongside the 'Perfect Ward' and safety audits to establish the safety and effectiveness of TNLU. Current scoring shows a high level of patient satisfaction with the service.

The vision for TNLU is to provide an efficient rehabilitation care pathway for patients reducing their need for care in the community.

Ward 9 acute medicine for older people (MFOP) inpatient ward

The ward consists of 22 inpatient beds for the elderly, led by an acute geriatrician working with the multidisciplinary team (MDT). The MDT consists of doctors, nurses, pharmacists, dieticians, social workers and therapists. The team also has a nurse consultant for older people. Together they work to deliver individual patient focussed care at all times.

The MDT has expertise in managing the older adult with frailty. The team undertakes early assessments for the acutely unwell frail elderly population in Buckinghamshire. The aim is to

support discharge and prevent readmission by providing high quality clinical and preventative care to improve the health of elderly adults with multiple conditions and complex needs.

Community Head Injury Service (CHIS)

The Community Head Injury Service (CHIS) provides core inter-disciplinary community brain injury rehabilitation, specialist brain injury vocational rehabilitation and specialist family services for people with acquired brain injury and their family and friends.

CHIS is based at the Camborne Centre, Aylesbury, providing services at the centre, in the home, in the workplace and other community settings (voluntary, leisure and service - eg Job Centre).

Achievements / developments in 2018/19 include the following:

- Contribution to establishment of new Thames Valley Acquired Brain Injury Forum
- Piloting a medical assessment clinic with consultant ortho-geriatrician
- Pilot of pre-vocational training module in conjunction with Headway staff at Bedford
- Development of draft job search tool kit
- Development of prompt sheet for employers and clients covering reasonable adjustments for aphasia
- Inclusion of client helper in last 'Managing Life and Fatigue Group'
- Information on Educational and Cognitive Groups has been reviewed and updated in light of increasing referrals of people with forms of acquired brain injury other than head injury
- CHIS staff involved in setting up disability awareness event and setting up disability network for BHT staff
- Completion and evaluation first run of new sex and sexuality after brain injury group
- Contribution to development of patient materials on use of technology in health care as part of Allied Health Professional Technology Networking Group

CHIS staff with Headway were 'Highly Commended' in British Medical Association Patient Information Awards 2018 for their Booklet on Sex and Sexuality.

Elderly Consultant Physician of the Day (ECPOD)

From 4 March 2019, the role of ECPOD was introduced, covered by a consultant geriatrician. The ECPOD assists the Physician of the Day (POD) in seeing patients aged 78 and over who were admitted the previous day and overnight. The ECPOD will also provide medical advice

to the Therapy and Nurse Led Unit if required, contribute to the supervision of junior doctors and will share learning regarding frailty trustwide.

The service quality will be measured by recording and analysing the following information.

- Number of patients on post-take ward round
- Number of patients on post-take ward round who are over 78
- Number of over 78 year olds seen by ECPOD
- Number of discharges made by ECPOD
- Number of community service referrals made by ECPOD
- Number of inappropriate tests/treatment avoided by ECPOD
- Number of treatment escalation plans (TEPS) completed
- Number of DNARs (do not actively resuscitate) put in place when required
- Feedback from acute staff
- Feedback from geriatricians
- Feedback from junior doctors.

Occupational Therapy (OT)

Occupational Therapists (OTs) are on all acute sites, community hubs and community hospitals enabling patients to maximise their functional abilities in Acute Medicine, Trauma and Orthopaedics, Hand Therapy, Rheumatology and Burns, Stroke rehabilitation, Neurological Rehabilitation, Cardiology, Accident and Emergency, Community Acute Rehabilitation, Community Assessment and Treatment, and in the Rapid Response and Intermediate care localities.

Achievements so far:

- Continued to gain a high score (nationally derived) for OT intervention for outcomes in Stroke treatment
- Collaboration with Wexham Park Hospital to streamline discharge plans for Buckinghamshire patients
- Enabled patients with Parkinson's in their home by having a timely, responsive OT outreach service reducing the number of patients requiring hospitalisation
- Hand Therapy held a conference and invited Derby Hospital renowned in hand therapy to support and to advise and gained very positive feedback regarding our service

- Continue to work very successfully alongside our nurse colleagues, shortening overall length of stay, enabling effective discharge and supporting the nurses to encourage patients to do what they can independently.

Going forward:

- Continue to work alongside our nurse colleagues to maximise the community hospital experience
- Work with acute and community colleagues together streamlining processes and reducing any duplication
- Work with social care colleagues on projects to benefit the integrated care system, for example, regarding equipment provision and care handling

Queens Nurses - Community Nursing

In June 2018 four District Nurses were awarded the Queens Nurse status for demonstrating a high level of commitment to patient care and nursing practice. Applicants must have worked in the community setting for at least 5 years and need to complete a significant piece of written work as part of the application process to demonstrate how the nurse meets both the ethos of the Queens Nursing Institute (QNI) and their overarching approach to nursing. Testimonials are obtained from patients, and from each nurse's manager.

The QNI provides a supportive network of community nurses who link via regional meetings and the annual conference. It offers formal recognition of commitment to improving nursing care in the community.

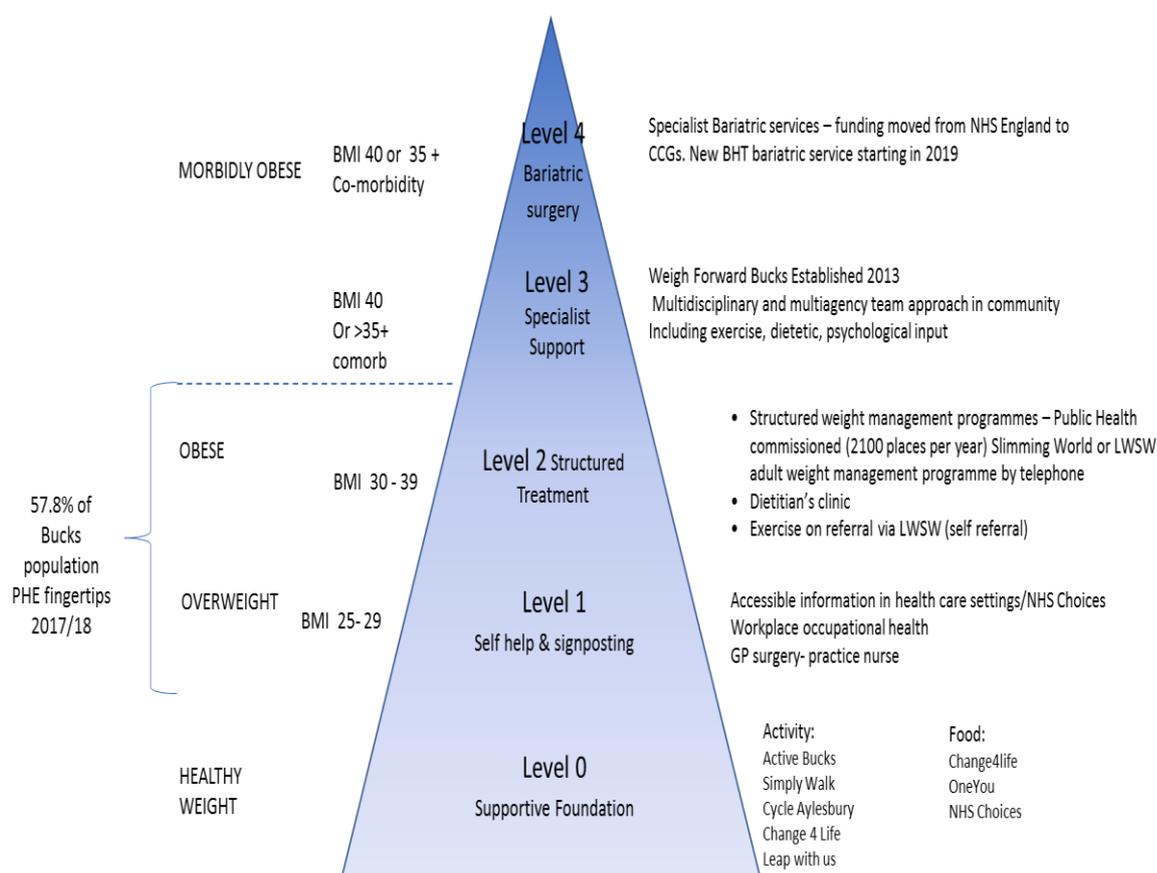


There is access to developmental programmes and this year Helen Mehra, lead nurse community nursing and transformation, was the Trust's first attendee on the QNI Executive Leadership Programme. This course is designed to bring about transformational change enhancing efficiency and productivity in a challenging financial climate.

‘Weigh’ Forward Bucks

Weight Forward Bucks is a collaboration between Buckinghamshire Healthcare NHS Trust and Oxford Health NHS Trust. It is a specialist Tier 3 weight management service run by the department of Nutrition and Dietetics that offers:

- A year long programme of 16 group sessions, and two one to one sessions
- 7 groups per year, with a maximum of 14 people per group
- 98 places available per year, with no waiting list currently
- Daytime and evening sessions, in the north and south of the county, groups start at three points during the year (January/February, April/May, September/October)



Our clients’ weight difficulties are often complex and multifactorial and they have all tried other weight loss approaches in the past without lasting success. Despite this, we have achieved the following:

- Attendance – almost 60% of participants completed the course
- Weight loss – 43% lost at least 5kg by the end of the course

- BMI - 65% of patients had a BMI decrease of more than 1 point
- Quality of Life – 52% of patients whose Quality of Life information we obtained reported improved Quality of Life
- Feedback – 91% of those who provided feedback said that they would recommend the programme to others

Palliative Care

Based at Florence Nightingale Hospice, the palliative care service consists of inpatient beds, community specialist nurses that cover both the north and the south of the county working closely with our community colleagues. A day hospice offering support and review for patients, a bereavement listening team of volunteers, lymphoedema specialist nurse, 24/7 carers for the north of the county and the hospital and in-reach palliative care team covering Stoke Mandeville, Wycombe and Amersham hospitals.

The team support palliative and end of life care patients and their loves ones.

Quality is measured by satisfaction surveys. These always return positive responses across all palliative care services.

Achievements in 2018/19 are:

- Launch of 'Purple Rose' initiative to support end of life patients to be recognised and to ensure appropriate plans are put in place to meet individual needs.
- New end of life care plans, advance care plans and treatment escalation forms being rolled out across the Trust



Wheelchair Service

The Wheelchair Service is based at Amersham Hospital.

The service assesses adults and children of all ages who meet the criteria for the service, and have a Buckinghamshire General Practitioner. The team undertakes assessments in a clinic, or at home. Clinics are held at the Halton Multiple Sclerosis (MS) centre, schools and the National Society for Epilepsy (NSE) centre.

The service has introduced new clinics particularly for children so that they are seen quickly.

Patient experience questionnaires are used to monitor the quality of the service and make changes to improve the service and make more effective.

Speech and Language Therapy (Adults and Acute Paediatrics)

Speech and Language Therapists (SLTs) work on the wards, in outpatients and out in the community in hubs, care homes, people's homes, community centres and outpatient facilities.

SLTs sees patients who have had a stroke, or who have Motor Neurone Disease, Multiple Sclerosis, Dementia, Parkinson's disease, voice disorders, head and neck cancer and patients on the Spinal Unit and in intensive care as well as the neonatal unit.

Achievements this year include:

- The Stroke SLT Team achieved an 'A' rating in SSNAP (Sentinel Stroke National Audit Programme)
- The SLT team worked with Scannappeal to fund a new endoscopy scope and set up a FEES (Fiberoptic Endoscopic Evaluation of Swallowing) service at Stoke Mandeville Hospital
- IDDSI (International Dysphagia Diet Standardisation Initiative) was introduced across the organisation
- Training and activities were organised for International Swallowing Awareness Day
- Carer training was organised on the Stroke Unit
- Excellent patient feedback was received regarding the Joint Voice Clinic

Next year we are working with therapists across the region to improve the SLT Service to people with head and neck cancer diagnoses.

Integrated Medicine

Emergency Department (ED)

Friends and Family Test (FFT)

ED has been piloting software (Envoy) to analyse FFT data. The second month of full data is now available and this pilot is scheduled to run for six months.

The pilot offers the opportunity to analyse real time data by theme, sentiment and mood. The Envoy platform provides unlimited access to information in an easy to understand format.

As a result of the Envoy FFT Pilot, ED has a clearer picture about the feedback from patients.

Benefits seen since the pilot began are:

- An increase in ED's FFT response rate from an average of 8% to over 27% in December 2018
- Live voice messages are relayed to staff as patient stories and used to encourage staff and drive improvements in the department
- Live patient feedback is immediately reviewed and acted on by the governance lead and matron in ED
- Access to daily FFT data showing at a glance the words and phrases patients are using the most and the context in which they appear
- Design and run bespoke surveys and analysing data instantly to show the team where the areas for attention are
- Identify areas for improvement based on last year's winter feedback and triangulating it with this year's data

Top themes reported in December 2018 feedback

Top 10 Themes			
+ Positive		- Negative	
1. Staff attitude	442	1. Staff attitude	53
2. Implementation of care	236	2. Environment	47
3. Waiting time	174	3. Waiting time	42
4. Environment	129	4. Clinical Treatment	40
5. Clinical Treatment	107	5. Communication	32
6. Admission	104	6. Implementation of care	29
7. Communication	93	7. Patient Mood/Feeling	20
8. Patient Mood/Feeling	60	8. Admission	18
9. Staffing levels	26	9. Staffing levels	14
10. Catering	9	10. Catering	2

ED data can be themed to show immediate feedback information about specific issues data from December 2018 has provided the following:

- Staff attitude was the most positive recorded feedback and it was also the most negative aspect of the feedback as well
- The length of time waited was both the third most recorded compliment and the third most recorded concern.
- Patient mood suggests the majority of visitors to ED report positive mood whilst in the department.

The Pilot is due to finish in May 2019.

Comfort Packs

Following an initiative started by a local Brownie pack, where packs were put together and delivered to the ED department last summer as part of a brownie badge, the department liked the idea so much they have continued to provide packs for patients who were not expecting to stay in. The packs contain wipes, tissues, comb, toothbrush and toothpaste.



ED Intranet project

ED identified the need for a way to share information between team members. A way to communicate, share learning, give easy access to information, provide an audit trail for all communication, make information sharing interesting, make the senior management team approachable and most importantly make this information available to the team from home and via mobile devices.

After research it was agreed to launch an Intranet (private network) which was launched in January 2019.

The new intranet has received very positive feedback and engagement from every team member since its launch. Its content is growing on a daily basis.

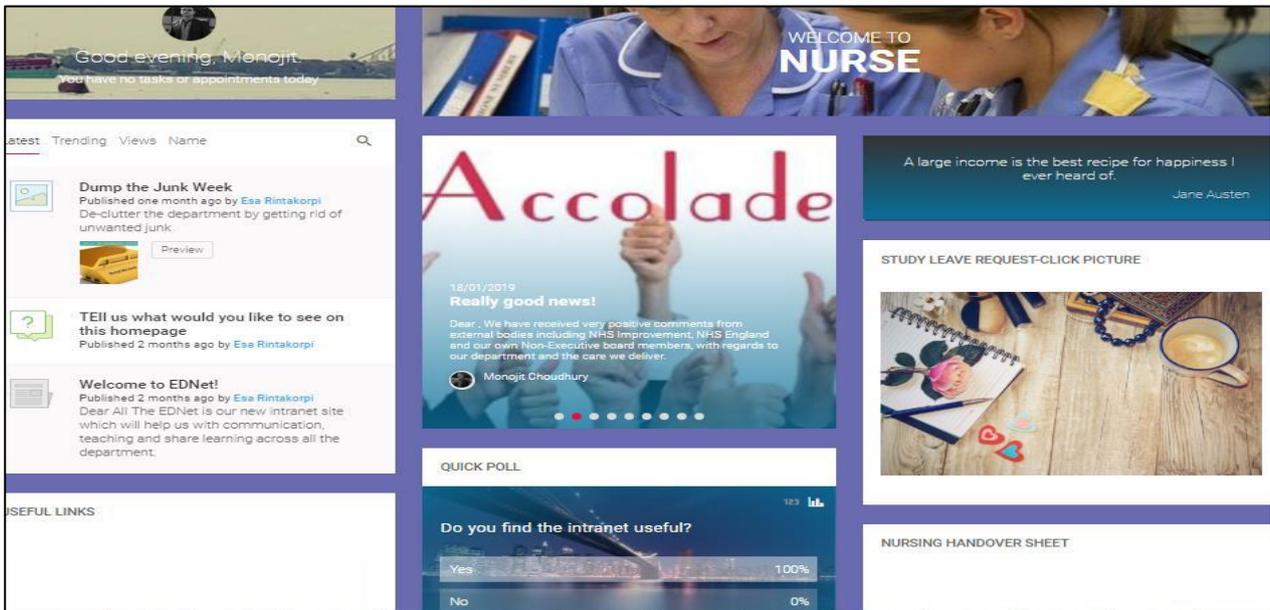
Features of the intranet

- Countdown to important events
- Share important information using banners
- Gives the team the ability to directly feedback to senior team and provide audit trail for actions taken
- Ask interactive questions
- Share patient feedback
- Get a snapshot of how people are feeling at work through quick polls

- Share learning
- Encourage people to write blogs
- Encourage people to read interesting topics beyond medicine
- Give staff interesting ECGs, radiology and journal links to read to keep up-to-date
- Dedicated pages for different groups of team members
- Dedicated governance page
- Policies and guidelines in one place and access from home and mobile device as well
- Dedicated mental health page with access to important information, all the forms and policies linked to mental health
- Recording of handover sheet electronically

The screenshot shows a website dashboard for the Emergency Department. At the top left, a blue banner says "Good evening, Monojit. You have no tasks or appointments today". The main header area features a "WELCOME TO EMERGENCY DEPARTMENT" message with a floral background. Below this, a yellow banner displays "88% Positive recommendation for January 2019" next to an icon of three people labeled "The Friends & Family Test". On the right, there is a "Academic Half Day" countdown timer showing 17 hours, 19 minutes, and 20 seconds, with a button to "Have a look into the programme". A vertical sidebar on the left contains links to "Doctor's Homepage", "Policies & Guidelines", "Nurses Homepage", "Clinical Governance", and "ENP Homepage". At the bottom right, there is a "DEPARTMENTAL UPDATES" section.

The screenshot shows a "LIFE FACTS" section with two featured articles. The first article, dated 25 FEB, features a photo of a street lamp and is titled "10 Things You Need to Know to Have a Strong, Happy Relationship". It includes the quote: "The most painful thing is losing yourself in the process of loving". The second article, dated 22 FEB, features a photo of a rainbow over a green landscape and is titled "We Keep Going, One Tiny Step at a Time, and We Should Be Proud". It includes the quote: "Don't wait until you reach your goal to be proud of yourself. Be proud of every step you take."



Emergency Department Buddies

A daily presence of buddies and volunteers help provide food and refreshment to our patients. They talk to patients and explain what to expect when in the department. They receive great feedback and are integral to the smooth running of the department and the patient experience.



Sepsis

The department has a sepsis nurse who works with all members of staff to improve the uptake of sepsis screening and treatment. Monthly audits are undertaken and the results shared widely with ED staff. 'Sepsis Stars' are awarded to those members of staff who have shown 'excellence' in recognising and treating patients with sepsis.

Results for April 2019 can be seen below, the best results on record as yet.

- Paediatrics – 100% screened for sepsis
- Adults – 86% screened for sepsis
- Total 90% screened

The audit also detailed those patients who were not screened or treated as per the guidance pathway and provided the following action plan:

- Audit to continue and include 30% paediatrics as representative of population
- Remind all triage trained nurses to ensure **all** majors patients are triaged on the triage form and screened for sepsis
- Continued discussion with consultants regarding doctors administering intravenous antibiotics when nurses are unable
- Continue to highlight importance of alert card prescription use for haematology/oncology patients
- Sepsis added to all ED mandatory study days using real life examples to learn from
- Date/time has been added to non-compliance to see if there is a theme for time of day
- Continue to promote Sepsis Stars for excellence in sepsis recognition and treatment
- Positive reinforcement as this is the highest compliance percentage for sepsis screening!

Cardiology

Research success

The UKGRIS (UK GRACE Risk Score Intervention Study) trial is progressing well with 35 sites open and new sites in setup. By implementing this study within BHT, the GRACE scoring system has been introduced which is a risk assessment of people who have been diagnosed with NSTEMI (type of cardiac anomaly) or unstable angina, and is important for determining early management plans. This allows the benefits of treatment to be balanced against the risks of treatment-related adverse events. Failure to categorise future risk can lead to people being given inappropriate treatment. A GRACE score is completed for all appropriate patients admitted through the Cardiac and Stroke Receiving Unit which means care is being delivered in accordance with NICE guidance.



Cardiac rehabilitation and the integrated community and inpatient heart failure service

The Heart Failure service has integrated with the Cardiac Rehabilitation Team to enable us to offer an integrated pathway to our patients. Following the publication of the National Audit of Cardiac Rehabilitation Quality and Outcomes Report 2018 we were delighted to be told that our cardiac rehabilitation programme has met all 7 minimum standards and can be listed as a certified programme. The programme will retain this status for a further year.

Improving patient experience of discharge

There is national evidence and guidance supported by the Department of Health and NHS Institute of Innovation and Improvement on the discharge process.

DFMs (Daily Facilitated Meetings) have been introduced to ward 2a to support safe, effective and timely discharge through a daily multidisciplinary team review highlighting and documenting issues/and or actions that need to be taken to facilitate the discharge.

Stroke

Innovation

Following the successful implementation of Neurologic Music Therapy (NMT), the stroke unit is now working with Rosetta Life to bring Stroke Odysseys to Wycombe. Stroke Odysseys is

designed to produce and embed an interdisciplinary arts intervention for stroke survivors that combine movement, song making, storytelling and performance.

They have a remarkable partnership with Garsington Opera that enables them to deliver session work in hospitals and communities and to deliver an annual performance project that will not only provide entertainment for staff and patients, but engage all patients in a participatory process that changes their perceptions of their disability, improves confidence about life after stroke and celebrates movement and voice.

