

Meeting: Trust Board Meeting in Public

Date: Wednesday, 28 July 2021

Time: 9.00am – 11.30am

Venue: MS Teams and live streamed to the public

Start Time	Item	Subject	Purpose	Presenter	Encl.
09.00	1.	<ul style="list-style-type: none"> Chair's Welcome to the Meeting and Meeting Guidance & Who's Who of the Board Apologies for absence: Mo Girach, Bridget O'Kelly, Andrew McLaren 	Information	Chair	Verbal
	2.	Declaration of Interests	Assurance	Chair	Verbal

General Business

09.05	3.	Patient Story	Information	Chief Nurse	Paper
09.25	4.	Minutes of the last meeting held on 26 May 2021	Approval	Chair	Paper
	5.	Actions and Matters Arising	Approval	Chair	Paper
09.30	6.	Chief Executive's Report	Assurance	Chief Executive Officer	Paper

Performance

09.40	7.	Integrated Performance Report <ul style="list-style-type: none"> Quality Workforce Finance 	Assurance	Chief Operating Officer	Paper
	8.	Recovery & Renewal Update	Assurance	Chief Operating Officer	Paper

QUESTIONS FROM THE PUBLIC

09.55 COMFORT BREAK – 10 minutes

Quality

10.05	9.	Infection Prevention & Control Monthly Report	Assurance	Chief Nurse	Paper
	10.	Quality and Clinical Governance Committee Chair Report	Assurance	Committee Chair	Paper
	11.	Learning from deaths		Chief Medical Officer	Paper

Finance

10.20	12.	Finance Report	Approval	Director of Finance	Paper
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	13.	Finance and Business Performance Committee Chair's Report	Assurance	Committee Chair	Paper
	14.	Charitable Funds Committee Chair Report and Terms of Reference	Assurance/ Approval	Committee Chair	Paper

Workforce

10.40	15.	Strategic Workforce Committee Chair Report	Assurance	Committee Chair	Paper
	16.	Annual Workforce Equalities Report 2020-21	Assurance	Chief People Officer	Paper
	17.	Freedom to Speak Up Guardian Annual Report April 2020 – March 2021	Assurance	Chief People Officer	Paper
	18.	Medical Appraisal & Revalidation Report	Approval	Chief Medical Officer	Paper

Risk and Governance

11.05	19.	Audit Committee Chair's Report	Assurance	Committee Chair	Verbal
	20.	Annual Patient and Public Equalities Report 2020-21	Assurance	Director of Strategy	Paper
	21.	Health & Safety Annual Report	Assurance	Commercial Director	Paper

Information

11.20	22.	Modern Slavery Act 2015 Annual Statement	Information	Chief Executive Officer	Paper
	23.	Learning lessons to improve our people practices	Information	Chief People Officer	Paper
	24.	Covid 19 Vaccination programme summary	Information	Chief People Officer	Paper
	25.	Guardian of Safer Working Hours Annual Report	Information	Chief People Officer	Paper
	26.	Board Attendance Record	Information	Chief Executive Officer	Paper
	27.	Private Board Summary Report	Information	Chief Executive Officer	Paper
	28.	Risks identified through Board discussion	Discussion	Chair	Verbal

ANY OTHER BUSINESS

QUESTIONS FROM THE PUBLIC

Date of Next Meeting:
29 September 2021, 9am

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

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

TRUST BOARD MEETINGS MEETING PROTOCOL

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

Copies of the agenda and papers are available on our website www.buckinghamshirehealthcare.nhs.uk.

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

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

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

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

Hattie Llewelyn-Davies
Chair

THE SEVEN PRINCIPLES OF PUBLIC LIFE

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

Selflessness

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

Integrity

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

Objectivity

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

Accountability

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

Openness

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

Honesty

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

Leadership

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

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

Meeting: Trust Board Meeting in Public

28 July 2021

Agenda item	A patient experience story- Jodie's story
Board Lead	Chief Nurse
Type name of Author	Amarjit Kaur- Head of Patient Experience and Involvement
Attachments	Video link to film
Purpose	Information
Previously considered	EMC 6 July 2021 Quality Committee 21 July 2021

Executive Summary

Jodie is 11 years old and is a paediatric oncology patient. In this film Jodie talks about her experience as a patient, what she has liked and what could be improved.