University accredited Stroke Course

Developing staff is a high priority for the Trust, and February saw the start of the BHT Stroke Unit's first university accredited stroke course, delivered in conjunction with Buckinghamshire New University. This 15 week course was open to the multi-disciplinary team and attended by both registered (working at academic level 6&7) and non-registered staff. All staff who have participated have enjoyed the experience and learning and are bringing this back into their daily work to support patient care.

Patient experience

Stroke is a catastrophic event and many of our patients in hospital can be low in mood. There is a flourishing relationship between the stroke unit and the on-site nursery. The children enjoyed visiting the wards to sing Christmas carols so much that they returned to deliver valentines cards for patients – including one to be sent on to a previous patient who they had sung with at Christmas.



Women, Children and Sexual Health Services

Paediatrics

The Paediatric Respiratory Nurse Specialist and the School Nursing Service joined the “Asthma Bus” initiative providing health education focusing on asthma self-management. The Asthma Bus visited three schools in Buckinghamshire and was open to children and young people and teachers of the school.

The number of Day Surgery operations carried out at Wycombe Hospital has increased enabling children and their families to recover in the Children’s Day Unit. Positive verbal and written feedback has been received from families following their operations at the hospital.

A burns and plastics nurse-led service providing post op wound checks, removal of sutures and follow-up is now available in Wycombe Hospital offering care to children closer to home.

An eating disorder service has been developed jointly with Child and Adolescent Mental Health Services, the Emergency Department team and paediatricians. This offers early diagnosis, early intervention and paediatric senior support to young people in the community to avoid hospital admissions.

Two new consultant paediatricians have joined the team, with two more being recruited in 2019 enabling all children admitted to be seen within 14 hours of admission in line with the national standards for paediatrics. The additional consultants will improve decision making, reduce delays in admissions and discharges and provide additional support for our trainee doctors. Additional outpatient clinics will be created for nephrology and epilepsy sub-specialities.

Following feedback from families, the parents’ lounge on the children’s day unit in Wycombe has been refurbished.

Following a listening event with families with children with complex needs, the following changes have been made so far:

- Where possible children with complex needs will be given a side room to ensure privacy and dignity during their stay.
- Promoting optimal rest/sleep overnight by reducing noise disturbance by ensuring medications are prescribed at set times and all bins in clinical areas are soft close.

Neonatal Unit

Occupational therapy and physiotherapy are now included as part of the multidisciplinary team, assessing and treating preterm babies whilst they are in the neonatal unit, following them up in the community and supporting families with on-going developmental care.

Following a peer review visit, the changes listed below have been made:

- A weekly chaplaincy service is available providing pastoral care for families who babies are staying in our neonatal unit
- Parents now have lockers available to store belongings securely

“Prematuri-Tea Party” in aid of World Prematurity Day. Families of premature babies who had been on NNU over the last year were invited to attend to talk through their experiences. Following feedback from this day, NNU have set up a monthly mother and baby group for families with premature babies, both in Wycombe and Aylesbury Childrens’ Centres, which will be supported by the neonatal community team.

Maternity

In outpatient gynaecology we have made changes to our early pregnancy services in response to feedback from users including improved access to appointments and a separate entrance in order to ensure women are seen in the most appropriate timeframe and have a positive experience. We have also introduced a menopause pathway.

The safety and experience of women and families who use our maternity service is of paramount importance.

Perinatal mortality rates have continued to reduce. In 2018/19 the extended perinatal mortality rate was 4.14 per 1,000 for the Trust compared to a national average of 5.84 per 1,000.

Approximately 5,000 babies a year are born at the Trust, and we ensure that all women have one to one care in active labour wherever they choose to give birth, whether this is at home, Wycombe Birth Centre, Aylesbury Birth Centre or Stoke Mandeville labour ward. Through service and clinical changes, we have reduced the number of babies requiring admission to the neonatal unit, thereby reducing the number of mothers and babies separated after birth and increasing breast feeding rates.

Specialist consultant-led antenatal clinics have been implemented for women at risk of pre-term birth, twins (or more), or who have had previous late pregnancy loss. These clinics

complement our specialist medical clinics that include diabetes and perinatal mental health pathway.

Women's experiences of care continue to improve particularly in the following aspects of care:

- Partners can stay as long as they want
- Women receive help and advice about feeding their baby
- Women felt their concerns were taken seriously

Engaging with women has been a high priority this year and we have undertaken surveys and engagement workshops so that women's preferences can be designed into the way we deliver midwifery services over the next two years, particularly regarding Better Births and Continuity of Care.

Buckinghamshire Sexual Health and Wellbeing Service (bSHaW)

2018/19 has seen continued development of the integrated sexual health service based at the Brookside Clinic, Aylesbury and the Shaw Clinic, Wycombe.

We have continued to adjust the mix of pre-booked appointment and walk in and wait clinics to ensure service users have a choice of clinic and can be seen within 48 hours of contacting the service. Telephone consultations are offered to reduce the need for some service users to attend clinic.

All national programmes focused on sexual health prevention/promotion have been adopted at an early stage by the bSHaW service, most recently the provision of HPV (human papilloma virus) vaccination to men who have sex with men.

We work with the providers of our website to ensure the information displayed is accurately, reflects current service provision and provides relevant health promotion information.

The multidisciplinary team has been enhanced by the investment in two new dedicated health advisers supporting improvements in partner notification and motivational interviewing for behaviour change.

The service has continued to participate in national research being successful in securing additional places for the 'Impact' trial focused on preventing the transmission of HIV. We are one of a small number of clinics nationally accepted to participate in the Lustrum trial to evaluate the effectiveness of offering patients diagnosed with chlamydia the opportunity when collecting their treatment to also access treatment for their partners(s).

We are proud of our patient feedback which is consistently positive. Feedback forms are available in clinic; two formal patient surveys are carried out every year. In autumn 2018 we focused on young people, results are displayed in clinic including plans to make service improvement in response to the feedback.

Positive feedback

- I was reassured and comforted by a lovely lady who was so bubbly and friendly. Best service I have received
- The doctor and nurse were so kind and respectful. They listened to everything I said and I was so well looked after. A student medic sat in on my appointment but I was asked first if this was okay and at every stage they kept checking if it was still fine for her to be there. I had such a lovely experience with the staff, I cannot praise them enough
- I was made to feel dignified and respected by the receptionists as I walked in they were lovely and very respectful of my privacy
- Friendly staff who explained everything clearly. Very clear, helpful, answer questions and give you information
- The health advisor was very kind and clear throughout the consultation

Suggestions for improvement:

- The only thing I can suggest is sometimes there are long waiting times but it's only because it's busy and the staff take the time to look after each patient
- Give clients an idea of their waiting time
- Make appointments easier to get
- I was treated with respect, however, as a non-binary person I was often misgendered

What have we done?

- We have ordered digital information boards to update all service users on waiting times
- We have already made it easier to book appointments and have a walk in clinic daily
- We will continue to work with all staff to improve communication skills and awareness of diversity
- We have held a workshop on transgender health for all staff

Children and young people

Improvements in the Neonatal Unit therapy pathway: As part of BLISS (a charity for babies born premature or sick) recommendations for Allied Health Professionals within Neonatal

Units. Occupational therapy, and physiotherapy are now included as part of the multidisciplinary team, assessing and treating pre-term neonates whilst they are in the Neonatal Unit. Follow up is offered in the community, as is supporting families with on-going developmental care, with the aim of improving outcomes.

‘Autistic Spectrum Disorder’ single point of access

This offers collaborative working with CAMHS, and has enabled a neuro-developmental single point of access, which was launched at the end of January 2019. This is to improve the child’s pathway/journey and clinical outcomes.

Health Visiting

The service achieved UNICEF’s Baby Friendly Initiative (BFI) stage 2 accreditation. The assessment assured that staff are equipped with the knowledge and skills to implement the ‘Baby Friendly’ standards. This helps promote breastfeeding, and support mothers with the feeding of their babies.

Speech and Language Therapy redesign

The Service Improvement team is working with the Speech and Language Therapy Service (SLT), to redefined their referral criteria/pathway and this has now been launched. This means that each school will have a named link SLT.

Family Nurse Partnership (FNP)

The annual review was a success in terms of celebrating the FNP achievements in 2018, with friends of FNP and clients from across the county in attendance. Father Christmas visited, and families received graduation certificates in recognition of their hard work and commitment to be the best possible Mum and Dad, through completing the FNP programme.

Specialist Services

National Spinal Injuries Centre (NSIC)



CARF - Committee for Accreditation of Rehabilitation Facilities

In May 2018, NSIC was visited by three CARF inspectors from the United States. The inspectors are everyday clinicians who provide care to people with spinal cord injury.

The CARF team looked at all aspects of service provision, patient experience, staff training, our business and governance systems, and how we communicate with stakeholders

(referrers / major trauma centres, SCI charities and users). A very positive feedback session was held on the second afternoon. These were some of the highlights:

- NSIC's Goal Planning and Key Worker programme was praised as a "real strength". The CARF team congratulated NSIC for an "extraordinarily in-depth programme".
- NSIC's Workforce Strategy was seen as "progressive" with some of the year-on-year improvements in nurse recruitment and retention described as "impressive", especially in the midst of a national nursing crisis.
- NSIC's fund-raising achievements were highly praised as "extraordinary and a tremendous help".

Overall, the inspectors gave their view that NSIC does a "really remarkable job" and thanked the team for being tremendously accessible and helpful and speaking to them with authenticity and transparency.

The inspectors went through a series of recommendations and consultations which will be included in their final report. NSIC will work through this after the outcome of the inspection has been formally confirmed. The National Spinal injuries centre has earned a further three year accreditation.

Patient Experience at the National Spinal Injuries Centre

The National Spinal Injuries Centre (NSIC) at Stoke Mandeville Hospital aspires to provide the best, patient-centred, effective and evidence based care to enable people with a spinal cord injury to reach their life goals. Listening to and involving patients is central to this. In July and August 2018 the NSIC, with the support of the engagement and involvement team, conducted a programme of events and other listening opportunities for patients.

The involvement and engagement team gathered the views of 57 NSIC patients using a mixed methodology; including two patient workshops, one for inpatients, one for outpatients, telephone and face to face interviews and a survey to patients who wished to attend the workshops but were unable to. This has led to shared development recommendations for improving patients' experience of the NSIC.



Cancer Services

Buckinghamshire 5 year Cancer Strategy was developed jointly by Buckinghamshire Healthcare NHS Trust, Buckinghamshire Clinical Commission Group, Public Health, General Practitioners, Macmillan and Cancer Research UK. The focus of the strategy is on key work streams covering prevention, screening, early diagnosis, flows and pathways, living with and beyond cancer, and end of life. The 5 year plan is now in its second year, and the strategy group meets on a quarterly basis.

Delivery of the plan is supported by Thames Valley Cancer Alliance and Macmillan who provide funding for the Cancer Pathway Improvement manager and Consultant Nurse who are both now in post.

Moving on with confidence

- The patient is assessed before starting the group using the cancer experience survey and HADS (Hospital Anxiety and Depression scale)
- There is a formal patient evaluation after each group
- Patients are invited back after 3 months for to score again to see if the coping strategies have been sustained
- Feedback is presented to cancer education information and support service steering group

For the latest survey results, patients were asked to rate their care on a scale of zero (very poor) to 10 (very good). BHT respondents gave an average rating of 8.7 in 2016 improving to 8.8 in 2017. Scores for comparable Trusts ranged between 8.5 and 8.8 in 2017.

Oncology

Thame community hub cancer clinic opened in March 2018

In March 2018 the Cancer Care and Haematology team developed a clinic on Wednesday mornings at Thame Community Hub. This clinic mirrors the pilot site launched at Marlow in August 2017 and follows positive patient and staff feedback. The clinic provides anti-cancer treatment (SACT) and supportive care closer to a patient's home, in an appropriate outpatient setting. In line with national guidance, this clinic is suitable for patients living within the local area who may be receiving SACT either orally, by sub cutaneous injection or who require central line care. This is a nurse-led service which is an extension of the existing cancer care and haematology unit's outpatient services.

Working in partnership with Macmillan Cancer Support, funding was secured to allow the team to further develop this model of delivery. In early February 2019, the Macmillan SACT Outreach Team designed an Oral Oncology Clinic run by nurses at Stoke Mandeville Hospital. This clinic benefits approximately six patients every week. Many people who live in Aylesbury and the surrounding areas can now have a quieter patient experience, compared to attending the busy hospital day case unit.

The SACT Outreach team is also mobilising a third site at Amersham Hospital which will commence in June 2019 and enable a greater proportion of patients from both Stoke Mandeville and Wycombe Hospitals to receive treatment closer to home.



Pathology

The Pathology team at the Trust has a mission to provide every patient with the best possible, high quality efficient service using the latest techniques available.

Cellular Pathology recently underwent their surveillance visit inspection from the United Kingdom Accreditation Service (UKAS), who are the sole national accreditation body for the

UK. The initial results were very positive. This means that patients will continue to benefit from the excellent, high quality service that cellular pathology provides. It also means that the efforts and hard work that staff have put into the department to ensure quality systems are working effectively has been recognised by UKAS.



Pharmacy

Significant strides have been made in quality and patient experience of Pharmacy and Medicines during 2018/19. Some of the highlights include:

Pharmacy@Bucks, a subsidiary pharmacy has taken over providing outpatient prescription services to both the Stoke Mandeville (April 2018) and Wycombe (April 2019) sites. This has shown a 60% reduction in waiting time for patients, with most waiting less than 15 minutes. Permanent pharmacists and support staff ensure that patients will also get a consistent and knowledgeable team to help them with their medicines related queries.

Developments have allowed a dedicated team to focus on known discharges, ensuring that discharge medications are ready earlier in the day. Using the mobile application 'Perfect Ward', pharmacy can consistently help wards review the safety and appropriateness of their medicines, practices and knowledge.

Cross system working has led to the creation of the 'Medicines Resource Centre', that will provide a medicines advice system for Trust and community patients, reducing duplication of effort. Other roles for this group include managing medicines choices ensuring quality, safety and value with input from prescribers in hospital and general practices.

Looking forward to 2019/20 the Trust is in the process of implementing an 'Electronic Prescribing and Medicines Administration' (EPMA) system. This system will provide doctors,

nurses and other healthcare professionals real time information on medicines, support with prescribing, allergy awareness and improved discharge documentation.

Radiology

The Radiology team continues to ensure it is making the best use of imaging to improve outcomes for our patients and the local community through effective use of imaging and image guided intervention. Successes over the last year include:

- Approval for replacement MRI scanners at Wycombe Hospital and an additional MRI scanner at Stoke Mandeville Hospital.
- Approval for the replacement programme for dental units. The units at Amersham Hospital are installed and in use and the units at Stoke Mandeville Hospital are in the process of being installed.
- Meeting the ongoing increase in demand for complex imaging with radiologist reporting, waiting list initiatives and outsourcing.
- Recent successful radiologist recruitment for paediatrics and breast imaging.

Patient Feedback:

For the last year the radiology department has been running a patient experience feedback project. The questions posed to adult patients change week by week and cover everything from cleanliness of the department to the friendliness of staff, efficiency and whether the patient was seen on time.

The results from the project are collated into a monthly report and published in the radiology monthly team brief so all staff are aware of patient feedback.

Improvements made as a direct result of this feedback are:

- The layout of the waiting room at Stoke Mandeville Hospital was changed for easier mobility.
- A sturdier chair was placed in the disabled changing room at Stoke Mandeville Hospital
- Facilities in the disabled toilet at Wycombe Hospital have been upgraded

Research and Innovation

2018/2019 has been an exciting year for research and innovation. We have grown the number of research studies (199 studies) that are open and the number of innovations we are supporting.

We are growing the number of partnerships with universities and with industry to increase opportunities for growth.

In 2018/19 nearly 6,000 patients consented to be part of research studies.

The partnership between the Trust, Bucks New University, Buckinghamshire Clinical Commissioning Group, and the Council for Bucks Life Sciences now has a delivery vehicle called Bucks Health and Social Care Ventures. There are currently 5 SMEs (small medium enterprises) on cohort 1 of the accelerator programme and cohort 2 will be launched in the summer.

The team has been building a social media presence to communicate to the community and to build awareness amongst colleagues and external partners and we have also built a new web page that will go live in April 2019.

Bethan Peach who is a retired medical researcher has joined the Patient Research Ambassador team as a volunteer to help promote NHS health research from a patient's point of view. Bethan said, "Engaging patients in clinical research can provide the NHS with a most powerful resource, and enables the patients themselves to help direct future health decisions."

Impact from some of our research and innovation

- CLOTS trial led to decompression socks being used. During the trial an estimated 10 lives per year were saved. This is now standard care in the Trust
- STAR study gives a single dose of stereotactic radiotherapy (SRT) to the eye of patients with age related macular degeneration. Our 2 patients were having repeated 4 weekly eye injections for many months prior to the SRT. Following the SRT the number of injections they have received has reduced significantly. The patients are very happy and there are cost savings to the Trust.
- DIAMONDS compares currently used standard lasers with the newer micro pulse laser in patients with diabetic macular oedema. The study centre has provided a micro pulse laser for the duration of the study which now gives us two options for patient treatment.

- BVMP was a trial to assess improved binocular visual function in young patients undergoing cataract surgery. Depending on the outcome of randomisation, we were able to offer a bifocal lens unavailable on the NHS.
- INJECT was a Phase IV study looking at the effectiveness of Ocriplasmin/Jetrea in patients with vitreo-macular traction. As a result of the study the Trust stopped using it. It was a very expensive drug.

Data on number of studies open

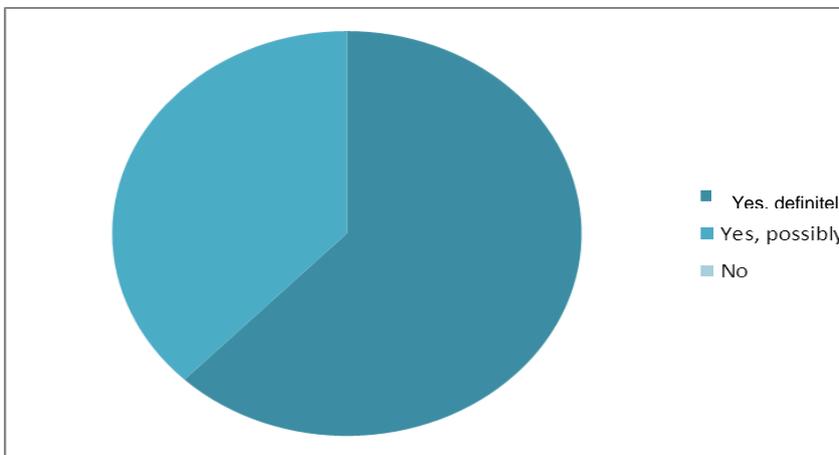
Study type	Number of active studies
Academic/student	3
Commercial non-portfolio	2
Commercial portfolio	36
Non-commercial non-portfolio	20
Non-commercial portfolio	138
Total	199

Specialty	Number of studies open
A&E	4
All patient areas	4
Cardiology	30
Community	7
Critical care	10
Dermatology	3
Diabetes	7
Gastro	14
Neurology (excluding Stroke)	5
Obstetrics & Gynaecology	17
Oncology & Haematology	44
Ophthalmology	8
Orthopaedics	1
Paediatrics	9
Pharmacy	4
Plastics & Burns	3
Radiology	2

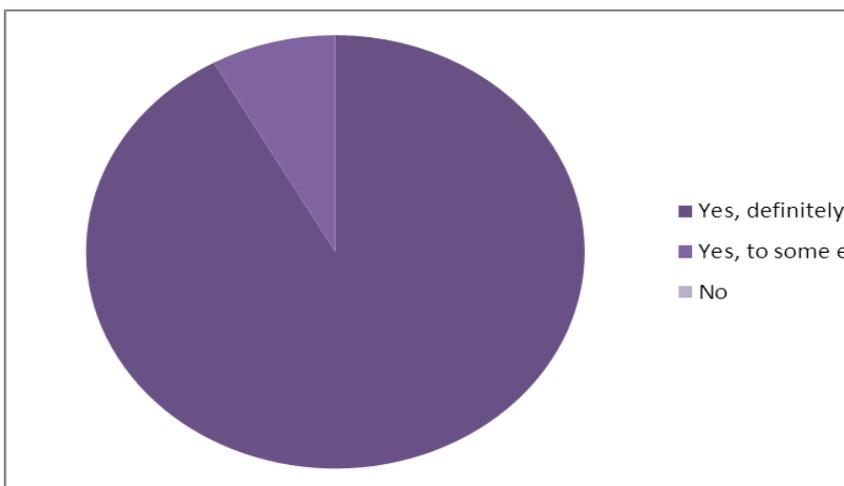
Respiratory	4
Rheumatology	6
Spinal	10
Stroke	7
Total	199

Research and innovation – Patient Feedback

Has your experience in research made you more likely to be involved again?



Do you feel that your participation in research was valued?



92% of our patients say research has been a positive experience



The team had a stand at the Bucks County Show this year which led to people registering on our Contact for Consent for research database along with a new Patient Research Ambassador.

Looking forward

2019/2020 is already set to be an exciting with the opening of the Research and Innovation facility which includes an Innovation Centre for SMEs to work with us. There are exciting collaborations coming together now for the new year which we look forward to reporting back next year.

Patient stories

Anna's research story

Can you tell me a bit about yourself?

I worked in banking & accounts and retired in 2008. Up until recently we had a narrow boat which kept us active and busy. Now I enjoy keep fit, walking and gardening. A few months ago I found my energy levels getting low and my skin or eyes were sometimes yellow. My GP sent me for blood tests which caused huge concern.

What type of study are you taking part in?

The UK Autoimmune Hepatitis Cohort (AIH-UK) observational study. It's where the immune system develops a fault and starts to attack parts of the body, in my

case the liver. This is a rare disease which only affects around 10,000 people in the UK.

How did you find out about the study?

My consultant, Dr Maggs, asked if I would like to take part when I was in clinic then Ruth Penn, the research nurse, met me at Stoke Mandeville when I had my biopsy.