Link to patient experience story:

https://youtu.be/ZAs_QZcCb2A

Decision	The Board / Committee is requested to endorse this story		
Relevant Strategic Priority			
Quality <input checked="" type="checkbox"/>	People <input type="checkbox"/>	Money <input type="checkbox"/>	
Implications / Impact			
Patient Safety	Improved care in response to patient feedback and involvement		
Risk: link to Board Assurance Framework (BAF)/Risk Register	BAF 1.1 : To listen to our patient's voice		
Financial	Relevant but not applicable		
Compliance <small>Select an item.</small>	Person Centred Care		
Partnership: consultation / communication	Working in partnership with patients		

Equality	Health inequalities are avoidable, unfair and systematic differences in health and experience between different groups of people. The trust is committed to the fair treatment of all patients and service users, regardless of age, colour, disability, ethnicity, gender, gender reassignment, nationality, race, religion or belief, responsibility for dependents, sexual
	orientation, or any other personal characteristics.
Quality Impact Assessment [QIA] completion required?	N/A

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

Ms H Llewelyn-Davies (HLD)	Trust Chair
Mr N Macdonald (NM)	Chief Executive Officer
Ms K Bonner (KB)	Chief Nurse / Director of Infection Prevention Control
Mr D Gibbs (DG)	Chief Operating Officer
Mrs N Gilham (NG)	Non-Executive Director
Mr R Jaitly (RJ)	Non-Executive Director
Mr B Jenkins (BJ)	Director of Finance
Mr A McLaren (AM)	Chief Medical Officer
Mr T Roche (TR)	Non-Executive Director

Non-Voting Members:

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

In attendance:

Mrs E Jones (EJ)	Senior Board Administrator (minutes)
Mr M Bindra (MB)	Associate Medical Director for Research and Innovation, Consultant Ophthalmologist and Vitreoretinal Surgeon, Joint Lead for Macular, Retina and Vitreo-retinal Services, Ophthalmology Research Lead (observing)
Ms J Mansell (JM)	Facere Melius (observing)
Mrs S Smissen (SS)	Immunisations Team Lead (for agenda item 3)
Ms A Kaur (AK)	Head of Patient Experience and Involvement (for agenda item 3)

01/05/21 Chair's Welcome, introductions and apologies

The Chair welcomed everyone to the meeting.

Apologies had been received from Dipti Amin, Mo Girach and John Lisle, Non-Executive Directors.

02/05/21 Declarations of Interest

There were no declarations of interest. HLD noted she had resigned from PA housing. EJ to arrange for the register to be updated. AH noted he was a GP in a practice outside of the Trust's area and working with NHSE/ in relation to older people.

03/05/21 Patient Story

KB introduced SS, Immunisation Lead and the Board watched a video which showed how the immunisations team had continued to provide immunisations for children throughout the pandemic, the only team in England to do so.

TR applauds SS for her leadership supporting the school immunisations team.

NG asked SS about safeguarding issues and working with children who may be anxious about vaccinations. SS explained the importance of making sure every child had a positive experience of immunisation as it was important for their future health.

AH recognised that work to address health inequalities was driven through innovations such as those implemented by the school immunisations team.

HLD thanked the team for presenting the patient story.

04/05/21 Minutes of the last meeting

The minutes of the last meeting on 31 March 2021 were **APPROVED** as an accurate record.

05/05/21 Actions and matters arising

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

06/05/21 Chief Executives Report

NM thanked colleagues for getting services back up and running and noted the Trust had been Covid free at least for a few days the previous week for the first time since March last year.

NM highlighted the award ceremony for staff which had been a heart-warming and inspirational day, celebrating and recognising the significant achievements of colleagues over the last year.

NM clarified Care Centric was a shared records system across partners which showed a summary of a history of a patient's record in one place which helped to create efficiency.

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

07/05/21 Integrated Performance Report and Recovery

DG presented the operational performance report which showed the recovery pathway had a positive first month in terms of activity. There was a huge challenge around the elective recovery and plans on restarting services to reduce the backlog which was a significant concern to be addressed.

There had been a renewed focus in A&E around the length of stay of patients in the department and an improvement had been seen in the figures for May.

RJ noted the report had been discussed in detail in the Finance and Business Performance Committee.

AH queried how the Trust would ensure that health inequality was not increased when working through the elective backlog. DG assured the Board the waiting list was analysed in terms of health inequality and would be brought to Quality and Clinical Governance and Finance and Business Performance Committee for assurance going forward.

In response to a query from NG, DG explained there had been a great deal of work looking at the administrative processes of how children were managed through the system. An increase in resource had been made available which had helped with the increased level of assessments. Oxford Health and the Trust were working together to improve care and achieve further improvements.

KB assured the Board the Trust was moving back to its normal response times for managing and resolving complaints. It was noted that all complainants had been informed of the response times and were able to access support if required.

NM highlighted the breadth of the roles within the children and young people service particularly looking at the impact of the pandemic on children. The Trust had a role in helping children to be ready for school providing language therapy and other developmental needs. There was a risk for the Trust around the impact of any delays in terms of developmental interventions. NM advised the Board would need to have oversight of the service.

DW stressed the importance of the system wide role around the children and young people service. The Health and Wellbeing Board were to have workshop looking at children's services which would prioritise the key issues for the system and the outcome would come back to the Board.

Recovery and renewal update

DG noted the report had been discussed at the Finance and Business Performance Committee.

RJ queried if the Trust would have access to the Elective Recovery Fund (ERF). DG informed the Board there was a reasonable degree of confidence this would be achieved recognising there was a huge backlog to be addressed.

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

QUESTIONS FROM THE PUBLIC

There were no questions from the public.

08/05/21

Infection Prevention & Control Monthly Report

KB presented the Infection Prevention & Control (IPC) Monthly Report for March highlighting Covid infections had reduced in line with the national trend.

There had been two cases of MSSA bacteraemia which were being investigated and would include antibiotic usage.

KB noted plans were underway to build an aerosol generating procedure area in the resuscitation area of the Emergency Department. It was noted lateral flow testing compliance was poor in some areas and staff groups and work was underway to improve this and be compliant.

HLD appreciated the benchmarking which was helpful for non-clinicians to have something to compare against.

NG thanked KB for the report which was easy for non-clinicians to read and asked if work was being done to make the recording of lateral flow tests less onerous. BOK explained recording was quick and easy, however staff needed to be reminded to submit their results which could be done on their phones.

NG noted the data systems were manual and patients were not alerted for infection risk in real time and queried if a solution to this had been identified. KB explained IPC and IT colleagues were working to find solutions at automating this reporting.

TR noted there had not been a recent audit of cleaning scores at Amersham Hospital. KB noted this would be rectified.

NM asked for clarification around the Covid 19 analysis of specimens.

AH commented on the IPC training figures and queried the balance of e-learning and face to face training for staff regarding PPE and infection prevention and control. KB responded

explaining the Trust's PPE champions officers were on hand to offer practical support, including donning and doffing, which complimented the online training.

AM informed the Board PPE training was included as part of the induction into the Trust and was reviewed throughout the year. BOK noted that there was a requirement for face to face training every 2 years for hand hygiene.

The Board **NOTED** the report.

09/05/21 Quality and Clinical Governance Committee Chair Report

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

10/05/21 Harm Review

AM presented the report which explained how the Trust was managing the risk of harm occurring to patients who were on the waiting list for elective surgery. A lot of work was being undertaken to reduce the numbers waiting for surgery. A score was given by consultants between 1 and 4 as an initial priority score and patients who were waiting had been notified and reassured. The scores were being continually validated and patients checked in with.

RJ noted the importance of communicating and reassuring patients of the steps being taken to address delays and information on how the Trust assesses those in greatest need of care. RJ queried if health inequalities could be exacerbated because of delays. AM explained there was no segmentation by equalities as data was monitored and the Trust were alert and followed the data. DW noted the Trust was part of a national population health programme which was producing benchmark tools to monitor, and reports would be shared, which was important for the community and the Trust.

NG questioned whether there was a risk patients from deprived communities would not be pulled equally from the waiting list. AM explained there was a potential risk however the system had been designed to be equitable and fair. AM confirmed the Trust was working with others in the system including primary care to ensure communication to patients was consistent. AM noted reassurance and having a point of contact was key including linking into the national work and supporting the system.

A report would come back to the Board in three months' time.

The Board **NOTED** the report.

11/05/21 Safest Staffing

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

The report covered the reporting period of March 2021 and included repatriating redeployed staff. Sickness levels were decreasing however the rate was still higher than normal. The biggest concern was high nurse vacancy rate and percentages would be aligned in the separate reports going forward.

BOK confirmed the nurse vacancy rate was a high risk and the Trust was recruiting and looking to skill mix groups. The figures did not include those who were waiting for their registrations from the NMC. Staff were being recruited from India and the Philippines ensuring their home countries were not negatively impacted by this. In addition, work was being undertaken with students who graduate this year to encourage them to work in the Trust. KB and HLD thanked the students who had supported the Trust and worked during the Covid waves.

KB highlighted there had been an increase in the number of attendances for children and young people with mental health concerns and support was being provided for these teams working collaboratively with colleagues in CAMHS and social care.

In response to a query from RJ, KB explained that she and BOK were actively working with the universities to retain student nurses for the Trust recognising the Trust was in an expensive area to live in for students at the beginning of their career.

BOK highlighted the work being undertaken with the system to manage the temporary workforce and stabilise the system which was supported by the CEOs in the system.

NG noted the improvement in the non-registered nursing turnover rate and queried what the Trust had been doing which had enabled this improvement. KB and BOK explained the education support through programmes such as the HCA forums and supporting colleagues through apprenticeships had helped.

NG queried if the stress and pressure the adult and community health teams had been under had improved. KB explained the absence rate was improving, the Trust was looking at rotational work and giving students the opportunity to work in the community as well as the hospital setting. KB noted the importance of health and wellbeing for staff.

In response to a query from TR, KB noted the importance of communicating to the public the work being done around staffing.

HLD thanked those who were involved in staffing the organisation and noted the report provided the Board with assurance.

The Board **NOTED** the report.

12/05/21 Month 1 Finance Report

BJ informed the Board the Trust had achieved a breakeven position for month 1 which was driven by the funding allocation for NHSI/E. The plan reflected the £22m deficit for H2. There was no capital or balance sheet included in the papers which reflected the pressure the team were under to produce the annual accounts. BJ thanked his team for their efforts in producing the month 1 report.