Why did you decide to take part?

Being a fairly rare disease I felt strongly I should participate, especially as there was a strong possibility it could be genetic and my children and grandchildren could be affected.

What do you have to do?

I have regular blood tests to monitor my treatment and an extra one is sometimes donated to the study. When I had my liver biopsy an extra bit of sample was also taken for the study. I'm followed up for 2 years and have to fill in questionnaires about how I'm feeling on some visits.

What would you say are the benefits to you?

The benefits to me are that I'm being closely monitored. Any questions I have are fully explained by research nurse Ruth, which is very reassuring.

What would you say to anyone else thinking about taking part in research?

Do not hesitate. You feel you are helping the research identify new test and treatments for the benefit of others.



Hilary's research story

What does informed consent mean?

Prior to taking part in research it is essential that a person freely gives informed consent. The potential participant must be given the information to make a voluntary decision about whether to take part or not, this includes the purpose of the research, what's involved for them and understanding the risks and benefits. The research professionals taking consent must also be trained and qualified to take it.

What do you have to do?

"I have to inject myself every two weeks. They give us a diary to fill in with dates and times you do it. I started off coming to see the team monthly at first for four months and it's gradually reduced to every six months now. The drug's now been licensed in the UK and the trial's stopping early, I only have two more visits left."

What would you say are the benefits to you?

"I'm participating in something that will benefit others and I'm monitored. When I did have a problem I could contact the team and come in. It's been reassuring."

What would you say to anyone thinking about taking part in research?

"Definitely people should take part. It's for the benefit of everyone else in the future isn't it?"



Hilary in clinic with Nicola Bowers, Senior Cardiac Research Nurse

Ian's cardiac research story

Can you tell me a bit about yourself?

My name is Ian and I'm 69. I'm a keen naturalist with a particular interest in owls. I do a lot of bird watching and I have to be a keen gardener as I have a big garden.

What type of study are you taking part in?

It's called Orion3 which is looking at medicines which lower the levels of bad cholesterol (LDL) in high risk cardiac patients. I will be part of it for four years.

Why did you decide to take part?

Because my cholesterol was too high and this was an opportunity to do something about it.

What do you have to do?

I have to turn up for my study visits, do blood samples and injections.

What would you say are the benefits to you?

The treatment has massively reduced my cholesterol level.

How did you find out about the study?

I was invited by the cardiac research team.

What would you say to anyone else thinking about taking part in research?

From the trial I am participating in I can't see any down sides.



PART TWO

Priorities for improvement and Statements of Assurance from the Board

Quality of performance against our priorities set out in 2018/19

During the last year we have focused on driving forward quality improvement in areas that were identified as part of the organisation's corporate objectives. In addition to these quality priorities we worked collaboratively to improve the overall patient experience.

We had twelve quality priorities in our Quality Improvement Programme. Each priority had an executive lead and delivery lead assigned to them with responsibility for delivering their projects, supporting the staff involved and reporting progress on a monthly basis to the Quality and Patient Safety Group and on a quarterly basis to the Quality and Clinical Governance Committee.

The twelve quality priorities were aligned to the organisation's three corporate objectives outlined below:

- Implementing a culture of safety
- Listening to our patient voice
- Developing a learning organisation

The following information provides an overview of performance against quality targets during 2018/19.

We recognise that not all of our quality and safety improvement priorities for 2018/19 have been achieved in full, however, significant improvements in some areas have been demonstrated and we will continue to work to further improve on these areas.

Results and achievements for the 2018/19 Quality Account priorities

The following section provides detail on what has been achieved in the delivery of the priorities - what went well and what has been identified as requiring further improvement.

Overarching results for Quality corporate objective

Quality priority	Status
Implement a culture of safety	
Listen to our patient voice	
Develop a learning organisation	

Key:

- Green** - Quality priority met
- Amber** - Quality priority partially met
- Red** - Quality priority not met

Implement a culture of safety

The key focus was to establish and embed the SAFER (a mnemonic for streamlining patient discharge processes) bundle and a single transfer of care process through the following eight key components:

1: Implementation of the SAFER Bundle (With the exception of Women, Children and Sexual Health Division who have their own national guidelines to follow)

Objective:	Implementation of the SAFER Bundle <ul style="list-style-type: none"> • 100% of patients will have an estimated date of discharge within 24 hours of admission • 35% of transport booked by 4pm for patients having a transfer of care the next day • 50% of eligible patients will be discharged from
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	inpatient ward before midday
Status:	partially met 
<p>Improvements achieved:</p> <ul style="list-style-type: none"> • 52% of transport booked by 4pm for patients having a transfer of care the next day • All inpatient wards across the divisions have shown a marked improvement in the percentage of transport booked by 4pm for patients being transferred the following day and have exceeded the Trust target of 35%. 	
<p>Further improvements identified:</p> <ul style="list-style-type: none"> • 38% of patients have an estimated date of discharge within 24 hours of admission (data extracted from Medway). • 20% of eligible patients will be discharged from inpatient ward before midday • Ensure we are able to capture the data required • Improve the number of patients being discharged from an inpatient ward 	

2: Establish and embed a single Transfer of Care process

Objective:	60% reduction in avoidable delayed transfer of care 60% reduction in transfer of care to community services without fully completed documentation.
Status:	Following an extensive internal review of how to measure this outcome, there was no accurate and appropriate way to capture information directly linked to a single transfer of care process.

3: Implementation of a Clinical Accreditation Scheme (2018 – 2020)

Objective:	Set up systems and processes for identifying and rewarding the maintaining of good quality standards in the delivery and management of patient care.
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	<ul style="list-style-type: none"> • By end of year, 15 areas accredited • Completion of nursing documentation (90% by 30 March 2019)
Status:	Partially met 
<p>Improvements achieved:</p> <ul style="list-style-type: none"> • A proposal to design and develop a Clinical Accreditation Programme has been approved to ensure the consistent delivery of safe, high quality patient care. Teams at a local level will lead continuous improvement and the Perfect Ward app will be the tool to deliver Clinical Accreditation across inpatient wards. • By the end of 2018/19 no areas were accredited, however, 3 inpatient wards have consistently performed at 90% and above since Q3 for Quality Rounds (using CQC Key Lines of enquiry) identified through Perfect Ward. These wards will undertake a final deep dive review in order to become fully accredited in early 2019. • On average all inpatient areas across the specialities have achieved between 90 - 100% compliance with the completion of quality round reviews using Perfect Ward. • Quarterly matron-led peer reviews across our inpatient wards have taken place for a second time during 2018/19. • Fifteen ward areas have received a 'deep dive' quality review which included an interview with the ward sister/charge nurse/matron, looking at the leadership and management of the area, communication and feedback from staff working in the area. This is in addition to defined care standards aligned to the Care Quality Commission (CQC) key lines of enquiry. • Six patient assessors have been trained and linked to a specific ward area. They support the wards with quality rounds, bringing a different view to the review. The patient assessors have so far completed one quality round and will, with their link ward, report their findings to the Trust's Patient Experience Group (PEG) meeting. • Documentation compliance for all specialities using Perfect Ward met the 90% target by the end of Quarter 4 (Jan-Mar 2019). • We have also worked with our pharmacy colleagues to support wards with the medicines management part of quality rounds which has shown month on month improvement in compliance. 	

Further improvements identified:

- Clinical Accreditation steering group to be set up with Chief Nurse and Non-Executive Director sponsor to continue to drive clinical accreditation and provide support to wards / areas to reach accreditation.
- Programme of deep dive quality reviews to be established for the year ahead with support from our Buckinghamshire Clinical Commissioning Group colleagues.
- Wards to be identified that are ready to receive clinical accreditation.
- Awarding the accreditation to be supported by our communications team.

4: Implementation of an e-prescribing system (2018 – 2020)

<p>Objective:</p>	<p>Year 1 – Electronic prescribing system (e-prescribing) set up and piloted in one ward</p> <p>Year 2 - E-prescribing system rolled out across the acute site and reduction in prescribing errors by 50% based on Q1 2018/19 data</p>
<p>Status:</p>	<p>Met </p>
<p>Improvements achieved:</p> <ul style="list-style-type: none"> • Electronic Prescribing and Medicines Administration (EPMA) system is still under development. The first patients should have their medicines electronically recorded in early 2020 with a full roll out across the Trust in Q2 and Q3. • Following a successful funding bid, a system supplier has been selected; project group recruited, requirements for the system agreed, process mapping underway and transformation plan in place. 	
<p>Further improvements identified:</p> <ul style="list-style-type: none"> • Communication and training to be developed to engage and support staff with the process as we get closer to going live. • The first patients should have their medicines electronically recorded in early 2020 and after a period of review and optimisation, the system will rollout across the 	

Trust through Q2 and Q3 of 2020.

5: Implementation of an electronic patient (e-observation) monitoring system (2018 – 2020)

Objective:	Year 1 - e-observation system established and piloted in ten wards Compliance with NEWS 2 recording and escalation 100% Year 2 - e-observation system rolled out across the acute site and occurrence of sepsis reduced in A&E by 50% base on 2017/18 data
Status:	Met 
Improvements achieved: <ul style="list-style-type: none">• The e-observation (monitoring) system has been fully piloted and we have established the system in 10 wards• We have improved recognition and response to acute patient deterioration and sepsis across the Trust• There has been a successful procurement and implementation of Careflow Vitals electronic patient observation system that will be used across all inpatient wards• NEWS2 is used in all acute areas of the Trust including the National Spinal Injuries Centre demonstrating compliance for recording on the system and all clinical staff have been trained in NEWS2 and Careflow Vitals.• ED has a dedicated sepsis nurse• ‘Sepsis Star’ given to staff who demonstrates excellent sepsis practice• Establishment of a regional sepsis survivors support group in collaboration with Oxford Academic Health Science Network• The education and learning team has been working with community care homes to improve recognition of deterioration and sepsis	
Further improvements identified:	

- Implementation of NEWS 2 in our community hospitals
- Ongoing Careflow Vitals implementation plan for Wycombe and Community hospitals by May 2019
- Introduction of phase 2 of the electronic observations project which enables enhanced nursing assessments to be recorded electronically
- Digitisation of sepsis screening to be introduced
- Data from Careflow Vitals to drive ongoing improvements in care
- Improved handover and workload allocation utilising the introduction of CareFlow Connect communications
- Continue to work with community partners to improve recognition of deterioration and enhance early, appropriate decision making with a view to reducing hospital admissions

6: Implementation of a trustwide automated decontamination programme

Objective:	Develop automated decontamination programme across the Trust.
Status:	Partially met 
Improvements achieved:	
<ul style="list-style-type: none"> • Piloted automated decontamination within the urgent care services at Stoke Mandeville Hospital • Post pilot audit demonstrated improvement • Tender process has begun to broaden the provision of the decontamination programme 	
Further improvements identified:	
<ul style="list-style-type: none"> • Procurement process developed to support a wider automated decontamination service in the Trust 	

7: Reducing gram negative results

<p>Objective:</p>	<p>Reduce gram negative blood stream (GNBSI) infections by 25% of 2017 achievement.</p> <p>Provide a final report that identifies improvements made, changes in practice, policy and processes and any further changes required to maintain and continually improve urinary catheter gram negative bloodstream infections in 2019/20</p>
<p>Status:</p>	<p>Partially met </p> <p>Gram Negative Blood Stream Infections (GNBSI) has been discussed nationally and regionally. Nationally the scale of the challenge has been recognised and time scales and targets have yet to be clarified. The focus locally has been on the value that is added following the completion of an investigation of each case. Findings demonstrated that of 30 assessed, one GNBSI was deemed 'avoidable'.</p> <p>Information on the GNBSI work is now included in the annual report.</p>
<p>Improvements achieved:</p> <ul style="list-style-type: none"> • The focus on GNBSI has been developing nationally and as part of that, in 2018/19 we began a process of completing root cause analysis on all GNBSIs. Due to the number of RCAs completed, of which one was identified as avoidable, the Trust will now focus on an alternative approach to reducing GNBSIs which will include sampling and monitoring of cases post 48 hours from admission. • Local findings have demonstrated that of 30 GNBSIs assessed only one was avoidable. 	
<p>Further improvements identified:</p> <ul style="list-style-type: none"> • There is no obvious direct causal relationship between antibiotic use and gram negative bacteraemias based on the evidence to date. Therefore, no specific 	

actions with regards to antibiotic prescribing/use to aid in the reduction of these infections can be identified over and above embedding good antimicrobial stewardship principles in line with Trust policy and guidelines.

8: Prudent use of antibiotics

Objective:	Prudent use of antibiotics and delivering: 72 hour review of antibiotics for 30 patients, as for Q1, with 90% compliance achieved. 1-2% reduction in total antibiotics consumption / 1000 admissions vs baseline 2-3% reduction on Carbapenem consumption per 1000 admissions vs baseline
Status:	Met 
Improvements achieved: <ul style="list-style-type: none"> • 90% compliance achieved for 72 hour review of antibiotics for 30 patients • 12% reduction in total antibiotics consumption / 1000 admissions • 18% reduction on Carbapenem consumption per 1000 admissions • The prudent use of antibiotics and reduction in consumption has exceeded the 2-3% target set for 2018/19 following a baseline audit. The prudent use of antibiotics, their consumption and review of patients taking antibiotics will continue to be monitored and reported through the Antimicrobial Stewardship Committee and the Infection Prevention and Control Committee, which reports to the Quality and Patient Safety Group. 	
Further improvements identified: <ul style="list-style-type: none"> • No further improvements identified 	

Listen to our patient voice

Our key focus was to work in partnership with patients to improve their experience of discharge from our care, outpatients and A&E. To achieve this goal we aim to be in the top 20% of performing Trusts in the country for overall patient experience by 2020 in line with the Patient and Carer Experience Strategy 2017 to 2020.

Improving the patient experience in response to what patients have told us from surveys, complaints and Friends and Family feedback.

Objective:	Year 1 - Recruit and train volunteer patient representatives to become members of patient forums across the Trust
Status:	Met 
<p>Improvements achieved:</p> <ul style="list-style-type: none"> • Patients /carers who support the Trust's Patient Led Assessment of the Care Environment (PLACE) have been recruited and trained to join the Trust Patient Experience Group (PEG) on a permanent basis. The PEG group has grown significantly and now comprises of 22 members. • Guidance on developing and supporting the role of patient representatives has been created and distributed. • Guidance for patient representatives has also been created and distributed which includes the following: <ul style="list-style-type: none"> To act as a 'critical friend' to the Trust on the delivery of the patient/carer strategy. To take part in quality assurance activities such as quality rounds, speaking to patients and working with staff on improving patient experience. To provide input and feedback on Trust policies and strategies that impact on patient/carer experience. 	
<p>Further improvements identified:</p> <ul style="list-style-type: none"> • As more patient experience representatives were recruited to support the Trust, it became more apparent that a coaching style of introduction and support should be used rather than formal training and as such the guidance will be reviewed and adapted accordingly. 	

Improving the patient experience

Objective:	<p>Reduce 12 hour and more waiting times in A&E by 40%</p> <p>Improve the turnaround time for TTO (To Take Out) medicines (this will form part of the Single Transfer of Care project)</p> <p>Reduce the number of cancellations in the outpatient department by 40%</p>
Status:	Partially met 
<p>Improvements achieved:</p> <ul style="list-style-type: none"> • 68% reduction in patients waiting for more than 12 hours in A&E • 30% improvement in turnaround time for TTO medication 	
<p>Improvements achieved:</p> <ul style="list-style-type: none"> • The Trust is continuing to implement processes to reduce outpatient cancellations. Although we have not seen a reduction of 40% set out for 2017/18 there are robust plans in place to ensure a significant reduction by 2019/2020. 	

Develop a learning organisation

Our key focus was to ensure the organisation learns when patients deteriorate or die within our care. To achieve this goal we aimed to create a Learning Organisation Framework based on serious incidents, deaths and avoidable harm. We already have a 'Freedom to Speak Up' Guardian to enable staff to raise concerns implemented as part of a national programme following the Francis Inquiry into 'Mid Staffordshire NHS Foundation Trust'.

Objective:	<p>Implement a training and development programme that provides staff at all levels the understanding of quality improvement and the tools to reduce the occurrence of avoidable harm</p>
Status:	Met 

Improvements achieved:

- In order to build skills in Quality Improvement (QI) we have adopted the NHSI Quality, Service Improvement and Redesign (QSIR) training programme, as our QI methodology of choice.
- QSIR provides a complete collection of quality, service improvement and redesign tools, theories and techniques that can be applied to a wide variety of situations.
- Training has been implemented during the last year and is available as either a 1 day 'Fundamentals' or 5 day 'Practitioner' course. These are run across the Buckinghamshire, Oxfordshire and Berkshire (BOB) STP, where shared experiences across all areas promote learning and support integration.
- There are 47 practitioners and 64 staff who have attended fundamentals training.
- Five members of staff have achieved graduate status and can now teach the course and within BHT.
- A network of QSIR practitioners has been formed and meetings are held quarterly to provide support and coaching to the practitioners.
- The BHT leadership team has incorporated quality service improvement and human factors into the new Senior Leaders Programme (SLP). A half-day session on human factors is available to both clinical and non-clinical senior leaders from across the Integrated Care System (ICS).

Further improvements identified:

- As part of our QSIR approach, a monthly fundamentals day will take place from April 2019.
- Drop in monthly clinics are planned where staff can seek advice and support with QI tools and techniques for their projects.
- Training will continue to build skills within the Trust.

The BHT Way

Introduction to the 2019/20 priorities for improvement

Our priorities for improvement are tied to our mission and vision in everything we do which is underpinned by our values and behaviours.

'The BHT Way' sets out our ambition to be **one of the safest healthcare systems in the country delivering safe, compassionate care every time for every patient.**



The BHT Way is underpinned by our **CARE** values of collaborate, aspire, respect and enable and throughout 2019/20 we continued to embed these throughout the organisation. We are focussing on the following three strategic priorities designed to ensure we deliver our vision:

- Continue to improve our culture
- Implement new workforce models
- Tackle inequalities and variation

Corporate Objectives

For 2019/20, following input from the Board, engagement events and work with the Senior Leadership Team it has been agreed to focus our objectives on 3 key areas that will transform our culture, workforce and clinical services.

These are not business as usual and initiatives related to the performance of the Trust will be reported and monitored separately through the Integrated Performance Report.

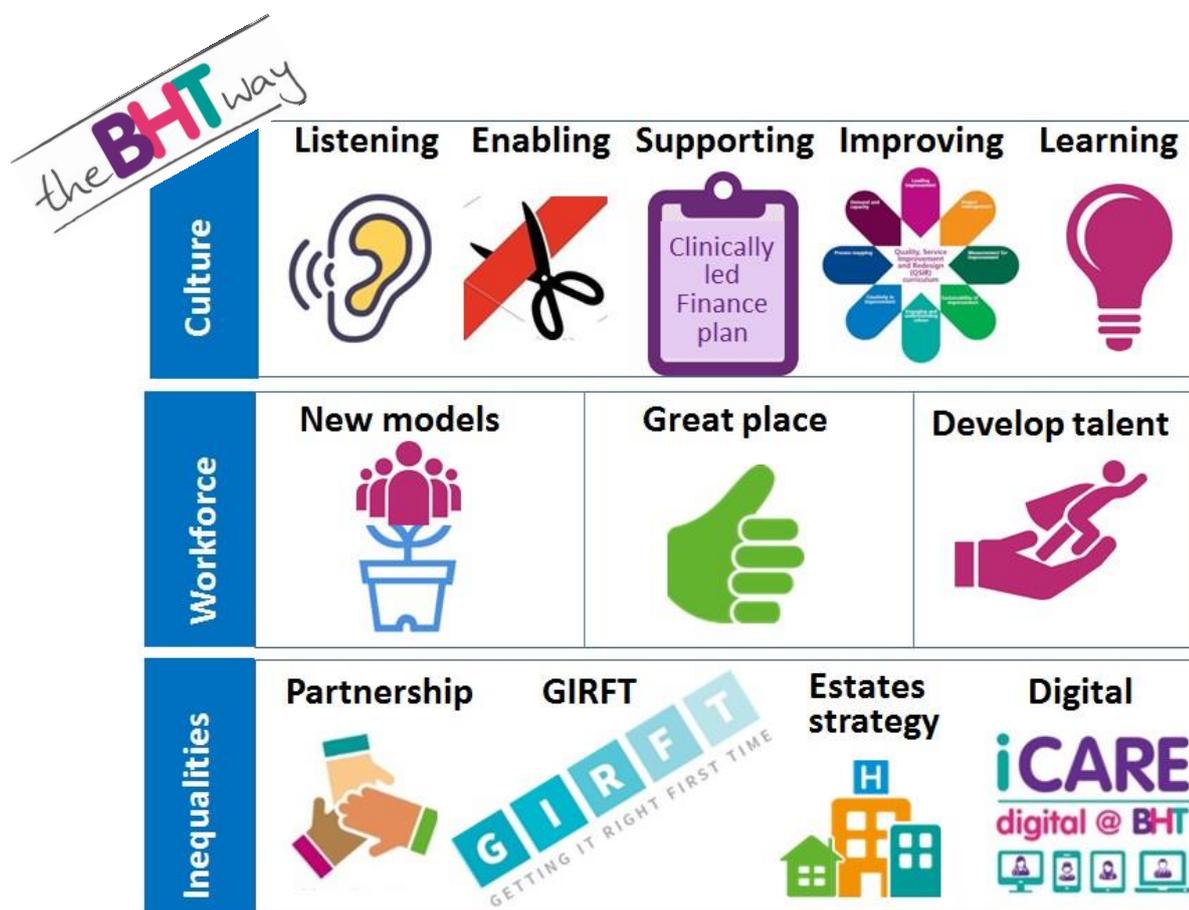
The following three corporate objectives and related programmes have been agreed:

Corporate objective	Projects	Executive lead	Committee
Continue to improve our culture	BHT Way – always improving: <ul style="list-style-type: none"> - Listening to the patient voice - An organisation that learns - Culture of quality improvement - Making it easier to get things done 	Chief Nurse Chief Nurse Director of Strategy Chief Operating Officer	Quality Quality Board Finance
	Clinically-led financial plan	Medical Director	Finance
Implement new workforce models	Innovate with new models of care and/or staffing to tackle gaps in workforce	Chief Nurse	Workforce
	Make BHT a great place to work	Director of Workforce & OD	Workforce
	Develop teams, talent and an inclusive workforce	Director of Workforce & OD	Workforce
Tackle inequalities and variation	Build new community partnerships	Director of Strategy	Board
	Get It Right First Time and reduce clinical variation	Medical Director	Finance
	Modernise outpatient services	Chief Operating Officer / Medical Director	Quality
	Embed use of accurate data across the Trust	Director of Strategy	Finance
Enablers To deliver: <ul style="list-style-type: none"> • Digital strategy • Estates strategy • Clinical strategy • Commercial transformation • Corporate service transformation 	Director of Strategy Commercial Director Director of Strategy Commercial Director Director of Finance	Finance Finance Quality Finance Finance	

Corporate objectives and plans link with our three strategic priorities and will be in place for 2 years. Our digital, estates, clinical and commercial strategies are designed to enable the delivery of our objectives. All Board committees, together with EMC, are being structured to oversee the delivery of this plan and associated projects.