BJ highlighted the key risks as being around pay and temporary staffing which was a big challenge to restore the levels to the previous agency cap levels. In addition, there was pressure to deliver the CIP programme across the organisation for the year. A workshop had been set up for colleagues to understand and go through the run rate position at a granular level.

The Board **NOTED** the report.

13/05/21 Finance and Business Performance Committee Chair's Report

NG highlighted the Committee had approved the annual capital plan and the Trust was seeking other sources of capital. The Committee had reflected on the significant work by DG and his team on the operational trajectories to ensure the Trust received the ERF which was complex work and ongoing.

The Board **NOTED** the report.

14/05/21 Strategic Workforce Committee Chair Report

HLD noted the Committee had received partial assurance around security and asked for this to be improved.

The Board **NOTED** the report.

15/05/21 Audit Committee Chair's Report

RJ noted the focus of the Committee had been the annual reports and audits.

The Board **NOTED** the report.

16/05/21 Compliance with Legislation

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

NM assured the Board that compliance gaps were closed in all but three areas and there was an action plan in place to address these gaps. The Quality and Clinical Governance Committee would work through the action plan.

The Board **NOTED** the report and were assured the Trust was moving towards compliance.

17/05/21 Annual Governance Statement

NM informed the Board the Annual Governance Statement (AGS) formed part of the Trust's Annual Report and Accounts. The AGS would be considered by the Trust's internal and external auditors and would be submitted as part of the Annual Report and Accounts by 29 June 2021.

There had been some structural changes due to the pandemic which had required rigorous operational structures and guidance from the regulators had been followed. The Audit Committee had reviewed the report.

The Board **APPROVED** the report.

18/05/21 Self-Certification

NM informed the Board the Trust was required to self-certify it could meet the obligations set out in the NHS Provider Licence and it had complied with governance requirements. NM explained that previously the Trust had been non-compliant due to being in financial undertakings. The Trust had met with the regulator who had recommended the Trust be removed from undertakings however due to the pandemic there was no formal process in place for this to be lifted however confirmation had been given verbally and the Trust was able to declare itself compliant.

The Board **APPROVED** the report.

19/05/21 Governance Manual

NM informed the Board the Standing Orders which regulate the way in which the proceedings and business of the Trust are conducted and the Standing Financial Instructions and Scheme and Limits of Delegations which identify who in the Trust is authorised to do what and individual's responsibilities had been consolidated into one document and named the 'BHT Governance Manual'.

NM recognised there was still work to be done for it to be simplified for the next version. A tracked version would be available to the Audit Committee members at their meeting in July for assurance.

The Audit Committee had recommended the Board approved the Manual.

The Board **APPROVED** the Manual.

20/05/21 Corporate Risk Register

KB presented the corporate risk register (CRR) outlining the top three risks as:

- Shortage of qualified nursing staff
- Impact on staff physical and psychological health and well-being during Covid 19
- Risk to the delivery and sustainability of the national standard for referral to treatment as per the guidance

In addition, a new risk around the backlog in ophthalmology had been added to the register. Two risks had been removed: Covid 19 risk to service delivery and sustainability and contamination risk.

RJ expressed concern around dates of completion and mitigations and actions. RJ suggested interim targets should be included for the Board to be able to measure progress against the actions which would make the register a useful document.

KB responded noting this was in progress and being reviewed and acknowledged the Board needed to have a clearer oversight.

RJ queried the risk assessments on staff from ethnically diverse backgrounds noting this was in progress until 2022. KB noted this was an ongoing piece of work as risk assessments would be repeated. BOK noted there was a tight process in place and in addition noted there was a difference in uptake in the vaccine between white and BAME colleagues and the Trust was working hard to close this gap.

KB noted there was a national requirement to move away from the use of the word BAME.

NG commented on the two risks around Health and Safety; the concrete blocks at Wycombe and the medical gas pipework, noting the completion dates had moved out. NG queried if the risk was around the Trust having the finances to undertake the work.

AW noted the medical gas pipeline was an issue of resilience and the Trust had put in more pipework and was waiting for some more equipment from BOAC. AW assured the Board there was no patient safety concern.

Regarding the Wycombe tower, AW noted scaffolding was in place for investigation work to take place on the concrete and the risk was being managed.

KB confirmed the now CRR was now in the remit of the Chief Nurse and informed the Board a Governance Manager had been employed to oversee this work.

In response to a query from TR, DG explained the risk around patient tracking was related to a project which would consolidate waiting lists ensuring validation of lists and improved oversight. The project was due to be completed at the end of July and would be reported in detail to the Finance and Business Performance Committee.

KB informed the Board the CRR was being transferred to a new electronic system.

The Board **NOTED** the report and that it was a work in progress.

21/05/21 Board Attendance Record

NM to be removed from the membership of the Strategic Workforce Committee and HLD from the membership of the Finance and Business Performance Committee.

The Board **NOTED** the report.

22/03/21 Private Board Summary Report

The Board **NOTED** the report.

21/01/21 Risks identified through Board discussion

NM noted the risks identified through Board discussion as follows:

- Challenge around the elective recovery programme
- Capacity for children and young people services
- Cleanliness audit at Amersham Hospital
- Communication to the population on the waiting list with a focus on equity of access challenge
- Nurse vacancy rate particularly around the adult community healthcare teams
- Tracking mitigating actions and robust management of the Corporate Risk Register

22/01/21

Any other Business

QUESTIONS FROM THE PUBLIC

There were no questions from the public.

Date of next Meeting: Public and Private Trust Board Meeting: 28 July 2021 at 9am

Action Log

Meeting

Public Trust Board

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

Min ref	Date opened	Subject	Action	Lead	Deadline	Update May 2021	Update July 2021	RAG	Date closed
	29/07/20	Integrated performance report	Quality Committee to monitor the OPD letter process and ensure it is up to date	Chief Operating Officer	08/12/20	Including in OPD transformation deep dive in work plan for F&BP	Deep dive into outpatients transformation scheduled for August Finance and Business Performance Committee	Amber	
	30/09/2020	CEO report	DG to ensure good communication with patients on waiting lists	Chief Operating Officer	25/11/2020	All long waiters have been written to as part of the validation project ongoing.	All patients waiting on the admitted waiting list without a TCI were contacted in February 21 and all patient responses were acted on, such as patient choice to defer etc. Removals were with clinical input. Patients waiting on non-admitted list without an appointment were contacted in April 21. Fully validated PTL entries were used prior to the comms and all BHT comms agreed with Comms Team prior to the exercise. A call line has been set up for patient response.	Green	CLOSED 16/07/2021
15/03/2021	31/03/21	Gender Pay Gap	A proposal to come to Board for a champion for the gender pay gap issue	Chief People Officer	28/07/21	Not due	We launch the Trust's women's network w/c 12 July. This network will consider the proposal for a champion in relation to the gender pay gap. We will update the Strategic Workforce Committee in September	Green	CLOSED 14/07/2021
Completed Actions									

21/01/2020	29/01/20	Future arrangements for NHS Commissioning	The Board to have a discussion on the future of specialist commissioning.	Director of Strategy	30/09/20				CLOSED 24/3/2021
10/06/2020	24/06/20	Digital Spend	Return on Investment on IT Strategy to come back to Board and to include reconciliation.	Director of Strategy	30/10/2020 - revised date of 31/3/21	Discussed at Private Board Meeting on 28 April			CLOSED

TRUST BOARD MEETING IN PUBLIC
28 JULY 2021
CHIEF EXECUTIVE'S REPORT

Introduction

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

Quality, performance and recovery

I have recently communicated a message to all colleagues working in the Trust that our current infection prevention and control measures, including the wearing of face masks and social distancing on all Trust sites, will remain in place despite the relaxation of some COVID-19 related restrictions nationally from 19 July. These measures apply to all individuals working on our sites, whether or not they are employed by the Trust, visitors and patients coming to our hospitals and those we treat in community settings.

This is vitally important to protect and keep safe our patients and the staff who care for them, especially in light of the current high rates of COVID-19 in our local communities, and the increase in COVID-19 patients admitted to our hospitals in recent weeks. Our modelling of data is ongoing to help plan what the impact of a potential third wave of the virus will mean for us, alongside winter planning.

Ensuring that we see and treat the many patients who have been waiting for appointments or interventions safely and efficiently continues to be a key priority. We have been monitoring our activity levels against 2019/20 activity in line with the Elective Recovery Fund (ERF) national initiative, together with our Buckinghamshire, Oxfordshire & Berkshire West Integrated Care System (BOB ICS) colleagues. I am pleased to confirm that we have continued to increase our activity, delivering the following percentage elective activity compared with 2019/20 for May, alongside April figures shared in my last report:

	April Activity (% of 2019-20)	May Activity (% of 2019-20)
Outpatients	94.2%	102.0%
Day-case	73.0%	77.7%
Elective	69.8%	80.7%

Indicative June activity values show a further overall increase in elective activity above May. However, from this month, NHS England and NHS Improvement (NHSE/I) have increased the additional tariff payment threshold from 85% to 95% which means work is currently underway to reforecast our likely income plan.

We have been successful in managing risk in patients with long waits; the number of elective patients waiting the longest has reduced month on month since April and prioritisation of patients with the highest clinical needs has also improved. Detailed guidance for the second half of 2021-22 around activity expectations and supporting financial mechanisms is yet to be released. However, ahead of receiving this, we have begun activity trajectory planning with SDUs using the current revised threshold. We still remain an outlier compared with other organisations in terms of volumes of patients with extended waiting times, especially over 52 weeks; this remains a significant area of focus for the executive team and myself as we work towards a sustainable waiting list reduction programme.