Links with operational and clinical teams are built through the delivery of the clinical strategy and business plans. These will be detailed and aligned with the health and social care system and contribute to the delivery of corporate objectives and significant transformation.

In April 2019 our flagship engagement event – the BHT Way – was set aside to launch the corporate objectives. It was used as an opportunity to hear from various individuals and teams who are implementing plans linked to corporate objectives and for leaders and staff to discuss how to make the corporate objectives real in their teams.



As a Trust we will continue to work with divisional structures to embed and monitor plans linked to delivering the corporate objectives and routinely discuss progress and challenges at future BHT Way events.

At a high level, each of the accountable executives, has worked with their teams to develop project initiation documents (PIDs) that outline critical milestones over the 2 years as well as

identify key performance indicators linked to our strategic priorities – quality, people, money. The delivery of these plans will be reported at the relevant sub-committee of the Board and will be used to drive the work programmes for these sub-committees during that period. The sub-committees provide assurance to the Trust Board about the governance as well as progress or risks to delivery.

As a result of the above changes to the way BHT has structured its corporate objectives the Board Assurance Framework is being updated to reflect the new corporate objectives. These structures will ensure that plans link to the corporate objectives and their impacts are measured in terms of the delivery of our strategic priorities of quality, people and money.

Having corporate objectives set for two years provides BHT with an opportunity to focus and prioritise delivery of these changes. It also provides a level of stability and direction to build further plans in the organisation and the system that will support the delivery of our vision to be one of the safest healthcare systems in the UK.

Quality Improvement

BHT is working towards embedding a Quality Improvement (QI) culture so that the creativity, passion and initiative of its entire staff can be harnessed for improving patient care. QI is the use of a systematic method to involve those closest to the quality issue in discovering solutions to a complex problem. It applies a consistent method and tools, engages people (both staff in clinical/corporate teams and patients/service users/families) more deeply in identifying and testing ideas, and uses measurement to see if changes have led to improvement.

A “BHT Way” day last October brought together 180 staff from a broad range of specialties, departments and levels of seniority to collectively think about what a trustwide culture of continuous improvement looks and feels like. Whilst BHT is able to demonstrate many individual examples of excellent quality improvement projects and initiatives, it became clear that we did not yet have a widespread culture of continuous improvement. Feedback from the audience gave several indicators for where to start this journey, building on our current status. Some of them were longer term, requiring investment in terms of time and expertise, but others were ideas the Trust can start to develop.

What would make improvements easier?



In addition, two NHS Trusts rated as outstanding with embedded Quality Improvement cultures were visited (Western Sussex Hospital NHS Foundation Trust and East London NHS Foundation Trust) and a national conference on QI hosted by NHS Improvement attended.

Implementing QI is the cornerstone of the Trust's Corporate Objective for 2019/20 to continue to improve our culture. The change programme is focused on three key elements:-

- Leadership for QI
- Building capacity and capability
- Creating a movement for change

A QI steering group has been formed and a driver diagram outlines agreed actions. Some of the proposals already exist in some form in the Trust but need to be enhanced and developed within the framework and branding of a quality improvement culture. Others will require identified resource to lead the initiative and drive it forward.

Ensuring Board and Executive leadership for QI is fundamental to establishing a culture of continuous improvement and Neil Macdonald the Chief Executive chairs the monthly Improvement Committee where new projects and ideas from clinical teams are approved, supported and monitored.

QSIR Training

One of the essential elements of any QI culture is building capability within the organisation using recognised QI tools and techniques. BHT has a central Quality Improvement team whose purpose has been to support teams to make improvements. Within BHT, we are aiming to build our capability in QI methodology and to achieve this aim the NHSI Quality, Service Improvement and Redesign (QSIR) training programme has been adopted as its quality improvement (QI) methodology of choice. QSIR provides a comprehensive collection

of quality, service improvement and redesign tools, theories and techniques that can be applied to a wide variety of situations.

The training is available as either a 1 day fundamentals or 5 day practitioner course. These are run across the Integrated Care System (ICS), where the shared experiences from across all areas of the health and local authority sector are very valuable in promoting learning and will support integration. A database of all those who have attended QSIR training has been set up and by the end of April 2019, there are 43 practitioners who have completed the training. There are also 45 staff within BHT who have completed the 1 day Fundamentals training. There are 5 QSIR practitioners who have now achieved graduate status enabling them to teach the course.

Training utilising the QSIR methodology has now also been implemented on the leadership pathways, preceptorship cohorts as well as bite size sessions to teams. From April 2019, The Fundamentals training will be provided in-house (although offered to ICS partners as well) on a monthly basis for 20-30 staff each time. The templates for QI tools and techniques will be available for all staff to access on the intranet or a separate repository.

Mandatory declarations and assurances

All NHS Trusts are required in accordance with the statutory regulations to provide prescribed information in their quality accounts. This enables the Trust to inform the reader about the quality of our care and services during 2018/19 according to the national requirements.

The data used in this section of the report has been gathered within the Trust from many different sources or provided to us from the Health and Social Care Information Centre (HSCIC). The information, format and presentation of the information in this part of the Quality Account is as prescribed in the National Health Service (Quality Accounts) Regulations 2010 and Amendment Regulations 2012 / 2017.

Statements of assurance

During 2018/19 Buckinghamshire Healthcare NHS Trust provided and/or sub-contracted seven NHS services. These are:

- Accident and Emergency (A&E)
- Acute Services (A)
- Cancer Services (CR)
- Community Services (CS)
- Diagnostic, Screening and/or Pathology Services (D)
- End of Life Care Services (ELC)
- Patient Transport Services (PT)

Buckinghamshire Healthcare NHS Trust has reviewed all the data available on the quality of care in seven of these NHS services.

The income generated by the NHS services listed represents 94% of the total income generated by Buckinghamshire Healthcare NHS Trust for 2018/2019. The Trust received the other 6% of its income for other aspects of work, for example research and development, education and training, sustainability and transformation funding and other miscellaneous income.

Clinical audit and national confidential enquiries

During April 2018 to March 2019, 46 national clinical audits and national confidential enquiries covered relevant health services provided by Buckinghamshire Healthcare NHS Trust.

During that period Buckinghamshire Healthcare NHS Trust participated in 94% (44/47) national clinical audits and 100% (5/5) national confidential enquiries of the audits and enquiries in which it was eligible to participate.

The national clinical audits and national confidential enquiries that the Trust was eligible to participate in during April 2018 to March 2019 are detailed in the table below.

The table shows which audits the Trust participated in and the percentage of eligible/requested cases submitted.

AUDIT	Applicable overall	Data collection (yes/no)	2018/19 status	% eligible/requested cases submitted or reason for non-participation
CANCER				
Bowel Cancer (NBOCAP)	applicable	yes	Participating	100%
National Lung Cancer Audit	applicable	yes	Participating	100%
National Prostate Cancer Audit	applicable	yes	Participating	100%
Oesophago-gastric Cancer (NOGCA)	applicable	yes	Participating	Data submitted through the Oxford Regional Network
National Audit of Breast Cancer in Older Patients (NABCOP)	applicable	yes	Participating	100%
WOMEN AND CHILDREN				
Diabetes (Paediatric) Audit (NPDA)	applicable	yes	Participating	100%
Maternal, Newborn and Infant Clinical Outcome Review	applicable	yes	Participating	100%
National Maternity and Perinatal Audit (NMPA)	applicable	yes	Participating	100%
National Neonatal Audit Programme (NNAP)	applicable	yes	Participating	100%
National Audit of Seizures and Epilepsies in Children and Young People	applicable	yes	Participating	100%

Feverish Children (Care in Emergency Departments)	applicable	yes	Participating	5 consecutive cases per week
CARDIAC, DIABETES AND VASCULAR				
Myocardial Ischaemia National Audit Project (MINAP)	applicable	yes	Participating	100%
Cardiac Rhythm Management (CRM)	applicable	yes	Participating	100%
National Audit of Cardiac Rehabilitation	applicable	yes	Participating	100%
National Audit of Percutaneous Coronary Interventions (PCI)	applicable	yes	Participating	100%
National Audit of Percutaneous Coronary Interventions (PCI)	applicable	yes	Participating	100%
National Cardiac Arrest Audit (NCAA)	applicable	no	Not participating	Data is collected and reviewed via a monthly local audit
National Heart Failure Audit	applicable	yes	Participating	100%
Inflammatory Bowel Disease (IBD) Programme	applicable	yes	Participating	19 cases in 2017/18
National Diabetes Audit – Adults	applicable	yes	Participating	100%
National Vascular Registry	applicable	yes	Participating	Data submitted by the Regional Vascular Service at Oxford
Rheumatoid and Early Inflammatory Arthritis	applicable	yes	Participating	100%
OLDER PEOPLE				
Falls and Fragility Fractures Audit Programme (FFFAP)	applicable	yes	Participating	100%
National Audit of Dementia	applicable	yes	Participating	100%
Sentinel Stroke National Audit Programme (SSNAP)	applicable	yes	Participating	100%
National Audit of Intermediate Care	applicable	yes	Participating	100%
National Asthma and COPD Audit Programme	applicable	no	Not Participating	Withdrew from audit with Trust agreement
ACUTE				
National Emergency Laparotomy Audit (NELA)	applicable	yes	Participating	100%

National Comparative Audit of Blood Transfusion Programme	applicable	yes	Participating	100%
Case Mix Programme (ICNARC)	applicable	yes	Participating	100%
Elective Surgery (National PROMs Programme)	applicable	yes	Participating	100%
Major Trauma Audit (TARN)	applicable	yes	Participating	100%
National Joint Registry Audit (NJR)	applicable	yes	Participating	93%
National Ophthalmology Audit	applicable	No	Not participating	Registered but awaiting approval and installation of required software
BAUS Urology Audit - Nephrectomy	applicable	yes	Participating	113.6%
BAUS Urology Audit - Cystectomy	applicable	yes	Participating	112%
BAUS Urology Audit – Female Stress Urinary Incontinence (SUI)	applicable	yes	Participating	100%
BAUS Urology Audit – Percutaneous Nephrolithotomy	applicable	yes	Participating	100%
BAUS Urology Audit – Radical Prostatectomy	applicable	yes	Participating	103% for 2015/16/17 combined
Vital Signs in Adults (Care in Emergency Departments)	applicable	yes	Participating	5 consecutive patients per week
VTE Risk in Lower Limb Immobilisation (Care in Emergency Departments)	applicable	yes	Participating	5 consecutive patients per week
Adult Community Acquired Pneumonia	applicable	yes	Participating	100%
National Audit of Care at the End of Life (NACEL)	applicable	yes	Participating	69 cases note reviews submitted
Non- Invasive Ventilation – Adults (BTS)	applicable	Yes	Participating	30/30
Surgical Site Infection Surveillance Service	applicable	Yes	Participating	100%
OTHER				
Learning Disability Mortality Review Programme (LeDeR Programme)	applicable	yes	Participating	All applicable cases (3) submitted
Seven Day Hospital Services	applicable	yes	Participating	100%

National Confidential Enquiry into Patient Outcome and Death	BHT applicability	BHT participation	Participation rate
Acute Heart Failure	Applicable	Participated	9/9 questionnaires submitted
Perioperative Diabetes	Applicable	Participated	9/14 questionnaires submitted
Pulmonary Embolism	Applicable	Participated	4/5 questionnaires submitted
Acute Bowel Obstruction	Applicable	Participating	still collecting data
Long Term Ventilation in under 25s	Applicable	Participating	still collecting data

The reports of 19 national clinical audits were reviewed by the provider in April 2018 to March 2019 and Buckinghamshire NHS Trust has taken the following actions to improve the quality of healthcare provided:

- FFFAP National Hip Fracture Database** – Following review of the data from this audit the Trust has introduced the ‘Golden Patient’ model. This means that when theatre lists are prepared hip fracture patients are treated as a priority and if possible the first patient on the list. This change should mean more patients will receive their surgery within the 36 hour target. Theatre nurses attend the daily trauma meeting to ensure that the list order is correct and also that the correct ‘kits’ are ready for the surgery. This change has led to improved communication and efficiency in theatres.
- Learning Disability Mortality Review Programme (LeDeR) 2017/18** – The results of this audit have been used to inform changes in the process for reviewing deaths involving patients with a learning disability. The Learning Disability nurses work closely with the Trust’s Mortality Review Lead to ensure they are included in all mortality reviews involving people with a learning disability. In this way learning can be identified and shared. The Learning Disability nurses also attend the ICS LeDeR review meeting
- Maternal, Newborn and Infant Clinical Outcome Review Programme 2017-18 - MBRRACE)** – Following review of the MBRRACE report mortality rates are now being closely monitored with a renewed focus on reducing neonatal deaths. Monthly perinatal mortality data collection occurs via the maternity dashboard and trends are discussed at the quarterly multidisciplinary perinatal mortality review panel. Recommendations from the Each Baby Counts report (2017) have been or are being actioned including; implementation of the Perinatal Mortality Review Tool (PMRT) to support local review processes, joint perinatal monthly morbidity and mortality meetings to share learning

amongst the wider maternity and neonatal team; annual audit of the number of placentas sent for perinatal pathology (target 90%); improved adherence to the Trust fetal growth monitoring guideline, which includes customised growth chart, and follows the RCOG recommendations for detection and prevention of babies small for gestational age.

- **NCEPOD Non-invasive Ventilation Study (2017)** – This study was a review of the quality of care provided to patients receiving acute non-invasive ventilation (NIV). The study found a wide variation in both the organisation of acute NIV services and the clinical care provided. Working with the Trust quality improvement team, the respiratory department is developing a pathway for patients receiving NIV which will bring together all the specialities involved. An NIV group has been set up with executive leadership from the Divisional Chair for Surgery and Critical Care. As recommended by NCEPOD, a senior respiratory consultant is the NIV lead for the Trust. The group is working through all the recommendations and hopes to implement changes mid- 2019.

Participation in research

The number of patients receiving NHS services provided or sub contracted by Buckinghamshire Healthcare NHS Trust in 2018/19 that were recruited during that period to participate in research approved by a research ethics committee was 5,561.

Income for quality and innovation

A proportion of the Trust's income in 2018/19 was conditional on achieving quality improvement and innovation goals agreed between Buckinghamshire Healthcare NHS Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation Payment Framework.

Further details of the agreed goals for 2018/19 and for the following 12 months period are available on request by emailing: bht.communications@nhs.net.

Care Quality Commission (CQC)

Buckinghamshire Healthcare NHS Trust is required to register with the Care Quality Commission (“CQC”) under section 10 of the Health and Social Care Act 2008 and its current registration status is ‘Registered’. Buckinghamshire Healthcare NHS Trust is registered with the CQC with no conditions attached to registration.

Buckinghamshire Healthcare NHS Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

Buckinghamshire Healthcare NHS Trust underwent an unannounced, focused CQC inspection between 6 -7 September, 2016. The inspection was undertaken using the new CQC framework which assessed whether services are:

- Safe
- Effective
- Caring
- Responsive
- Well-led

The following sites were inspected: Stoke Mandeville Hospital, Wycombe Hospital, and Buckingham Community Hospital.

The overall Trust rating of Requires Improvement has not changed from the comprehensive inspection in 2015. The chart below depicts the Trust’s overall rating.

Ratings	
Overall rating for this trust	Requires improvement 
Are services at this trust safe?	Requires improvement 
Are services at this trust effective?	Requires improvement 
Are services at this trust caring?	Good 
Are services at this trust responsive?	Requires improvement 
Are services at this trust well-led?	Requires improvement 

The following themes for improvement arose from the inspection areas:

- Safe management of medicines
- Pharmacy workforce resourcing
- Embedding end of life care plans for all patients – some variability
- Variation in documentation- medical and nursing
- Infection control- clean equipment in 2 areas

The CQC noted areas of concern, for which it issued compliance notices regarding Regulation 12 – safe care and treatment and Regulation 18 - safe staffing. A compliance action plan has been submitted to the commission by the required deadline and the Trust has already achieved several improvements in respect to these.

A copy of the CQC inspection report can be accessed here

<http://www.cqc.org.uk/provider/RXQ>

In early 2019 the Trust was again inspected by the CQC and the results of this inspection are available at the above internet address.

Data Quality

Buckinghamshire Healthcare NHS Trust submitted records during 2018/19 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data relating to <i>admitted patient care</i> which included the patient's:	The percentage of records in the published data relating to <i>out-patient care</i> which included the patient's:	The percentage of records in the published data relating to <i>accident and emergency care</i> which included the patient's:
Valid NHS Number was 99.7% (National Average 99.4%)	Valid NHS Number was 100% (National Average 99.6 %)	Valid NHS Number was 99.9% (National Average 97.5 %)
General Medical Practice code 100% (National Average 99.9%)	General Medical Practice code 100% (National Average 99.8%)	General Medical Practice code 100% (National Average 99.3%)

Buckinghamshire Healthcare NHS Trust will be taking the following actions to improve data quality:

The Trust will create a Data Quality (DQ) dashboard to monitor five agreed key indicators that reflect local priorities and are directly linked to the organisations areas of risk

Indicators:

- Missing / incomplete clinic outcome codes by specialty / clinician
- NHS number completeness
- Registration of duplicate records
- Duplicate pathways created for the same specialty
- Appointments put on hold weekly

The Trust will expand the existing data quality audit programme to include separate checks on RTT (Referral To Treatment) data. The programme will rotate through the organisation's specialties.

The Trust will create a central list of the data quality checks, how they are reported, who investigates them, corrects the data and if feedback occurs. For example, a data quality team, in the information department, checks for missing NHS numbers, postcodes and GP practices. The corporate application team has a list of data quality tasks that they perform daily. Medical records manage merging of duplicate records. We will then be able to review the training these staff receive to be assured that they are appropriately skilled.

Manage and maintain standard operating procedures (SOPs) trustwide for data collection and validation. This includes statutory returns with sign off by relevant managers in divisions prior to submission.

To develop a data quality strategy aligned to the New ICS Information Strategy 2019-24(Draft).

Promote and reinforce the corporate message that data quality is the responsibility of all.

Ensure the Data Quality Steering Group holds a log of data quality issues and monitors agreed actions and improvements.

The Department of Health Core Quality Indicators

The core quality indicators that are relevant to Buckinghamshire Healthcare NHS Trust are detailed below. They relate to:

- Summary Hospital level Mortality Indicator (SHMI)
- Patient Reported Outcome Measures (PROMS)
- Readmission rate into hospital within 28 days of discharge
- The Trust's responsiveness to the personal needs of our patients
- Friends and Family Test for staff
- Percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism
- The C. difficile infection rate per 100, 000 bed days
- The number of patient safety incidents reported and the level of harm

Summary Hospital Level Mortality Indicator (SHMI)

The table below details performance against the Summary Hospital level Mortality Indicator (SHMI):

Prescribed Information	Reporting Period	BHT Score	National Average	Highest Score (Best)	Lowest Score (Worst)
The value of the summary hospital-level mortality indicator (SHMI) for the Trust for the reporting period	2017/18	0.972	1.005	0.727	1.247
	2018/19	0.9924	1.0034	0.888	1.1261
The banding of the SHMI for the Trust for the reporting period <ul style="list-style-type: none"> • Band 1 = Worse than expected • Band 2 = As expected • Band 3 = Better than 	2018/19	Band 2	Band 2	Band 3	Band 1

expected					
The percentage of patients deaths with palliative care coded at either diagnosis or specialty level for the Trust for the reporting period	2017/18	44.6%	31.6%	11.5%	59.8%
	2018/19	47.6%	33.6%	Not given by NHS digital	Not given by NHS digital

Buckinghamshire Healthcare NHS Trust considers that this data is as described for the following reasons:

- SHMI makes no adjustment for palliative care and the Trust has palliative care beds within the acute services that are included in the calculations.

Buckinghamshire Healthcare NHS Trust intends to /has taken the following actions to improve this score, and so the quality of its services, by:

- Continuing to improve sepsis care specifically related to screening and “suspicion to needle times”
- Analysing mortality data in the Mortality Review Group and investigating variations.

The Medical Examiner service enables an independent scrutiny of adult inpatient deaths in partnership with families and carers, and identifies opportunities for learning.

Patient Reported Outcome Measures (PROMS):

Patient Reported Outcome Measures (PROMS) measure health gain in patients undergoing hip replacement, knee replacement, varicose vein and groin hernia surgery in England, based on responses before and after surgery. The table below details performance against the Patient Reported Outcome Measures (PROMS):

Prescribed Information	Reporting Period	BHT Score	National Average	Highest Score (Best)	Lowest Score (Worst)
Groin hernia surgery	2016/17	0.118	0.08	0.14	0.06
	2017/18	0.127	0.089	0.198	0.008

Varicose vein surgery	2016/17	0.073	0.099	0.152	0.016
	2017/18	0.035	0.086	0.361	0.002
Hip replacement surgery	2016/17	0.398	0.44	0.53	0.33
	2017/18	0.441	0.458	0.666	0.179
Knee replacement surgery	2016/17	0.28	0.32	0.39	0.24
	2017/18	0.318	0.337	0.506	0.232

Buckinghamshire Healthcare NHS Trust considers that this data is as described for the following reason:

- The Trust has made regular and timely data submissions to NHS Digital and the figures are consistent with those produced by the Trust's internal data systems.