I am pleased to report areas of high performance in Cancer services, as measured by specific metrics. Although we have not achieved the treatment within 62 days standard which continues to be a challenge, we have again over achieved on the 28 day faster diagnosis, first appointment within two weeks and 31 days to first treatment performance measures. These are important in minimising the time our patients carry uncertainty and anxiety about their conditions.

Demand on our Emergency Department (ED) has been increasing and waiting times continue to be a challenge. There was a 30% increase in A&E attendances in June, compared with March this year, largely driven by 'walk in' patients. Despite this, we made an improvement against the 4-hour target of 95% in May and are seeing greater numbers of people within the 4-hour standard. The demand challenge however remains a critical quality issue and a key organisational focus. Ambulance handover times increased but we improved on the number of patients in the department with a total length of stay above twelve hours. We are working hard with our GP partners to put

in place additional resource to support the very high levels of demand for primary care; this includes increasing the number of GPs in the Emergency Department. We are also partnering with The Royal Berkshire Hospitals NHS Foundation Trust's emergency department around a programme of shared learning and mutual support.

Governance

I would like to formally welcome Joanna James to the Trust, our new Trust Board Business Manager. Joanna will be the organisational lead for all matters related to Trust Board governance and will support the Chair in ensuring that Trust Board procedures are complied with and that the Board fulfils its statutory duties.

Tom Roche, Non-executive Director, has undertaken a review of the current committee structure of the Commercial committee and how it relates to the Property and Commercial Transformation (P&CT) and Finance & Business Performance committees (F&BP). I support his recommendation that the Commercial committee remains suspended, allowing discussions and decisions normally made there to continue being taken in the P&CT committee. This committee should continue to feed information into the Transformation committee and the F&BP committee. This arrangement should be reviewed towards the end of quarter three of 2021/22, once we have a more detailed understanding of our financial risks for the second half of this financial year and for 2022/23.

Learning

In May we recorded five instances of *clostridioides difficile* infection and one in June. Disappointingly, we reported two instances of MRSA bacteraemia infection in May and none in June, bringing our 2021/22 total to 3 cases. There were zero never events in the same months. In May we recorded 395 births and 409 in June; in the same months we recorded 72 and 81 deaths, respectively.

We continue to learn from what we have done right as well as where our patient care may not have met the high standards that we aspire to. In May and June we recorded 56 and 46 formal complaints respectively, and 44 and 49 excellence reports. The following is an excellent example of the patient-centric care we aspire to deliver at all times:

“This doctor managed a likely case of ‘Vaccine Induced Thrombosis and Thrombocytopenia’ last month. This was one of the first known cases in the region. He correctly identified the disorder, sought advice from national experts and stayed late into the night to ensure the patient received the appropriate specialist treatment. He also communicated really well with the patient and their family throughout.”

People

On 20 May we hosted a socially distanced staff awards presentation ceremony at Wycombe Hospital for our One Team One Goal 2020 awards which was live streamed. It was a very special event, recognising how individuals and teams united to face the pandemic and rose to the challenge. There were ten very deserving winners of the new category: CEO Awards for Outstanding Contribution during COVID-19. Celebrating successes is an important part of our organisational culture and I was delighted to publicly recognise the outstanding achievements of colleagues.

Earlier this month we completed construction of our new research and innovation centre which is now accommodating colleagues. The Trust partnered with the Bucks Local Enterprise Partnership (LEP) to build this new research and innovation centre on the Stoke Mandeville Hospital Site. The new three-story modular eco-build offers modern agile working space to start-up small and medium sized businesses from across the region, as well as housing our own state-of-the-art Research and Innovation Department. It will give our clinicians direct access to the latest digital health developments, medical technologies and artificial intelligence. It has been built with 99% recyclable materials, harvests rainwater, is energy efficiency and even features a living wall.

I am pleased to share that we launched our Women's Network on 15 July as part of our drive to develop female colleagues in the Trust. The Network will help women achieve their career aspirations and provide support for significant life events through regular inspirational meetings.

In June we invited teams to enter a competition to decorate their working space in celebration of a country competing in the UEFA Euro 2020 tournament and the enthusiasm and creatively shown by colleagues was truly impressive. The winning team, Chartridge and Waterside wards at Amersham Hospital, crocheted a full Belgian buffet and also involved patients who threaded flags and made flowers.

Many of us enjoyed celebrating the England team's success in the Euro tournament, though unfortunately the final result was not as we had hoped. However, the abominable racial abuse aimed at players following the

defeat was shocking and upsetting. We do not condone any form of discrimination and continue to work hard to embed an inclusive culture in the Trust, driving forward education and learning amongst staff to reduce inequalities and bias. Critical to this will be making it much easier to report, respond and support our colleagues who at times are themselves the subject of such behaviour.

Place and System

In June, NHSE/I published the Integrated Care Systems (ICS): design framework document which sets out further details of the next phase of system development and provides guidance to help organisations with developing plans. This follows from the Government's White Paper Integration and Innovation: working together to improve health and social care for all but is subject to Parliament's amendment and approval of legislation. The publication includes 10 partnership principles, an overview of expectations for ICS governance and management arrangements and the statutory duties of ICS NHS bodies, anticipated from April 2022. Indicative outputs expected from each ICS over the transition period this financial year are also outlined in the document as well as additional details such as funding flows and the requirements for digital and data.

The NHS System Oversight Framework for 2021/22 was a further document published by NHSE/I in June which replaces the NHS Oversight Framework for 2019/20. This outlines an approach to oversight of ICSs, Clinical Commissioning Groups (CCGs) and Trusts, reinforcing system-led delivery of integrated care. Oversight will focus on the delivery of the priorities outlined in the 2021/22 Operational Planning Guidance, using a single set of metrics for ICSs, CCGs and Trusts to highlight any additional support required for individual organisations or systems.

Community Diagnostics Hubs (CDHs) are facilities that offer multiple diagnostic services in a location away from main hospital sites. They are one of NHSE/I's priorities as a part of the national elective recovery challenge following the pandemic. The BOB ICS was directed to identify locations and providers to establish CDHs and have selected Amersham Hospital as a first wave Year 1 priority to be in operation by quarter 3 of this financial year 2021/22. The proposed location aligns to the Trust 2025 Strategy and development plans. There are several potential benefits to this plan, including improvement of the health outcomes of our community by reaching earlier, faster and more accurate diagnoses of health conditions.

Financial reporting

We have completed our year end accounts for 2020/21 after a challenging external audit programme. We had to request an extension to the deadline for the submission of our accounts and had a number of challenges working with our external audit partner to hit the agreed plan. The Trust's financial position moved from a break even position to a £5m surplus as a result of the changes we agreed with the auditors which involved accruals that the Trust had made for liabilities in asbestos removal, and workforce wellbeing / recovery initiatives.

The Trust is putting in place measures to ensure appropriate mitigations for these liabilities in the financial year 2021/22. My personal thanks go to all in the finance team who have done an extraordinary job in delivering our accounts.

For the first quarter of this financial year 2021/22, we reported a break even position in line with the provisional annual budget agreed with the Board in April, with the full year forecast remaining at £22.3m deficit.

Proud to be BHT

Over the last couple of months, various teams in the organisation have achieved recognition for excellence. Our dedicated stroke unit at Wycombe Hospital has again achieved the highest standard for care. Results from the Jan-March 2021 Sentinel Stroke National Audit Programme show it has maintained its 'A' status – as it has done throughout the pandemic. Our anaesthetics department has received Anaesthesia Clinical Services Accreditation (ACSA) from the Royal College of Anaesthetists for the second year running and the Trust's paediatric team received the award for the training unit of the year in the Paediatric Awards for Training Achievements (PAFTAs) – organised by the Royal College of Paediatrics and Child Health awards.

In June, the Trust performed the first NHS corneal cross-linking treatment ("CXL") in Buckinghamshire and Oxfordshire. Using the Avedro KXL machine, Consultant Ophthalmologist Mike Adams performed the procedure at Stoke Mandeville Hospital. CXL is a treatment for an eye condition called keratoconus, which primarily affects young adults and which, if left untreated, can lead to visual loss and can necessitate more invasive corneal transplant surgery. CXL stops the condition progressing and stabilises the patient's vision.

At the end of May, we launched our new public website. This was developed in conjunction with our patient Communications Advisory Panel, is device responsive, has patient / visitor led navigation and is compliant with accessibility standards, scoring 91% compared to an industry benchmark of 88.3%.

In June we celebrated and raised awareness of several events including Volunteers week, Carers week, Knowledge and Library Services National Awareness Week, World Heart Rhythm week and Windrush day. We also celebrated Pride week with LGBTQ+ colleagues and local communities, proudly raising the Pride flag. We are committed to maintaining an inclusive culture where everyone - colleagues, patients and visitors - feels safe to be themselves.

Finally, we enjoyed the NHS Big Tea on 5 July, marking 73 years of the NHS and the Queen awarding the George Cross to the entire NHS. This is an award granted for acts “of the greatest heroism or of the most courage in circumstances of extreme danger” and I couldn’t be more proud to be a part of our National Health Service and all that we have collectively achieved, particularly over the last year.