Buckinghamshire Healthcare NHS Trust intends to /has taken the following actions to improve this score, and so the quality of its services, by:

- In 2018/19 we stopped recording PROMS data for varicose veins as we operate on so few now
- Hips and knees – employed an enhanced nurse practitioner for orthopaedics who has been working hard with the whole team to successfully improve the capture of PROMS data both pre and post operatively.
- A new physio standard has been introduced in that all patients post knee replacements are now reviewed two weeks post discharge in a face to face environment
- PROMS data is reviewed and discussed in arthroplasty team meetings and an action plan is in place to support and track improvements

Readmission rates

The table below details performance against the readmission rate into hospital within 28 days of discharge

Prescribed	Reporting	BHT	National	Best	Worse
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Information	Period	Score	Average	Performer	Performer
The percentage of patients aged 0 to 15 readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period	Oct 16 – Sep 17	10.5%	8.7%	2.5%	14.4%
	Oct 17 – Sep 18	11.2%	9.0%	1.0%	17.9%
The percentage of patients aged 16 or over readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period	Oct 16 – Sep 17	6.5%	8.1%	2.4%	16.1%
	Oct 17 – Sep 18	6.8%	8.4%	2.4%	17.1%

Buckinghamshire Healthcare NHS Trust considers that this data is as described for the following reason:

NHS Digital does not provide data on this for the reporting period, so we have provided the latest data from Dr Foster which runs to October 2018.

The Trust intends to /has taken the following actions to improve this score, and so the quality of its services, by:

- Emergency Department review clinics to ensure safety net for patients who are discharged but may need reviewing or follow up that is not available in the community
- Regular communication through social media to sign post the public to most appropriate providers
- Discharge plans for readmitted patients are reviewed in collaboration with the Red Cross and other support agencies
- As part of the winter plan, long stay patient team from Red Cross worked with patients for up to 12 weeks at home
- Deeper analysis of the 0-15 performance will be undertaken to understand the reasons behind the higher than average readmission rate for children

Responsive to the personal needs of patients

The table below contains the indicator values for NHS Outcomes Framework indicator 4.2 - the average weighted score of 5 questions from the inpatient survey relating to responsiveness to inpatients' personal needs. The most recent data on the indicator for responsiveness to inpatients' personal needs is the NHS outcomes framework indicator 4.2 and was released 23 Aug 2018.

Prescribed Information	Reporting Period	BHT Score	National Average	Highest Score (Best)	Lowest Score (Worst)
The data made available to the NHS Trusts of NHS foundation Trusts by NHS Digital with regard to the Trust's responsiveness to the personal needs of its patients during the reporting period.	2016/17	66.8	69.6	86.2	58.9
	2017/18	68.0	68.1	85.23	60.2
	2018/19	64.3	68.6	85	60.5

We have seen a slight drop in our score this year from 68 to 64.3. This score is based on the results from the following questions in the inpatient survey:

	2016	2017	2018	Average	BHT
Care: was involved as much as wanted in decisions	91%	88%	91%	90%	91%
Care: found staff member to discuss concerns with	75%	75%	74%	73%	74%
Care: enough privacy when discussing condition or treatment	95%	93%	95%	94%	95%
Discharge: told side-effects of medication	57%	48%	54%	57%	54%
Discharge: told who to contact if worried	74%	71%	74%	77%	74%

Our performance in four out of six of the questions is above average. However our performance in the questions related to discharge remains below average. Over the last year we have made good progress in improving a number of aspects of our discharge planning,

however areas for improvement in the coming year will focus on ensuring patients are given enough information on the possible effects of medication, and that they are clear on who to contact if they are worried.

We have continued with implementation of the 2017/2020 Patient Experience Strategy which focuses on four key areas:

- Voice of the Child
- Accident and Emergency
- Discharge planning
- Outpatients

In 2018 the Trust took the following actions to improve patient experience in these areas:

Voice of the child

- Young people have been involved in redesigning the Paediatric Decision Unit (Stoke Mandeville Hospital) including additional waiting area space and the creation of a three bedded bay. Rooms were also re-decorated to improve the overall experience for children
- A listening event dedicated to children with complex needs resulted in a review of 'open door' policy and reducing noise at night
- A project capturing views of oncology children via video resulted in introduction of entertainment systems

Accident and Emergency

- Friends and Family Test 47% recommendation rating to 92%
- IT platform to capture patient experience in A&E, includes recording patients speaking about their experiences, launched December 2018
- We have introduced A&E volunteer buddies to support improvement in non-clinical patient care
- A major refurbishment of A&E and Outpatients to improve patient flow and experience has commenced

Discharge planning

- A dedicated pharmacy technician linked to clinical site team being piloted to ensure planned and potential daily discharges have TTO's (To Take Out) completed.
- Introduction of a discharge facilitator for short stay and acute assessment units.

- Introduction of volunteers calling patients that have been recently discharged to support in patient experience of discharge.

Outpatients

- The introduction of SMS messaging for appointment reminders has led to DNA rates being amongst the lowest in the country
- Electronic GP referral system in place with 98% of GP referrals now coming through electronically resulting in a more safe and effective process for patients
- The introduction of a bulk mail system to support an improvement in how we send information and appointments to patients - 59% of all outpatient letters now sent via bulk mail
- Free magazines have been introduced in to our waiting areas and comprise a variety of topics to suit varying interests

Perfect Ward is now established across 63 areas within the Trust and we are pleased to report that we now have patient assessors trained and conducting environmental and patient audits within inpatient wards. This has enabled a wider patient perspective and a direct influence on the quality of care provided in our wards.

2018 inpatient survey

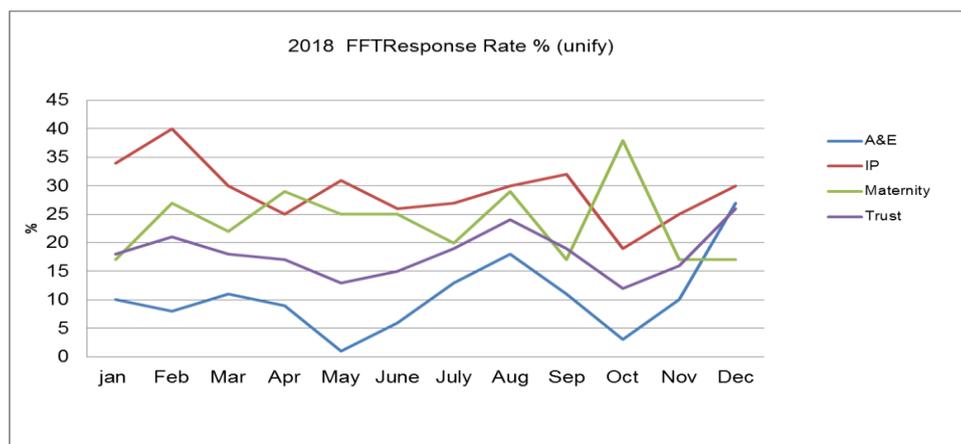
The Trust has significantly improved its performance in the 2018 Picker inpatient survey.

- 12th most improved Trust in England, up from 55th in 2017
- Average positive score ranking 36th out of 77 Trusts commissioned by Picker
- 3 out of 5 of the top scores in survey and 4 out of 5 most improved scores relate to discharge, demonstrating impact of the Trust's focus on improving patient experience in this area
- 99% of patients felt they were treated with dignity and respect, (national average of 98%)
- 86 % rated overall patient experience 7/10 or more (2017 score 84%, national average 85%).

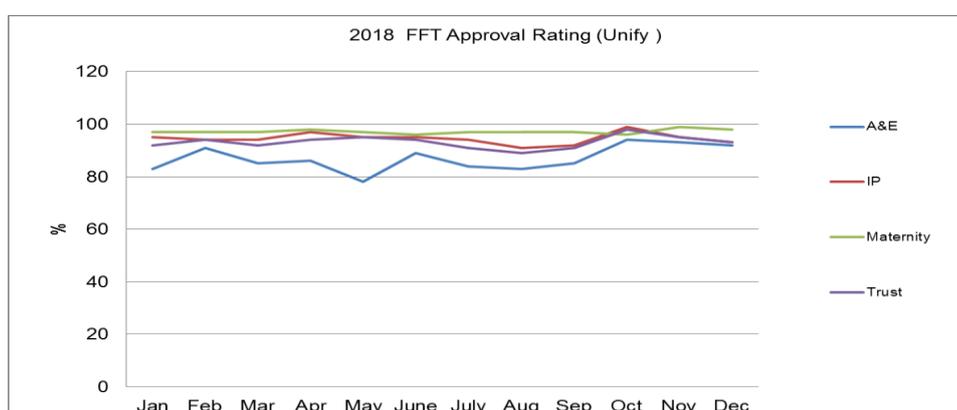
Friends and Family Test (FFT)

In December 2018 the Trust began a pilot of an online FFT platform in accident and emergency, community services and maternity. Early results are very positive for example we saw an increase in response rates from 8% to 27% in accident and emergency.

FFT response rate January-December 2018



FFT approval rating January -December 2018



Friends and Family test for staff

The table below details performance against the Friends and Family Test for staff: Would staff recommend the Trust as a provider of care to their friends and family?

Prescribed Information	Reporting Period	BHT Score	National Average	Highest Score (Best)	Lowest Score (Worst)
The data made available to the National Health Service Trust or NHS foundation Trust by NHS Digital with regard to the percentage of staff employed by, or under contract to, the Trust	2016/17	67%	68%	95%	45%
	2017/18	67%	69%	87%	60%

during the reporting period who would recommend the Trust as a provider of care to their family or friends.	2018/19	70%	70%	90%	49%
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The Buckinghamshire Healthcare NHS Trust considers that this data is as described for the following reason: the figure from the National NHS Staff Surveys 2017 and 2018 is an annual survey which is published by the Department of Health. This annual survey is a poll of NHS Trust staff each year.

Buckinghamshire Healthcare NHS Trust intends to /has taken the following actions to improve this score, and so the quality of its services, by:

- Details of the actions taken are set out in the sections describing the work of the Trust Freedom to Speak Up Guardian and the NHS Staff Survey.

Venous Thromboembolism

The table below details performance against the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism

Prescribed Information	Reporting Period	BHT Score	National Average	Highest Score (Best)	Lowest Score (Worst)
The data made available to the National Health Service Trust or NHS foundation Trust by NHS Digital with regard to the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.	2017/18 Quarter 3	96 %	95%	100%	76%
	2018/19 Quarter 3	95%	96%	100%	55%

Buckinghamshire Healthcare NHS Trust considers that this data is as described for the following reasons:

- The Trust has made regular and timely data submissions to NHS Digital and the figures are consistent with those produced by the Trust internal information systems.

Buckinghamshire Healthcare NHS Trust intends to /has taken the following actions to improve this score, and so the quality of its services, by:

- Ensure compliance with NICE guidance
- Monitor effectiveness of the VTE policy as a priority objective
- Promote patient information and patient engagement re VTE prevention
- Create e-learning package for the Trust
- Standardise the quarterly ward audits and improve the feedback pathways to departments/divisions

Clostridium Difficile infection rate

The table below details performance against the C. difficile infection rate per 100,000 bed days.

Prescribed Information	Reporting Period	BHT Score	National Average	Highest Score (Best)	Lowest Score (Worst)
The data made available to the National Health Service Trust or NHS foundation Trust by NHS Digital with regard to the rate per 100,000 bed days of cases of C.difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period.	2016/17	17.06	13.2	82.7	0
	2017/18	17.47	13.7	91.0	0
	2018/19	18.42	Not Avail*	Not Avail*	Not Avail*

* Data not available at the time the report was written.

Buckinghamshire Healthcare NHS Trust considers that this rate is as described for the following reasons:

The yearly objective for Buckinghamshire Healthcare NHS Trust (BHT) was 31 cases. BHT ended the year with 45 cases. A root cause analysis is undertaken of all cases together with the CCG and the outcome of that work concluded that:

- 28 of the 45 cases were unavoidable
- 17 of the 45 cases were avoidable

Avoidable is defined as follows:

- Lapse/lapses in care identified that has/have directly contributed or there is reasonable correlation with the patient acquiring this episode of C.difficile infection at Buckinghamshire Healthcare NHS Trust.
- For example, if the antibiotics prescribed to the patient in question were not in line with published BHT guidelines and not appropriate for the clinical syndrome/s, then the case will be deemed avoidable.

This analysis demonstrated that there are three main areas to consider:

- The judicious use of antibiotics across the Trust
- A review of cleaning methods and approaches
- Collaborative team working within wards

Buckinghamshire Healthcare NHS Trust intends to /has taken the following actions to improve this score, and so the quality of its services, by:

- Undertaking an extensive piece of work reviewing the use of antibiotics and has achieved a 14.4% reduction in Carbapenem usage (national target of 2% reduction in consumption/1000 admissions) and a 6.7% reduction in total antimicrobial usage (national target 1% reduction in total antimicrobial consumption/1000 admissions).
- Piloting the use of automated decontamination in 2018/19 on the Stoke Mandeville site which resulted in a reduction of C. difficile infections in the following months.
- Embedding the use of the Perfect Ward app which allows staff to jointly audit ward practice, including infection prevention practice.

In the year ahead all three of these areas will continue to be a focus. In addition, the Trust is introducing a Scrutiny Panel review with the Clinical Commissioning Group, Medical Director and Chief Nurse for each new C. difficile infection.

Patient safety incidents

The table below details performance against the number of patient safety incidents reported and the level of harm:

Prescribed Information	Reporting Period	BHT Score	National Average	Highest Rate	Lowest Rate
Rate of patient safety incidents (per 1000 bed days) when benchmarked against medium acute trusts	2017/18	37.63	46.2	111.69	23.47
	2018/19	39.7	44.5	107.4	13.1
Percentage of patient safety incidents resulting in severe harm or death when benchmarked against medium acute trusts	2017/18	0.5%	0.3%	2%	0%
	2018/19	0.2%	0.4%	1.2%	0%

Buckinghamshire Healthcare NHS Trust considers that this number and/or rate is as described for the following reasons:

- The Trust is committed to reducing harm and pro-actively encourages staff to report incidents and near misses and,
- This is evident in the much improved number of incidents uploaded in this time period.

Buckinghamshire Healthcare NHS Trust has taken the following actions to improve this number and/or rate, and so the quality of its services, by:

- Analysing and learning from its mistakes encouraging an open and transparent reporting culture with incident reporting discussed from ward to Board.
- The promotion of near misses as 'good catches' when discussed in meetings and in the Staff Induction Handbook where reporting is aligned to the Trusts' CARE values.
- Promoting feedback from investigations to staff reporting incidents in a timely manner as part of the Quality and Safety Performance Framework and to ensure timely application of duty of candour. Duty of candour fields on the current electronic risk management

system have been revised to enable staff to provide assurance through increased detailed recording on how duty of candour is applied.

- Moving towards a mature patient safety culture which values openness, transparency and quality, the Corporate Patient Safety team continues to facilitate the development of patient safety subject matter expertise amongst the divisional clinical governance leads.
- Scheduling regular meetings with divisional clinical governance leads to build inter divisional relationships for the benefit of joint investigations and shared learning.
- Aspiring to achieve a continual reduction in the proportion of incidents that result in death and severe harm in comparison to the proportion of incidents that are near misses or result in no or minor harm.

Mortality data

During 2018/19, 1,170 of Trust patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

April 2018-March 2019	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Totals
Number of BHT deaths	273	253	302	342	1,170
Number of deaths reviewed by Medical Examiner	273	253	302	342	1170
Deaths subject to case note review (Structured Judgement Review SJR)	41	33	34	41	149
Serious incident investigations	1	2	4	3	10
Deaths more likely than not to have been due to problems in care	0	0	0	0	0
Overall percentage of deaths more likely than not to have	0%	0%	0%	0%	0%

been due to problems in care					
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2017/18

Number of deaths in April 2017-March 2018 reviewed/or investigated after previous reporting period	For those still awaiting review number due to problems more than likely than not to have been due to problems in care	Overall percentage of deaths due to problems more than likely than not to have been due to problems in care
18 ME Reviews 34 SJRs	0	0%

Learning from deaths: improving patient safety and quality of care

Buckinghamshire Healthcare NHS Trust introduced the role of Medical Examiner (ME) in December 2017. The ME service has provided an opportunity to develop a system that provides independent scrutiny of adult inpatient deaths in partnership with families and carers, and identifies opportunities for learning.

The Trust revised mortality review process has a standardised and evidence based Structured Judgement Review (SJR) process for reviewing case records of adult patients. The primary aim is to improve healthcare quality through qualitative and quantitative analysis of mortality data using a standardised, validated approach linked to quality improvement.

End of year results

- A total of 1,170 deaths underwent independent consultant review
- Annual mean selection for structured judgement review (SJR) 12% in line with national expectations
- 88% of cases were identified as having no care problems
- SJR compliance increased to 89%
- A total of 535 compliments, culminating in 34% of excellence reporting

BHT mortality review process

Following the introduction of a Medical Examiner Service, independent screening of all in hospital adult deaths has shown consistent compliance at 100% in comparison to a compliance of 81% in previous years. The ME selects cases for SJR where further learning has been identified, serious incidents (SI) are declared in accordance with the NHS England SI Framework 2015. All SIs are presented to a multi-disciplinary panel with executive and Clinical Commissioning Group (CCG) oversight.

Learning from deaths - SJR findings

SJR findings show no statistical significance in the number of deaths on any given day of the week or day of admission. Learning related to the first 24 hours of admission identified the need to focus on improvements in timely sepsis recognition. This has led to an increase in Q4 Suspicion to Needle Time (STNT) to 81%, and Emergency Department (ED) sepsis screening increased to 87%.

End of life care is evaluated focusing on timely decision making, good communication with relatives and ensuring symptomatic control. The palliative care team have also introduced the purple rose initiative promoting personalised care plans at the end of life.

Patients with a learning disability

The Learning Disabilities Mortality Review (LeDeR) programme is a national programme aimed at making improvements to the lives of people with learning disabilities (LD). All LD deaths undergo national LeDeR reporting with access to the SJR Datix platform. Patients with a learning disability have a reduced life expectancy - this is evidenced in SJR review and nationally recognised. Liaison with primary care has led to the creation of an admission and discharge pathway for LD patients - this was following learning at LeDeR review. Ongoing focus on the care of learning disability patients includes best practice guidance, health passports, communication aids, focused training and education and specialist input from Learning Disability (LD) nurses to guide treatment.

Cardiac arrest reviews

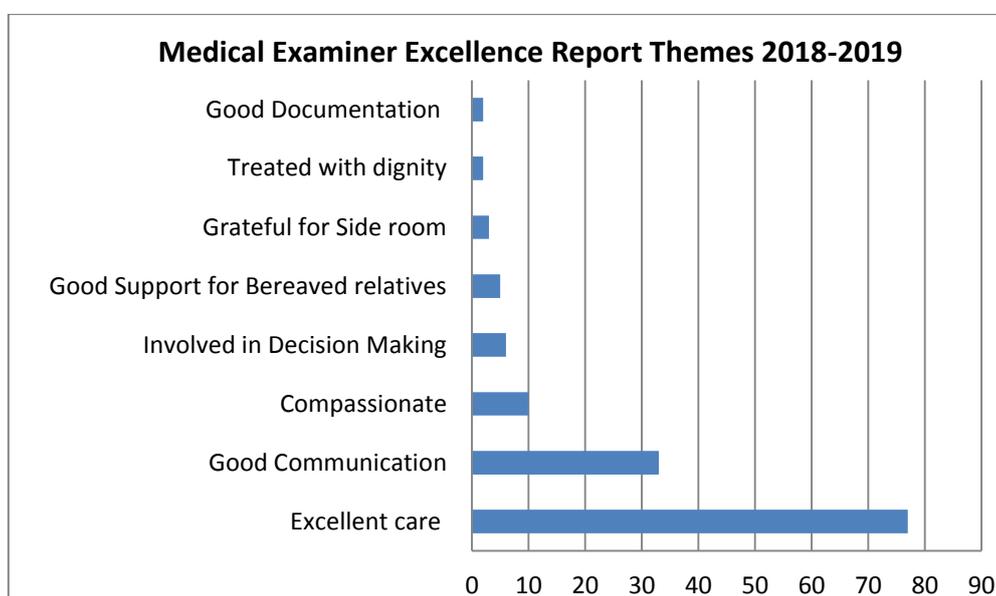
Following multi-disciplinary SJR review it was evidenced that initiation of DNACPR and Treatment Escalation Plans (TEPs) required improvement across the Trust. Training has been provided to consultant groups. A TEP working party has been established with a view to universal adoption of TEP for all adult inpatients within 48 hours of admission.

Relatives Feedback

Feedback from bereaved relatives has been overwhelmingly positive. Compliments received are relayed to ward teams in the form of rapid feedback.

- Over 30% of all compliments were endorsed by the Medical Examiner as cases of excellence
- Theme analysis of excellence reporting includes excellent care, good communication, compassion and involvement in decision making - these themes are disseminated to the divisions for departmental reporting

Relatives' narratives and patient stories relay a very powerful message and have been used in training and education to support change. Relatives also provide positive feedback on the benefits of discussion with the medical examiner as per the example below.

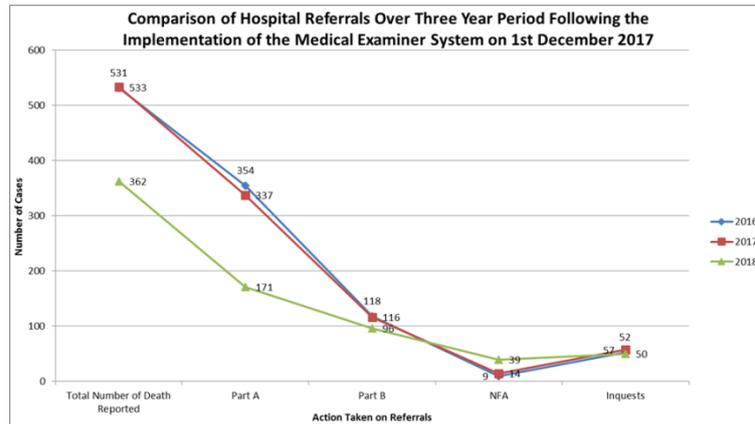


In accordance with national guidance SJR feedback to relatives is via an established pathway and endorsed within BHT mortality review policy.

Improvements and actions

Local partnerships

- Local agreement with the coroner has led to a reduction of 32% in coroner referrals since the launch of the medical examiner service



As an integrated care system, we have worked closely with the local authority, coroner’s office and registrar. Quarterly meetings ensure learning is disseminated beyond BHT and with our regional partners.

Primary care feedback

Over 100 cases of care home admissions have been audited. This data has been presented nationally. Themes relate to end of life care better placed in the community, the importance of frailty assessment and treatment escalation planning in the community. Further presentations are scheduled to promote the role of medical examiner (ME) amongst General Practitioners with the next implementation phase of National ME to the community.



Pictured above: the mortality review team

Information governance

The Trust recognises the importance of managing information and personal information in particular, appropriately and securely. The Senior Information Risk Owner (SIRO) is responsible for ensuring the Board has comprehensive and reliable assurance that appropriate controls are in place and that risks are managed in relation to all information used for operational and financial purposes.

The Data Security & Protection Toolkit sets out the National Data Guardian's (NDG) data security standards and demonstrates an organisation is working towards or meeting the NDG standards. The purpose of the assessment is to enable organisations to measure their compliance against the law and central guidance and to see whether information is handled correctly and protected from unauthorised access, loss, damage and destruction. During 2018/19, internal auditors RSM undertook a sample review of the Trust's completed DSP Toolkit assertions to test for completeness and validity of evidence associated with the 10 Data Security Standards.

The Caldicott and Information Governance Committee monitor the performance of the Trust against the requirements of the Data Security and Protection Toolkit. The Trust has self-assessed its performance on information governance requirements using the standards stipulated in NHS Data Security and Protection (DSP) Toolkit. The Trust has satisfactorily met all the mandatory standards for 2018/19 submission. Final end of year submission was at the end of March 2019.

During 2018/2019 there were five reportable data breaches. These breaches were reported to the Information Commissioner which were reviewed, assessed and none were upheld and no further action taken as they felt that appropriate and timely remedial actions were promptly taken by the Trust, which helped to contain the situation and no serious harm or adverse effects ensued.

Implementing the Priority Clinical Standards for Seven Day Hospital Services

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

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

The four priority clinical standards are:

- Standard 2: Time to initial consultant review
- Standard 5: Access to diagnostics

- Standard 6: Access to consultant-led interventions
- Standard 8: Ongoing daily consultant-directed review

Results from the self-assessment submitted in 2018:

Clinical Standard	Seven day hospital self-assessment – four priority standards	Overall
2	90% of emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital	97% Standard met
5	Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week: <ul style="list-style-type: none"> • Within 1 hour for critical patients • Within 12 hours for urgent patients 	Standard met
6	Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on site or through formally agreed networked arrangements with clear written protocols. These interventions would typically be: <ul style="list-style-type: none"> • Critical care • Interventional radiology • Interventional endoscopy • Emergency general surgery • Emergency renal replacement therapy 	Standard met
8	All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate).	97%

	Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.	
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Freedom to Speak Up

Results from the National Staff Survey for 2018 have shown improvements termed as “significant” in the following two areas. Increases in results for a single year are more usually expected to be in line with 1% so we are pleased to be able to headline these very positive results.

- Results demonstrate a **4% increase** in staff saying they would feel secure in raising concerns about unsafe clinical practice. This also brings us inline to meet the national score for our relevant similar Trusts of 70% (sector score).
- Furthermore, we have also seen another **4 % increase** in staff saying they are confident that the organisation would address their concern. This brings us to just 1% below the national sector score of 58%.
- These are also important results, making a contribution to our overall safety culture score which also improved from 6.5 last year to 6.7 in the most recent results.

These results help us demonstrate positive progress on the journey to building a positive speaking up culture at BHT. Our ‘Freedom to Speak Up Guardian’ (FTSUG) has now been in post for two years and has seen year on year growth in numbers of staff accessing the service to raise concerns, with numbers of cases last year at 46 now exceeding 70.

Governance arrangements include a Trust policy and procedure and the FTSUG reports regularly through a number of committees including a delegated sub-committee of the Board and to Trust Board directly.

Learning and changes as a result of concerns is shared through a variety of routes which includes reports, committees, Trust Board, presentations and our trustwide lessons learnt programme, in which our FTSUG participates annually. Our “Building a Climate of Respect”

campaign is just one example of action taken to address concerns raised by staff. We launched a video trustwide with clear messaging led by our Chief Executive Officer (CEO) and others, to support all staff in promoting a zero tolerance to poor behaviours, bullying or harassment. We have also developed an extensive online resource guide. These have both been well received and feedback has suggested they have added value in helping staff to feel better able to speak up about behaviour. This has been shared across the regional network of FTSUGS and with the National Guardian Office.

There are multiple ways staff at BHT can raise concerns across the Trust in addition to the FTSUG. Staff can and should use their usual line management reporting routes but we also have a lead executive for speaking up and a designated Non-Executive Director (NED). In addition, there are a variety of systems and processes such as incident reporting and exit interviews that enable staff to raise a concern with a large range of staff in roles such as clinical leads, tutors, safeguarding teams, our director for Medical Education and the Guardian for Safe Working Hours. Executives and other Non-Executives (NEDs) led by our Chair and CEO continue to proactively encourage staff to build a positive speaking up culture across the organisation and are always willing to listen to staff concerns.

PART THREE

Further aspects on quality improvement

Infection control and prevention

GNBSI – Gram Negative Bacteria Site Infection

NHS Improvement ambitions (system wide targets), based on 2017-2018 figures are:

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

BHT therefore adopted this 'ambition' target to be applied internally within the Trust with respect to BHT acquired BSIs

- BHT internal ambition was 10% reduction for 2018-2019 based on 2017-2018 figures

For 2018-2019, based on 2017-2018, the % reductions are:

- E. coli = 6.7%
- Klebsiella = 11.8%
- Pseudomonas = 25%
- **TOTAL = 11.5%**

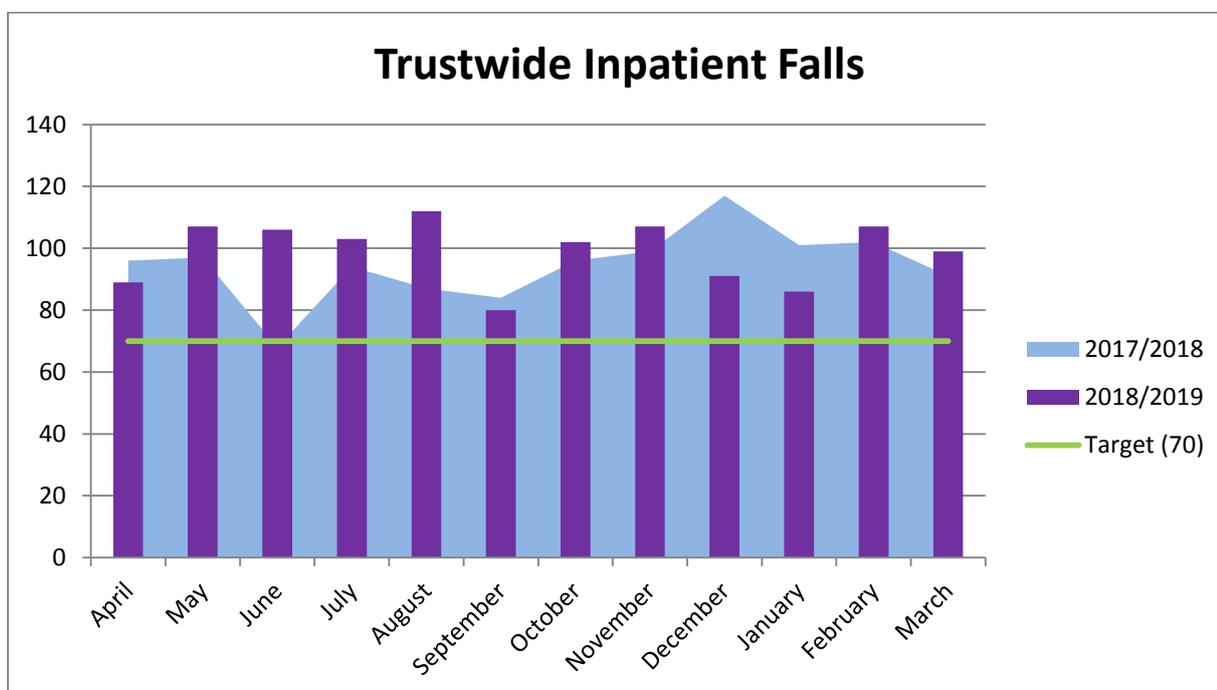
	2017 - 2018	2018 - 2019	TOTAL
E. coli (Total Reported)	45 (231)	42 (252)	87 (483)
Klebsiella (Total Reported)	17 (56)	15 (55)	32 (111)
Pseudomonas (Total Reported)	16 (27)	12 (24)	28 (51)
TOTAL (Total Reported)	78 (314)	69 (331)	147 (645)

Inpatient falls

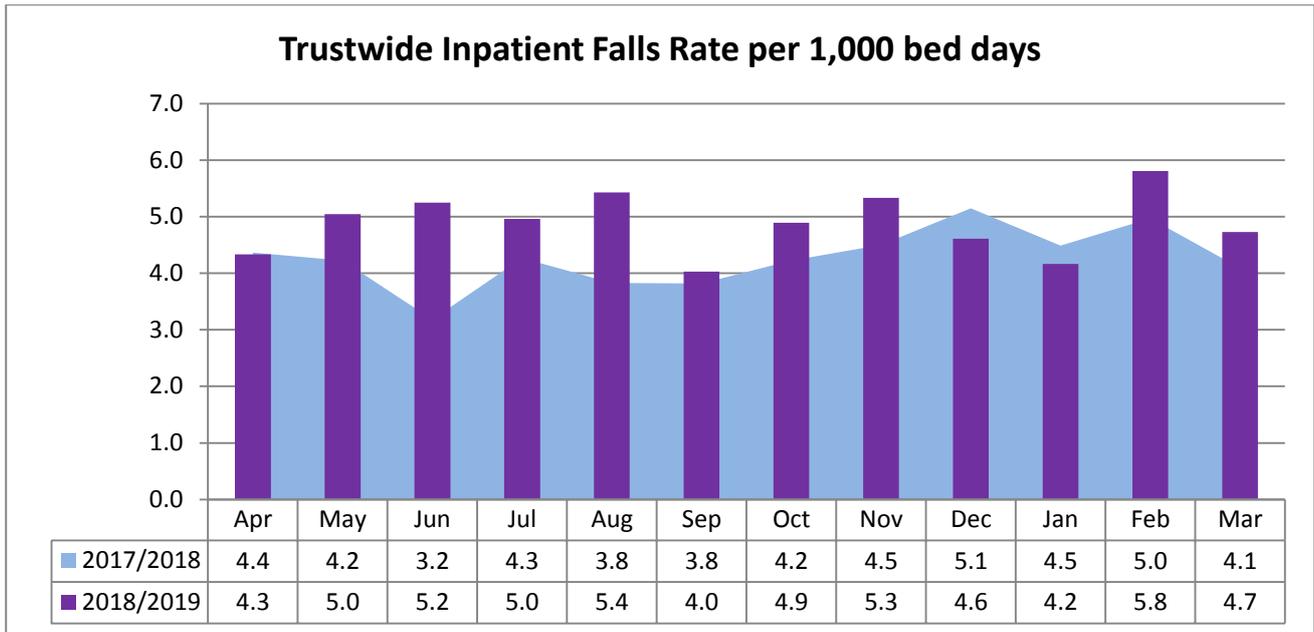
There is a continued strong focus on the reduction on inpatient Falls for the Trust, and a target of no more than 70 falls per month has been set.

Interventions include:

- Focus on 'stay in the bay' or 'stay with me' to ensure we maximise observation of patients at risk
- Implementation of the Fallsafe bundle
- Completion of risk assessment and appropriate care planning
- Appropriate equipment
- 'Specialing' of patients at high risk



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2017/2018	96	97	68	94	87	84	96	99	117	101	102	91	1132
2017/18 Moderate or above harm	0	3	1	1	1	0	2	0	1	1	1	4	15
2018/2019	89	107	106	103	112	80	102	107	91	86	107	99	1189
2018/19 Moderate or above harm	0	1	0	2	1	1	1	1	3	2	3	0	15



Falls with harm

	2017/18	2018/19
Total	1132	1189
No harm	651	709
Low Harm	466	465
Moderate Harm	14	13
Severe Harm	1	1
Death	0	1

In 2018/2019 we have had 13 falls with moderate harm, 1 fall with severe harm and 1 harm which resulted in death.

Pressure ulcers

There continues to be a strong focus on the reduction of Trust acquired pressure ulcers especially due to the rise seen in 2017-18.

During 2018-2019 the target was to reduce category 3 and 4 pressure ulcers by 100% and category 2 by 25% - 30 new recommendations across NHS Trusts for standardisation of reporting.

Total category 3 & 4 pressure ulcers

- 2016-2017 = 5 deemed avoidable
- 2017-2018 = 14 deemed avoidable
- 2018-19 = 9 deemed avoidable

Trust acquired category 2 pressure ulcers

- 2016-2017 = 281
- 2017-2018 = 275
- 2018-2019 = 220

Interventions include:

- New NHSI guidance wanting all pressure ulcers investigated – numbers will rise across Trusts
- Last year 257 patients admitted with category 3 / 4 /deep tissue damage - present on admission to BHT
- 126 of the patients admitted with category 3 or 4 deep tissue damage were admitted for surgery or following a long lie or from external Trust locations – this accounts for 50%
- Levels of harm have to be accurate and not linked to a pressure ulcer category – BHT to revise April 2019
- 2019-20 more emphasis on actions required from all divisions
- New posters for moisture associated skin damage compiled to comply with NHSI guidance
- 342 face to face training sessions on pressure ulcers across BHT – provided by Tissue Viability Nurses and link nurses
- To carry out joint investigations going forward with residential homes and care agencies

Current BHT position for category 3, 4 & deep tissue injury – total numbers:

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2016/2017	3	2	3	4	0	2	2	2	0	1	1	4	24
2017/2018	1	1	5	1	4	4	3	3	6	5	2	5	40
2018/2019	4	1	1	1	2	0	3	2	2	2	5	5	28
2018/19 Deemed avoidable	1	0	1	0	0	0	2	0	1	1	2	1	9
% reduction	0	0	0	0	0	0	0	0	0	0	0	0	↓30%

Current BHT position for category 2

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2016/2017	32	31	20	29	18	15	22	17	28	29	20	20	281
2017/2018	16	31	20	24	20	23	28	16	22	28	20	27	275
2018/2019	29	21	16	19	19	18	11	16	27	13	18	13	220
% reduction	17	17	17	17	17	17	17	17	17	17	17	17	↓20%

Medical device related pressure ulcers (new audit) – also included in above figures

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2018/2019	3	1	1	3	1	0	1	3	5	0	0	0	18

Moisture- associated skin damage (new audit) (MASD)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2018/2019	x	x	x	x	x	x	x	x	x	x	x	x	x

Actions for improvement

- Care rounds discussed in daily safety round with consultant and senior nurse
- New dressings being looked at that are see-through so wound can still be observed
- Tissue Viability community post re-advertised for divisional Tissue Viability Nurse

- All areas now using pressure ulcer care plan
- Mattress selection pathway
- Hybrid mattress trial just completed on St George's ward (NSIC)

Duty of candour

The Trust is committed to high quality healthcare and to observe the requirement to be open, transparent and candid when things go wrong. The duty of candour requires that where a safety incident results in moderate or severe harm, or death, that the Trust disclose this to the patient and/or their family and any other 'relevant person', within 10 working days with an expression of regret, and an explanation of next steps.

NHS organisations have a duty to provide patients and their families with information and support when a reportable incident of this grade has, or may have occurred and provide updates at agreed points until the incident has been fully investigated with actions to support improvements.

Duty of Candour training is now a statutory e-learning module for all staff and uptake of training is monitored and addressed through the education and learning team.

The Trust has a current policy regarding being open and duty of candour and has standardised written information for patients where the duty of candour applies, which includes an outline of what the patient or family should expect. This may be adapted according to a specific incident but includes details of the investigation process and provides contact details of a senior member of staff who will keep the patient/relative informed of progress and who can be contacted with any questions.

The application of duty of candour is always approached with sensitivity with staff mindful that for some patients or families we will need to rebuild their trust in our ability to care for them or their loved one. We do this by asking the patient or family what questions they would like us to answer when investigating an incident which should then, when answered, demonstrate that we are willing to listen and learn where we need to improve.

Safeguarding

Safeguarding adults

The safeguarding adult team is developing closer working links with the hospital social work team, especially in respect of collaborative working to carry out Section 42 enquiries. These are enquiries related to any action that is taken (or instigated) by a local authority (under Section 42 of the Care Act 2014), in response to indications of abuse or neglect in relation to an adult with care and support needs who is at risk and is unable to protect themselves because of those needs.

More robust processes are now being developed with Trust clinical governance leads to ensure that the recommendations and actions from section 42 enquiries are captured and monitored at local level.

For the coming year the safeguarding adult leads plan to build on the developing relationships with hospital social workers to enable earlier help and support for staff around effective discharge and the implementation of Mental Capacity Act (MCA) and Deprivation of Liberty (DoLS) in day-to-day practice. Continuous audit of MCA and DoLS practice will be used to demonstrate improvement or key areas of concern.

The safeguarding adult team works in close partnership with local authority counterparts and will be co-operating in the anticipated forthcoming changes to Buckinghamshire Safeguarding Adults Board (BSAB) and sub-groups. The principles of making safeguarding personal is a key area of focus for BSAB and BHT will be assertively promoting these throughout the coming year.

Safeguarding children

The safeguarding children team continues to work effectively within the local partnership arrangements and is supporting anticipated changes in respect of the multi-agency safeguarding hub (MASH) and exploitation sub group.

Local arrangements in relation to the exploitation of children are currently being enhanced in order to recognise those areas of exploitation other than sexual. It is well recognised that the exploitation of young people can happen in varied ways. Many young people are subject to modern-day slavery as well as gang and drug related exploitation (county lines), which very often extends into their lives as young adults. This is now being acknowledged in

Buckinghamshire and changes in ways of working are now underway; BHT is a key partner in these changes.

The transition of young people into adult services is becoming an area of greater focus within local children's services and this issue is also being recognised in the NHS long term plan. Changes in national and local safeguarding priorities for children will require closer cooperation between children and adult services. The safeguarding structures and arrangement within BHT and the ways of working within the safeguarding team already identify the interface between child and adult services. This will be a key area of focus and improvement for the coming year.

Learning disability liaison

The work of the Learning disability (LD) liaison nurses continues to expand as the number of patients referred to them by Trust staff increase. This is a positive development and indicates growing awareness by BHT staff of the specific needs of people with learning disabilities and the support available.

Future plans for improving staff awareness for specific groups of people with LD will include focused training and support for staff, especially those working in the Emergency Department (ED) in respect of the effective management and support of people with Autistic Spectrum Disorders (ASD). Discussions will be taking place about the prospect of providing means of identifying people with ASD (or indeed with any other communication needs) in ED so as to ensure that their specific needs can be better met. This approach is in line with the principles of making safeguarding personal.

Mental health

BHT safeguarding team works effectively in partnership with colleagues in Oxford Health Foundation Trust (OHFT) including safeguarding equivalents and the BHT Psychiatric In-Reach Liaison Service (PIRLS). BHT also attends the monthly Partnership in Practice (PiP) meetings at the Whiteleaf Centre in Aylesbury and participates in the Crisis Care Concordat.

This is a growing area of development within BHT and the recognition of the parity of esteem for mental health needs alongside those for physical health is being promoted. Whilst it is recognised that more needs to be done in this area of care the achievements of the past year include:

- The development of a Mental Health Act Administration Policy and associated training.

- The establishment of a Mental Health Group which meets quarterly and is attended by Trust staff from all specialities including midwifery, elderly care, children and adult community services as well as colleagues from OHFT.
- Working with colleagues from Public Health to promote suicide prevention awareness which includes sending a member of BHT staff on a City and Guilds training programme.

Training

Safeguarding training is a large part of our strategy (compliance data is below). We have also been working on a comprehensive training needs analysis which is consistent with the requirements of both children's and adult's intercollegiate documents.

The table below sets out the training compliance data for the year ending 31 March 2019 as compared to the same time period in the previous year. Whilst there has been steady improvement in most training types, level 3 Safeguarding children training compliance is becoming an area of concern. Up until March 2019 training compliance at level 3 had been sustained at 90% and above, although gradual decline had been noted at recent meetings of the Trust Safeguarding Committee. This deficit will be addressed by alerting divisional leads and ensuring that additional training events are made available to the relevant staff groups.

We are investigating the drop in Deprivation of Liberty (DoL) training levels and following up into the new financial year to ensure that compliance levels are met.

Safeguarding training compliance BHT			
Training type	Target	31.03.2018	31.03.2019
Child protection level 1	95%	88.23%	91.02 %
Child protection level 2	95%	79.47%	88.38%
Child protection level 3	95%	94.05%	89.88%
Safeguarding Adult Awareness	95%	86.26%	89.83%
MCA	95%	88%	97%
DoLS	95%	90.49%	88.89%
WRAP (Prevent)	95%	97.13	96.86%

As the Care Quality Commission indicates in their position statement on safeguarding training, whilst the level of training is a good indication as to how well the provider responds to safeguarding concerns, it is not the sentinel indicator of good child safeguarding arrangements in an organisation. The organisation needs to demonstrate that they have a 'comprehensive safeguarding system' underpinned by policies, effective risk assessments, and high profile leadership as well as quality assured training and that they know that these are consistently in place. BHT is confident that its safeguarding arrangements and the current structures allow for continuous scrutiny, learning and improvement.

Audit

The BHT safeguarding team has developed a safeguarding audit schedule for the coming year. Progress will be reported to and monitored by the Trust Safeguarding Committee.

Looked after children

The Looked after Children (LAC) team are working in partnership with the Local Authority to improve the timeliness of health assessments in line with statutory guidance. The LAC team sought support from the Trust service improvement team to develop process maps to demonstrate the intricacies involved when arranging the health assessment for a looked after child. This work will identify areas for improvement.

Alongside the process mapping, standard operating procedures have been developed in conjunction with social care and are awaiting final sign off before implementation.

The LAC team are now using RiO (electronic patient record system) to produce reports on the progress of an individual child's LAC health assessments. The reports demonstrate on a month to month basis the number of health assessments that are due and those that have been completed.

All children aged 16-17 leaving care are entitled to receive a summary of their health records so young people leaving care have access to their health information. BHT and Children's Services agreed to distribute health summaries to the 131 children who left care during 2016 and 2017. BHT and Social Care worked together to write to all young people to advise them of their entitlement to a health summary; and to gain their informed consent for the health information to be produced and issued. A follow up letter was sent to those young people

who did not respond. Health summaries have now been provided to all the young people that replied.

All letters sent included the contact details for the LAC Health Team and indicated that the young person could get in touch with the team at any point in the future, either to request a health summary or to discuss other health matters. As young people approach turning 18 in 2019-2020 they are routinely provided with a leaving care health summary, this matter is now business as usual.

The LAC team continue to deliver training and updates to BHT colleagues across the Trust to ensure competence in line with the Intercollegiate Framework (RCN, RCPCH 2015). Bespoke training to Specialist Community Public Health Nurses (SCPHN's) and SCPHN students has also been delivered to aid the quality and timeliness of health assessments that are completed by BHT personnel. A new mechanism for reminders and escalation to individuals and their managers is being implemented to further aid this work.

The LAC team have developed an audit plan 2019-2020. The first audit will review the content and quality of leaving care summaries; a dip sample will be reviewed. A further audit of the LAC caseload will be undertaken to ensure LAC are appropriately referred onto the RiO caseload and an alert has been added to their health record. This will review standard operating procedures and ensure governance and quality measures are being appropriately followed.

Domestic abuse

Domestic violence and abuse is identified as a major public health issue, impacting on survivors and their children and families' physical and emotional health and well-being and may also include homelessness, loss of income/work, isolation, poverty and financial hardship (NICE 2015). Early intervention can reduce the many consequences of domestic violence and abuse (Violence against Women and Girls 2016-2020 Department of Health).

Aligned with the requirement for all NHS Trusts, BHT has a Domestic Violence and Abuse policy (awaiting final sign off at the time of writing this document) in line with the principles of The National Public Health Outcomes Framework for England (2013-2016) and NICE Quality Standard Domestic Violence and Abuse (QS116) 2016.

The safeguarding children and adults teams offer support and advice on domestic abuse issues across BHT both within the community and hospital setting, this includes any staff

member. This guidance includes whether referrals are necessary to the local authority (First Response or Adult social care). The safeguarding teams assist staff with completion of the DASH forms (Domestic Abuse Stalking Honour based violence forms).

The children's safeguarding team works in collaboration with partner agencies, including the Police and children and adult social care teams attending Multi Agency Referral Assessment Conferences (MARACs). These are regular local meetings where information about high risk domestic abuse victims (those at risk of being killed or seriously harmed) is shared between local agencies. By bringing all agencies together at a MARAC, a risk focused, co-ordinated safety plan is formulated to support the survivor. The children's team research all cases listed for the MARAC meetings which take place weekly. Information to raise awareness of those discussed at this meeting is disseminated to the relevant GP practice. In addition the safeguarding teams support and train staff in areas of high demand such as the emergency department, maternity and health visiting teams to raise awareness of any changes to policy and signposting across the Trust.

Identified staff groups such as midwives, health visitors, mental health and sexual health practitioners are required to complete routine enquiries. This creates an opportunity to ask all women who access these services about their experiences, if any, of domestic violence or abuse, regardless of whether there are indicators of abuse or violence is suspected. All safeguarding teams are aware that men as well as women can be a victim of domestic abuse. A member from the safeguarding adult and children teams attends the quarterly Domestic Abuse strategy group and provides feedback to staff across BHT.

Stalking is a criminal offence and should always be taken seriously. BHT takes extremely seriously the health, safety and welfare of all its employees, volunteers, students, patients and visitors. It believes that violence and/or aggression including stalking of staff and others is unacceptable. Members of staff have the right to be able to perform their duties without fear of being stalked by other staff, patients/clients or members of the public. No member of staff should consider violence or aggression including stalking to be an acceptable part of their employment. While differences of attitude or culture and the interpretation of social signs may mean that what is perceived as stalking by one person may not seem so to another, the defining feature of stalking is that the behaviour is a repeated, unwanted intrusion and causes the recipient to be fearful for themselves or those close to them. As with bullying and harassment the motivation for this unwanted behaviour is not a mitigating factor. Stalking

may involve individual acts which themselves might not cause alarm but have a cumulative effect. Any such behaviour will be reported to the police.

Trust employees will attend domestic violence and abuse training at a level identified appropriate to their role and responsibilities (Buckinghamshire Healthcare NHS Trust Strategy 2018 and NICE 2015, Nice Quality Standard 2016), such as DASH training and the opportunity to undertake a DVA Champions Role if appropriate. Further clarification of the training level appropriate to role can be accessed via the learning and development team and the safeguarding team.

The safeguarding teams deliver in conjunction with external partners such as Women's Aid Level 2/3 domestic abuse training.

Learning from never events

Never events are few in number, rarely attributable to one practitioner, and often found to involve a set of circumstances for which each individual aspect, perhaps inconsequential on its own, collectively creates an environment in which a 'never event' can occur. Serious incident investigation reports and action plans are always undertaken for all never events and important features include a robust investigation, rigorous analysis and an action plan with sustainable recommendations.

NHS England provides technical guidance on the specific criteria for inclusions and exclusions of what constitutes a never event. They are '...a subset of serious incidents.' *NHS England Revised Never Events Policy and Framework 2015 – definition extract from p.7 &8.* The Never Events List was updated in February 2018 with the list and supporting documentation accessible on the NHS England website.

During 2018/19 none of the reported never events were repeats of the circumstances of the never events reported in 2017/18, which suggests that the learning from 2017/18 was robust.

For 2018/19 Buckinghamshire Healthcare NHS Trust reported 5 never events. The date, number and categories of never events were:

- Quarter 1 – April 2018 (3 Never Events)
- Quarter 2 – August 2018 (1 Never Event)
- Quarter 3 – October 2018 (1 Never Event)

- Quarter 4 - Zero (0 Never Event)

The declared Never Events are summarised below:

- Retained urology guidewire piece - poor integrity of the wire casing, with no long term physical harm to the patient.
- Retained fragment following removal of single lumen tunnelled line, with no long term physical harm to the patient.
- A wrong tooth extracted as part of an intervention where multiple teeth were being extracted, and anatomical presentation was atypical.
- Unintentional connection of a patient requiring oxygen to an air flowmeter, no harm came to the patient. This was regarded as a near miss.
- Retained vaginal swab, following labour, with no long term physical harm to the patient.

In all cases duty of candour met contractual requirements. Each incident has been separately investigated and actions taken to minimise the risk of recurrence; key messages for learning from never events which occurred in the Trust in 2018/19 included:

An appreciation of how our staff can influence clinical human factors to prevent incidents through:

Situational awareness: gathering enough information; querying anomalies; checking 'mental pictures' with others; recognising increased risks.

Decision-making: checking when we are uncertain before proceeding with a task; removing a heavy reliance on assumptions whilst recognising that some assumptions assist with smooth running of tasks.

Teamwork: ensuring a sufficient exchange of information for a shared understanding of what needs to be done.

These are linked to our responsibilities within the Trust recognising the importance of:

- Actions which address Patient Safety Alerts to prevent significant incidents
- Vigilance in both familiar and infrequent procedures
- Avoiding an over reliance on assumptions
- Checking and questioning to offer constructive challenge
- Checking equipment at relevant points in a procedure
- Good documentation as a fundamental part of high quality care

- Learning what did not go well, but also from exemplars, by modelling, seeing and reporting excellence.

Additionally, learning from never events in 2018/19 was shared through a range of forums such as newsletters, through team safety boards, Trust wide communications and through the Serious Incident Learning Group with topics on Learning from Never Events (August 2018) and Exploring the Principles of Effective Handover. (December 2018).

A trustwide presentation on never events themes was delivered by the Chief Nurse and Head of Patient Safety and Litigation (February 2019). This presentation also explored the recommendations in the national report on Never Events by the Care Quality Commission and NHS Improvement (*'Opening the Door to Change'*, December 2018).

The Trust has been asked to support scoping work which the National Healthcare Safety Investigation Branch (HSIB) are undertaking with regard to 'retained vaginal swab incidents following labour' as these are a relatively common occurrence nationally; for this reason all Trusts where this type of never event has occurred are being asked to share their learning and engage with the HSIB investigators, and the Trust welcomes this collaboration.

Complaints

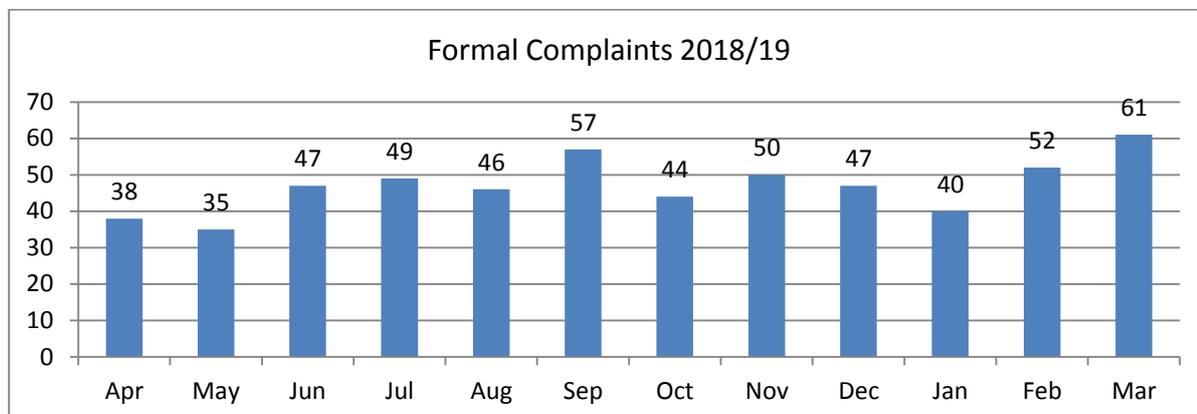
We know that a high quality complaints handling service is central to ensuring continuous improvement in the quality and safety of care at Buckinghamshire Healthcare NHS Trust.

The Trust invites patients, carers and visitors to contact our PALS (Patient Advice & Liaison Service) for support and advice regarding all services. This approach enables the PALS and complaints team to work together to appropriately manage enquiries and concerns that are raised by our service users. In 2018/19 we recorded 4663 PALS contacts from enquirers seeking advice and information about our services. This was an increase of 27% on last year.

Our complaints ethos is built on the Ombudsman's "Principles for Remedy" that state that complaints resolution should be based on:

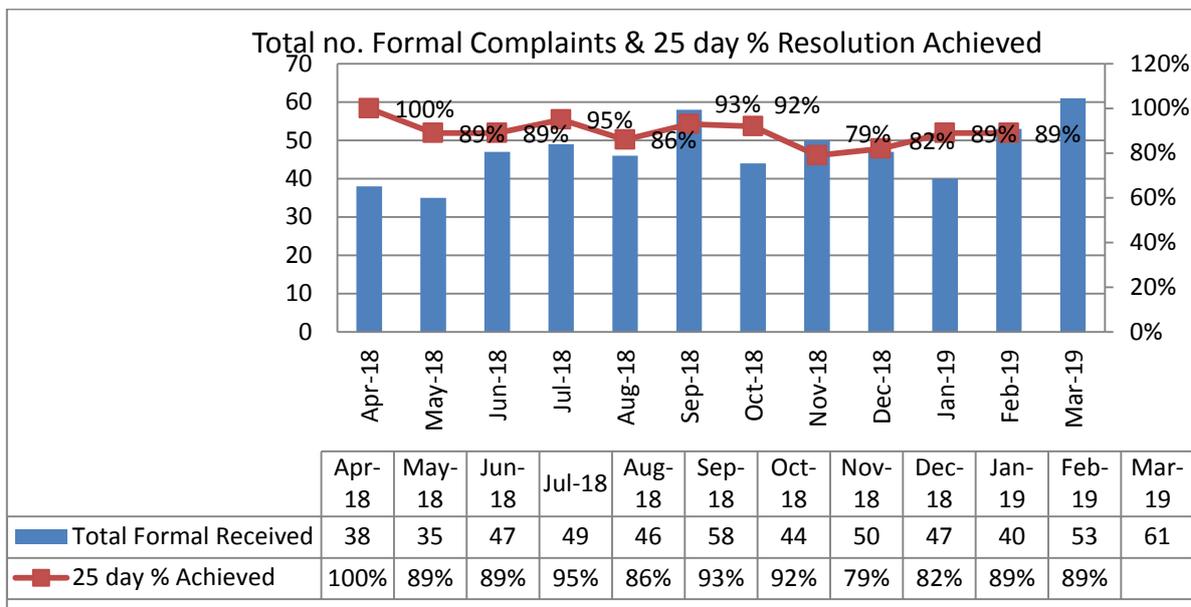
- Getting it right first the first time
- Being customer focused
- Being open and accountable
- Acting fairly and proportionately
- Putting things right
- Seeking continuous improvement

In 2018/19 Buckinghamshire Healthcare Trust received 565 formal complaints compared to 535 formal complaints received in 2017/18. This represents a 6% increase in complaints received when compared to the previous year.

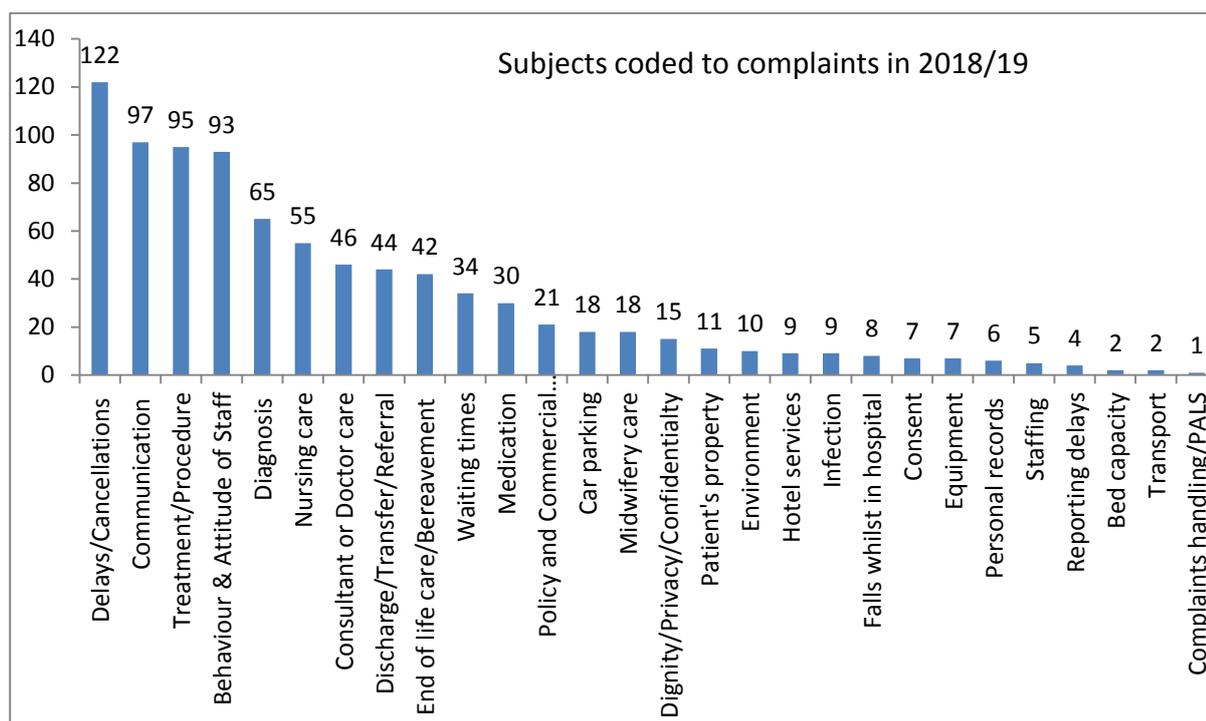


The Trust encourages feedback from a number of sources including our local partners, colleagues and patients which may include complaints. Complaints provide valuable feedback for the Trust about the quality of our services and the opportunity to learn from patients' experiences and drive real change in our service provision.

The following graph shows the number of formal complaints received each month throughout the reporting period. The Trust has set an internal target of 85% of all category 4 complaints to be responded to within 25 working days. Category 4 complaints are those that cannot be immediately resolved through the PALS service, do not cross multiple services or other healthcare providers, or require a more complex investigation. The graph below shows our performance during 2018/19. We achieved an average of 89% of complaints responded to within the 25 day time frame at the time of the report date.



The graph below illustrates the reasons that people raised formal complaints against the Trust in 2018/19. Delays and cancellations, communication and treatment/procedure were the main causes for complaints in 2018/19:



In 2018/19 there were 12 complaints referred to the Parliamentary and Health Service Ombudsman (PHSO). Of the 12 cases referred, 4 were not upheld, 1 was partly or fully upheld and 7 are currently being investigated.

In April 2018, we introduced a newly designed quality survey for complaint handling based on the 'User-led Vision for Raising Concerns and Complaints' published by the PHSO in November 2014. The report 'My Expectations for Raising Concerns and Complaints' presented 'I statements', as expressions of what patients and service users might say if their experience was a good one at every stage of the complaints process. The results indicated that we have delivered an accessible service and responded in a way that was easy to understand. The area for improvement centred on timeframes and complainant updates. It is important to note that all complainants who used the service agreed that they would complain again if they needed to.

Q1. I felt that it was easy to make a complaint.	Q2. I felt that my complaint was dealt with within the timeframe agreed in my acknowledgment letter and I was kept informed of any delays.	Q3. I thought that the response was easy to understand.	Q4. I felt my concerns were addressed in an open and honest way.	Q5. I felt my concerns were taken seriously.	Q6. I would complain again if I felt I needed to	Q7. Overall rating
87%	73%	77%	67%	70%	100%	6.6

Learning from complaints

A key component of every complaint investigation is the learning identified to inform improvement. Each complaint has an action plan that is recorded and monitored by the individual clinical divisions.

In 2018/19 YTD, we have documented 582 actions in relation to complaints closed.

Action taken in 2018/19	Coded
Feedback for specific staff member/s OR teams	196
Complaint shared anonymously with wider staff	73
Process change to be reviewed/plan set or complete	56
Appointment expedited, made or offer of appointment	41
Staff training or Academic Half Day	37
Agenda item for Governance/Quality Meeting/Team Meeting	34
Feedback or liaison with another Trust/provider/GP	23
Documentation changed or introduced	22
Audit requested/to be carried out	16
Policy change or Guidelines reviewed - planned or complete	13
Increase in clinics or service provision	12
Inter-departmental working/MDT planned	12
Equipment/software changed or purchased	11

Reimbursement or ex-gratia payment	10
Signage changed or environment upgraded	10
Team communication sent in writing	8
Invitation for Public and Patient Involvement	5
Care plan change	2
Case Study or Patient Story provided by patient for learning	1
Totals:	582

NHS Staff Survey

The 16th NHS national annual staff survey was conducted between October and December 2018. All staff within the Trust were invited to participate in the survey either online or in paper format; 2,954 surveys were returned representing a 51% response rate. This was an increase when compared to the previous year's response rate of 49%, and compares favourably with the national average response rate for combined acute and community Trusts in England of 41%.

Four of the six divisions achieved over a 50% response rate.

Corporate	Specialist Services	Integrated Medicine	Integrated Elderly & Community Care	Women & Children & Sexual Health	Surgery & Critical Care
68%	45%	40%	56%	52%	51%

There have been several changes to the national reporting structure this year. Key Findings have been replaced with 10 themes, and themes are all scored on a scale of 0-10. For all themes, higher scores indicate more positive results. In previous years, the staff engagement score was recorded on a scale between 1-5, but it is now scored between 0-10. Legacy data has been converted into the new format to allow for trend analysis.

Highlights

There are 10 themes which summarise groups of questions regarding staff experience. BHT is performing better than average in 6 themes, and in line with the national average in 4 themes. Since 2017, BHT has achieved statistically significant improvements in safety culture and staff engagement and no significant reductions in any themes.

Theme	Equality, Diversity & Inclusion	Health & Wellbeing	Immediate Managers	Morale	Quality of Appraisals
BHT	9.2	6.2	6.9	6.2	5.5
National average	9.2	5.9	6.8	6.2	5.4
Theme	Quality of care	Bulling & Harassment	Violence	Safety Culture	Staff Engagement
BHT	7.5	8.3	9.6	6.7	7.0
National average	7.4	8.1	9.5	6.7	7.0

Staff engagement

The Trust's overall staff engagement score was 7 out of 10, a significant increase since 2017 and the biggest increase in staff engagement at BHT since 2015. Of note, the Division of Integrated Elderly & Community Care reported an overall staff engagement score of 7.4 and the Division of Surgery and Critical Care reported a score of 7.2.

Equality, diversity & inclusion

The overall score remained at the same level as the previous year at 9.2. Within this, we are pleased to report that metrics reported as part of the Trust's national NHS Staff Survey have shown some improvements, notably the percentage of BAME (Black Asian and minority Ethnic) staff believing that the Trust provides equal opportunities for career progression (81% in 2018, compared to 78% in 2017 and higher than the average of 74% for similar Trusts).

Key actions this year were:

- Launch of our revised Equality and Diversity Policy (formerly Equal Opportunities Policy) in November 2018
- Introduction of a new Equality, Diversity and Inclusion (ED&I) steering group to set the strategic direction for ED&I and to drive this forward within the Trust

- The establishment of BAME and Disability Staff Networks. Work has also commenced on establishing an LGBTQQIA+ (Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Intersex, Asexual, Allies and Pansexual) Staff Network.
- The introduction of a reciprocal mentoring scheme initially for BAME staff. This scheme provides the opportunity for staff to mentor senior leaders within the Trust, to enable them to understand some of the lived experiences of staff with these protected characteristics.

There is, however, more work to do to ensure that BHT is a great place to work for all staff.

Recognising great professionalism and care

Monthly CARE awards

The Trust monthly CARE awards recognise individuals and teams who go to extraordinary lengths to deliver the Trust's values. Members of staff can be nominated by the community they care for or by colleagues and peers and awards are made in four categories that align with Trust values:

- Collaborate together as a team
- Aspire to be the best
- Respect everyone, valuing each person as an individual
- Enable people to take responsibility

Recipients of CARE awards are invited to a special ceremony that's a part of each public Board meeting to collect their award from the Chief Executive.

Annual CARE awards

Our annual staff awards recognise and celebrate the achievements and commitment of individuals and teams working for the Trust. Award winners are staff, volunteers and contractors who demonstrate safe, compassionate care and who embody our values and behaviours; Collaborate, Aspire, Respect, Enable.

Excellence reporting

For many years now the Trust has utilised incident reporting as a way to learn from the errors that we manage during our working lives. However, it's important that we learn from positive experiences too, the times of outstanding care and service. We need to know about these examples as much as we need to know about the adverse incidents that occur.

Staff are encouraged to submit their experiences of excellence at work so these examples can become part of the organisation's shared learning. Examples could be anything from positive outcomes for patients following effective escalation of deteriorating conditions to a particularly helpful member of staff going out of their way to ensure that someone's care pathway runs smoothly. Excellence reports identify specific examples the Trust can learn from and replicate elsewhere across the organisation.

Thank you cards

Our Trust thank you cards can be used by all managers to make it a little easier to acknowledge good work as it's being delivered. They are not as formal as nominating someone for a CARE award, or submitting an excellence report, and are used for acknowledging effort 'in the moment', as part of our day to day activities.

The premise for the 'thank you' cards is simple – managers, going about their day to day activities, if they spot someone going the extra mile or clearly exemplifying our CARE values, someone who just gets on and does their job quietly and effectively, or indeed if a staff member does something out of the ordinary then they use a thank you card to acknowledge this there and then on the same day.

Managers are encouraged to write a personal message on the card about what they witnessed and then give the card personally to the member of staff concerned.

Who we have involved in the Quality Account

1. We invited colleagues within the Trust to contribute to this Quality Account. The Quality Account was drafted by a Trust manager from the Quality Management team.
2. We wrote to the local Clinical Commissioning Groups, the local HealthWatch and the Buckinghamshire Health and Social Care Committee chair inviting their contribution. The report draft is circulated giving 30 days for their comments on the report to be added in this section.
3. These are added as appendices once we receive feedback.

Statement from Clinical Commissioning Group



Buckinghamshire
Clinical Commissioning Group

Second Floor
The Gateway
Gatehouse Rd
Aylesbury
HP19 8FF

Tel: 01296 587220

Email: buckscggs@nhs.net

10th June 2019

Dear Colleague,

Statement from Clinical Commissioning Group (CCG)

Buckinghamshire CCG, response to Buckinghamshire Healthcare NHS Trust
Quality Account 2018/2019

Buckinghamshire Clinical Commissioning Group (CCG) has reviewed the Buckinghamshire Healthcare NHS Trust Quality Account against the quality priorities for 2018/2019. There is evidence that the Trust has relied on both internal and external assurance mechanisms, to provide a comprehensive Quality Account review.

The CCG has provided detailed narrative separately to this statement to provide clarification on a number of points where information could be presented further to provide additional context.

The Quality Account demonstrates the Trust has made some progress in the quality priorities identified for the year under review, of the 11 areas identified as requiring quality improvement 5 areas met the quality priorities, 5 areas were partially met and 1 area was not rated as the outcome could not be measured, the areas that are considered to be partially met are to be carried over into the 19/20 Quality priorities.

The CCG would like to highlight that previously submitted areas of focus as detailed below and in our letter of the 8th March 2018 were not commented on within the Quality account for 2017/18; and therefore would require these to be included within the 18/19 Quality account for completeness.

- Use of the workforce resource planning tool to support the 'Care Hours per Patient

Day' programme

- Embedding and sustaining retired CQUINs from the 2016/17 financial year
- Progression of the Safeguarding Strategy implementation

The CCG would like to see progress against the following areas from 2018/19 into the 19/20 programme:

1. Implementing a Culture of Safety – includes establishing and further embedding the SAFER bundle and a single transfer of care process alongside other initiatives the latter requires a review as this was identified as difficult to measure as an outcome as reported in the Quality Account.

2. Listen to Our Patient Voice – A focus on improving three main areas, 12 hour waits in A&E, Outpatient cancellations and turnaround time for To Take Out medicines (TTOs).

The CCG would like to recognise the positive work that has been conducted in relation to the role of the Medical Examiner and the collaborative working for the LeDeR Learning Disability Mortality review programme with the CCG and other stakeholders within the ICS.

The Quality Account highlights there is a need for continued quality improvement over, avoidable infections, falls prevention and management and the applications of DNACPR and Treatment and Escalation Plans.

For 2018/19 Buckinghamshire Healthcare NHS Trust reported 5 Never Events which are summarised below.

- Quarter 1 – April 2018 (3 Never Events)
- Quarter 2 – August 2018 (1 Never Event)
- Quarter 3 – October 2018 (1 Never Event)
- Quarter 4 - Zero (0 Never Event)

Reference; Quality Account 2018/19 Page 115

The CCG has worked with BHT to review the Never Events, identify learning and seek assurance on activities to reduce recurrence working with the Trust and NHS Improvement.

The Quality Account provides a detailed overview of the Trust's performance over the last 12 months and clearly identifies the achievements within the period reported, but also areas within service delivery where improvements could be made. We are grateful to the Trust for working collaboratively with commissioners and we will continue to work together to support the Trust on its improvement journey

Yours sincerely,



Louise Patten

Chief Executive

Oxfordshire and Buckinghamshire Clinical Commissioning Groups

Statement from Healthwatch Bucks

Response to Buckinghamshire Healthcare Trust Quality Account 2018-19

Part 1

We are pleased to see “Listening to and Involving our Patients” so high up the list of priorities for the Trust. We look forward to understanding how progress in this area is tracked.

We would like to understand how patient experience of going to theatre improves because of the Theatres Cultural Improvement Programme.

We are very pleased to see that volunteers help improve patient experience in the Emergency Department. We look forward to seeing how volunteers can do this throughout the Trust.

Many of the services used patient feedback to show quality. We would like this to be done across all services where possible. For example, patient feedback is not mentioned as a measure for the Elderly Consultant Physician of the Day.

We like to see where action has been taken as a result of patient feedback. This was in some sections, for example Paediatric Day Surgery, Radiology and Buckinghamshire Sexual Health and Wellbeing Service, but not all.

We were interested in the new approach to the Friend and Family Test being piloted by the Emergency Department. We look forward to understanding the outcome of the pilot.

We would like to understand what difference the Daily Facilitated meetings has made to improving patient experience of discharge in ward 2a.

Part 2

We see the inpatient survey results about responsiveness to personal needs is below the national average. The Trust is working to improve how patients leave hospital(discharge).

We see that the number of staff who would recommend the hospital as a provider of care for their family or friends is below average. The Trust is acting to address this.

We are pleased to have had supported the Trust to listen to the patient voice in particular Outpatients, Accident and Emergency and GP streaming.

We are pleased to have had supported the Trust to listen to the patient voice in particular Outpatients, Accident and Emergency and GP streaming.

Part 3

We are pleased to see that results of the staff survey are generally positive. We were pleased to see BAME staff feedback on promotion. We could not see figures on bullying and harassment which were available last year.

At Healthwatch Bucks we think that staff who are happy at work are more likely to provide patients with a good experience. This means we pay close attention to these figures.

We can see that figures for complaints have remained level. The report also shows that action can be taken as a result.

Overall

We encourage Bucks Healthcare Trust to use plain English when writing documents for the public.

We congratulate everyone who works for the Trust on the achievements of the last year. They reflect the hard work and commitment of staff throughout the organisation. We look forward to working with the Trust next year.

Thalia Jervis

Chief Executive

Statement from Health and Adult Social Care Select Committee

Buckinghamshire County Council's Health and Adult Social Care (HASC) Select Committee holds decision-makers to account for improving outcomes and services for the residents of Buckinghamshire. The Committee scrutinises issues in relation to NHS services, including how services are commissioned and the overall performance of the services.

As a critical friend to the Trust, we are pleased to have an opportunity to provide feedback on the Trust's Quality Account for 2018/19.

In last year's quality account, we focussed our response around the targets which had not been met, particularly around emergency neck of femur, patient experience and staff survey response rates, sepsis screening and pressure ulcers. In January 2019, the Committee was reassured that progress had been made in these specific areas to improve quality of care.

In light of this, we were particularly pleased to note the introduction of the 'Golden Patient' model for hip fracture patients and the introduction of the 'Freedom to Speak Up Guardian'. We were also pleased to note the pilot on-line Friends and Family Test platform which had resulted in an increase in response rates in Accident and Emergency. We also note the increase in the number of staff who would recommend the Trust to family and friends, which is now in line with the national average.

Whilst acknowledging the Trust's interventions around pressure ulcers resulting in a reduction of 30% in category 3, 4 and deep tissue injury and 20% reduction in category 2, we will continue to monitor the targets and specifically the interventions around the Trust's commitment to placing more emphasis on actions required from all divisions and the joint investigations with care homes and care agencies.

We were pleased to note the introduction of a Sepsis Nurse within the Emergency Department and the awarding of 'Sepsis Stars' for staff. We understand that a new national definition was introduced around sepsis ("suspicion to needle time"). We would request that next year's quality account includes the metrics around sepsis.

Having undertaken an in-depth inquiry into Hospital Discharge in 2017 which made a number of recommendations to help improve the process, we read with interest the Trust's work around establishing and implementing new processes to improve patient discharge, particularly around patient transport and the turnaround time for TTO medicines, as part of the single transfer of care project.

We note the effective partnership working with Oxford Health around mental health services and the Trust's commitment to recognise and promote parity of esteem for mental health alongside physical health. We also note the partnership working with Buckinghamshire County Council in areas, such as Safeguarding and Domestic Violence. The drop in DOLs training was noted but we understand that a new approach to Liberty Safeguarding will be introduced soon.

We make the following general observations:

- Accident and Emergency waiting times over 12 hours, whilst improved, remain on Amber;
- Perinatal mortality rate has reduced to 4.12 and is lower than the 5.2 national average (per 1000 births);
- A higher than anticipated rate of Clostridium Difficil.

Conclusion

Through its quality accounts, the Trust continues to demonstrate its commitment to improving services and outcomes for patients, evidenced by excellent examples and case studies. We acknowledge the Trust's progress and achievements in many clinical areas but we would have liked to see more metrics in the quality accounts to back-up these achievements. For example, cataracts – how much has the patient waiting times been reduced and how many additional operations have taken place?

The Health & Adult Social Care Select Committee will continue to review and challenge the Trust's performance over the coming months. The Committee acknowledges the workforce challenges, both nationally and locally, so we will be particularly interested to hear more about the Trust's plans to develop innovative new models of care and/or staffing to tackle gaps in the workforce.

We continue to welcome the Trust's open and transparent way of working with its partners and look forward to more integrated and partnership working over the coming year.

Submitted by Buckinghamshire County Council's Health and Adult Social Care Select Committee

Date: 27 June 2019

Statement by Directors

Statement of directors' responsibilities in respect of the Quality Account 2018/19

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amendment Regulations 2017).

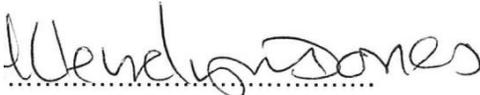
In preparing the Quality Account for 2018/19, directors are required to take steps to satisfy themselves that:

- the Quality Account presents a balanced picture of the Trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the appropriate Overview and Scrutiny Committee (OSC) have provided their view of the Trust's quality account
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and the Quality Account has been prepared in accordance with Department of Health guidance.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

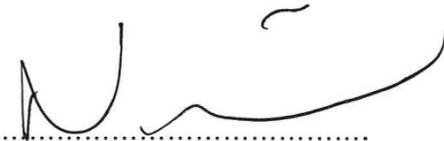
By order of the Board

26 June 2019

A handwritten signature in black ink, appearing to read "Wendy Jones", written over a horizontal dotted line.

Chair

26 June 2019

A handwritten signature in black ink, consisting of a large, stylized initial followed by a long horizontal stroke, written over a horizontal dotted line.

Chief Executive

Appendix 2- Auditors Limited Assurance Report

Independent Practitioner's Limited Assurance Report to the Board of Directors of Buckinghamshire Healthcare NHS Trust on the Quality Account

We have been engaged by the Board of Directors of Buckinghamshire Healthcare NHS Trust to perform an independent assurance engagement in respect of Buckinghamshire Healthcare NHS Trust's Quality Account for the year ended 31 March 2019 ("the Quality Account") and certain performance indicators contained therein as part of our work. NHS Trusts are required by section 8 of the Health Act 2009 to publish a Quality Account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010 and as subsequently amended in 2011, 2012, 2017 and 2018 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to the limited assurance engagement consist of the following indicators:

- Rate of Clostridium difficile infections per 100,000 bed days for patients aged two or more on the date the specimen was taken during the reporting period
- Percentage of reported patient safety incidents resulting in severe harm or death during the reporting period

We refer to these two indicators collectively as "the indicators".

Respective responsibilities of the directors and Practitioner

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health and NHS Improvement has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the Regulations).

In preparing the Quality Account, the directors are required to take steps to satisfy themselves that:

- the Quality Account presents a balanced picture of the Trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health and NHS Improvement guidance.

The Directors are required to confirm compliance with these requirements in a statement of directors' responsibilities within the Quality Account.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2014-15 issued by the Department of Health in March 2015 (“the Guidance”); and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

We read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Account and consider whether it is materially inconsistent with:

- Board minutes for the period 1 April 2018 to 26 June 2019;
- papers relating to quality reported to the Board over the period 1 April 2018 to 26 June 2019;
- feedback from the Trust’s main commissioner dated 10/06/2019;
- feedback from local Healthwatch organisation dated 27/06/2019;
- feedback from the Health and Adult Social Care Select Committee dated 27/06/2019;
- the Trust’s 2018/19 complaints report published under regulation 18 of the Local Authority, Social Services and National Health Service Complaints (England) Regulations 2009;
- the patient survey for Maternity services dated September 2018 and the patient survey for Urgent and Emergency Care dated April 2019;
- the 2018 national staff survey;
- the 2018/19 Head of Internal Audit’s annual opinion over the Trust’s control environment;
- the 2018/19 annual governance statement; and
- the Care Quality Commission’s inspection report dated 18/06/2019;

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these documents (collectively the “documents”). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Board of Directors of Buckinghamshire Healthcare NHS Trust. We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and Buckinghamshire Healthcare NHS Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement under the terms of the Guidance. Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- limited testing, on a selective basis, of the data used to calculate the indicators tested against supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; and
- reading the documents.

A limited assurance engagement is narrower in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques that can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

The nature, form and content required of Quality Accounts are determined by the Department of Health and NHS Improvement. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

In addition, the scope of our limited assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Buckinghamshire Healthcare NHS Trust.

Our audit work on the financial statements of Buckinghamshire Healthcare NHS Trust is carried out in accordance with our statutory obligations and is subject to separate terms and conditions. This engagement will not be treated as having any effect on our separate duties and responsibilities as Buckinghamshire Healthcare NHS Trust's external auditors. Our audit reports on the financial statements are made solely to Buckinghamshire Healthcare NHS Trust's directors, as a body, in accordance with the Local Audit and Accountability Act 2014. Our audit work is undertaken so that we might state to Buckinghamshire Healthcare NHS Trust's directors those matters we are required to state to them in an auditor's report and for no other purpose. Our audits of Buckinghamshire Healthcare NHS Trust's financial statements are not planned or conducted to address or reflect matters in which anyone other than such directors as a body may be interested for such purpose. In these circumstances, to the fullest extent permitted by law, we do not accept or assume any responsibility to anyone other than Buckinghamshire Healthcare NHS Trust and Buckinghamshire Healthcare NHS Trust's directors as a body, for our audit work, for our audit reports, or for the opinions we have formed in respect of those audits.

Conclusion

Based on the results of our procedures, as described in this report, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Account identified as having been subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

Handwritten signature in cursive script that reads "Grant Thornton UK LLP".

Grant Thornton UK LLP
Chartered Accountants
London

28 June 2019

Appendix 3 – Glossary

7DS	Seven day services
7DSAT	Seven day services self-assessment template
A&E	Accident and Emergency department
ACSA	Anaesthesia Clinical Services Accreditation
ADHD	Attention deficit hyperactivity disorder
AHP	Allied Health Professional
AHSN	Academic Health Science Networks
ASD	Autistic spectrum disorder
BFI	Baby Friendly Initiative
BHT	Buckinghamshire Healthcare NHS Trust
BLISS	Charity for babies born premature or sick
BME	Black and minority ethnic
BMI	Body Mass Index
BOB	Buckinghamshire, Oxfordshire and Berkshire
bSHaW	Buckinghamshire Sexual Health and Wellbeing Service
CAMHS	Child and Adolescent Mental Health Service
CARE values	Collaborate, Aspire, Respect and Enable
CARF	Committee for Accreditation of Rehabilitation Facilities
CATS	Community Assessment Treatment Services
CCGs	Clinical Commissioning Groups
C.diff	Clostridium Difficile
CEO	Chief Executive Officer
CHIS	Community Head Injury Service
CIRCLE	Correlate Intelligence Responsibly, Circulate Learning Effectively

CQC	Care Quality Commission
DFM	Daily Facilitated Meetings
DNARCPR	Do Not Attempt Cardiopulmonary Resuscitation
DoLS	Deprivation of Liberty Safeguards
DQ	Data Quality
DSP	Data Security Protection
DTNT	Door to needle time
ECG	Electrocardiogram
ECLO	Eye Clinic Liaison Officer
ECPOD	Elderly Consultant Physician of the Day
ED	Emergency Department
EMC	Executive Management Committee
EPMA	Electronic and Medicines Administration System
FEES	Fiberoptic Endoscopic Evaluation of Swallowing
FFT	Friends and Family Test
FNP	Family Nurse Partnership
FTSUG	Freedom to Speak Up Guardian
GNBSI	Gram Negative Blood Stream Infections
GPAS	Guidelines for Provision of Anaesthetic Services
GPs	General Practitioners
GRACE	Global Registry of Acute Coronary Events
HIV	Human Immunodeficiency Virus
HPV	Human papilloma virus
HQIP	Healthcare Quality Improvement Partnership
HSCIC	Health and Social Care Information Centre
HSJ	Health Service Journal

ICS	Integrated care systems
IDDSI	International Dysphagia Diet Standardisation Initiative
IEC/IECC	Integrated Elderly and Community Care
IOL	Intraocular Lens
LD	Learning disability
LDL	low-density lipoprotein – bad cholesterol
LeDer	Learning Disabilities Mortality Review
LWSW	Live Well Stay Well
MCA	Mental Capacity Act
MDT	Multi-disciplinary team
ME	Medical Examiner
MFOP	Medicine for Older People
M&M	Mortality and morbidity
MSK	Musculoskeletal
MSW	Medical Support Workers
NDG	National Data Guardian
NED	Non-Executive Director
NEWS2	National Early warning signs
NHS	National Health Service
NHSI	NHS Improvement
NICE	National Institute of Clinical Excellence
NMT	Neurologic Music Therapy
NNU	Neonatal Unit
NSE	National Society for Epilepsy
NSIC	National Spinal Injuries Centre
NSTEMI	Non-ST-elevation myocardial infarction – a type of heart attack

OD	Organisational Development
OHFT	Oxford Health NHS Foundation Trust
OT	Occupational Therapy
PEG	Patient Experience Group
PHE	Public Health England
PLACE	Patient led assessment of care environment
POD	Physician of the Day
PROMS	Patient Reported Outcomes measures
Q1	Quarter 1, first quarter of the financial year (April-June)
Q2	Quarter 2, second quarter of the financial year (July-September)
Q3	Quarter 3, third quarter of the financial year (October-December)
Q4	Quarter 4, fourth quarter of the financial year (January-March)
QI	Quality Improvement
QNI	Queens Nursing Institute
QSIR	Quality Service Improvement and Redesign
RCP	Royal College of physicians
RTT	Referral to Treatment time
SACT	Systemic anti-cancer treatment
SAS	Specialty and Associate Specialist Doctor
SCI	Spinal Cord Injury
SHMI	Summary Hospital-level Mortality Indicator
SI	Serious Incident
SIRO	Senior Information Risk Owner
SJR	Structured Judgement Review
SLP	Senior Leaders Programme
SLT	Speech and Language Therapy

SME	Small medium enterprises
SMH	Stoke Mandeville Hospital
SOP	Standard Operating Procedures
SPEAC	Surgical and Plastics Emergency Ambulatory Care
SRT	Stereotactic Radiotherapy
SSNAP	Sentinel Stroke National Audit Programme
STNT	Suspicion to Needle Time (Sepsis)
STP	Sustainability and transformation partnership
T&O	Trauma & Orthopaedics
TEP	Treatment Escalation Plan
TNLU	Therapy and Nurse Led Unit
TTO	To take out (medicines given to patient on discharge from hospital stay)
UK	United Kingdom
UKAS	United Kingdom Accreditation Service
UKGRIS	UK GRACE Risk Score Intervention Study
UV	Ultra Violet
VTE	Venous Thromboembolism
WC&SH	Women, Children & Sexual Health
WH	Wycombe Hospital