Neil Macdonald
Chief Executive

Appendix 1 – Trust CARE value awards

Appendix 2 – Executive Management Committee and Transformation Board

Appendix 1 – Trust CARE values awards

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

May 2021

Category	Role	Nomination	Nominated by
Collaborate	Ward 12 Wycombe	All worked very well together, with a peri-arrest patient, MDT approach. Sometimes working outside of their comfort zone, but asking questions when unsure to expedite a patient into the care of the intensive care team	Member of Staff
Aspire	Consultant Nurse for Older People	She is a pillar in the department, working more hours than she is paid for and making a real difference to our most vulnerable, frail patients. She is deeply interested in dementia, safeguarding and education and has been commended by medical students for her teaching, which made them understand what Geriatric Medicine is about. She will always be there to help any colleague who asks her support and will go beyond all acceptable limits to ensure our patients are provided the highest quality of care. We need more like her!	Member of Staff
Respect	Ophthalmology	Over the last 14 months I have had to shield a lot, since starting back at the beginning of April and they have done a lot of work to make sure my job is safe. setting out protocols for me to follow and always making sure I'm ok.	Member of Staff
Enable	Contract Director Medirect	We want to appreciate him for his support to this organisation over this last 14 months, both he and his colleagues have been incredibly responsive, accommodating and collaborative in all of our dealings. The most recent example of this is his willingness to go the extra mile and support the organisation in this year's One Team One Goal Awards. We asked him if he would source some items for a "goodie bag" we wanted to offer colleagues as they signed in for their One Team One Goal presentation slot. He was very accommodating, came up with some options and when we asked him for the costs, he advised us this would be complimentary - no charge, this was totally unexpected and incredibly kind. On the day of the awards, nothing was too much trouble from moving the chairs and tables, to cleaning and even dropping off a supply of milk for tea and coffee for our presenters. We want to take this opportunity to say thank you to him for his unwavering support to BHT over the last 14 months and also with the staff awards.	Member of Staff

June 2021

Category	Role	Nomination	Nominated by
Collaborate	Lead Nurse - Community Nursing and Community Transformation	She brings an air of calm to the division; nothing is too much to ask and she rises to any challenge that comes her way. As a new member of the SMT in IECC I have found her support and guidance invaluable, no question is too daft and she goes above and beyond to ensure that we work as a collective, with one aim. Her input on our new venture of a virtual ward is exciting and she is invigorating and inspiring to work with.	Member of Staff
Aspire	Advanced Physiotherapist, NSIC	She has tirelessly worked to deliver optimal care and management to patients with spinal cord injuries attending the NSIC Out-Patient Department. Her diligence and attention to detail and prompt intervention aims to support those with SCI with their lifelong needs. These needs can be complex and evolving. Sally aims to provide treatment, advice and direction to enable optimum function and outcomes and avoid the many complications that living with a SCI can	Member of Staff

		generate. Sally takes on board additional responsibilities and aims to consider the wider implications of healthcare provision within a system that is constantly under high pressure. She participates and contributes to development of new systems and provides insight and thoughtful options, often suggesting processes that may assist. As a member of the spinal physio team Sally endeavours to feedback knowledge from her experience of SCI across the lifespan into the clinical rehabilitation of those newly injured through education and information sharing with her physiotherapy colleagues.	
Respect	Head Physiotherapist, NSIC	I have recently returned to work following a substantive period of sick leave. Dot was consistent in maintaining contact during my absence, in supporting me pre return and in providing compassionate support following my return. Her flexibility, empathic manner has made returning to work straightforward when my personal circumstances have been far from straight forward.	Member of Staff
Enable	Cardiology	She has incredible patience to help, support and enable other team members (including myself) to learn and take on new responsibilities within their role whilst also managing an extremely busy department. I joined in March along with another team member shortly after me and she juggles so many things at the same time and is rather remarkable and a true aspiration. She will dedicate the time to us to help us be better at our job and to take on new responsibility to grow and she does all of this whilst juggling so many other things but remains calm and professional. She is a true super star and we are lucky to have her! Thank you, NHS!	Member of Staff

Appendix 2 – Executive Management Committee and Transformation Board

Executive Management Committee 18 May to 20 July 2021

Executive Management Committee meets on a weekly basis and covers a range of subjects including early strategy discussions, performance monitoring, consideration of business cases and moderation of risk documentation. During the last year this has also included important updates relating to our COVID-19 pandemic response. The meeting is chaired by the Chief Executive Officer and attended by Executive Directors and other key leaders within clinical and corporate services. The following provides an overview of some of the key areas considered by the committee since 18 May 2021.

Quality and Performance

Cancer services performance
Patient experience report
Young people mental health
Research and Innovation committee
Integrated Performance Report
Movement of urology activity
Deprivation of Liberty Safeguarding
Emergency Department improvement plan
Long covid report
Emergency Department quality metrics
Thames Valley radiology imaging network
Wycombe birth centre
Clinical audit programme
Enhanced Care in care homes
Admission avoidance workshop report
Preparedness for wave 3 - critical care
Wycombe hospital MRI scanner
Community block contract services review
Care Quality Commission insight report quarterly summary
Safe staffing, including maternity
Community paediatric service delivery recovery
Medical appraisal and revalidation annual report
Medicines management report
Preparedness for wave 3 – Infection Prevention and Control priorities
Patient story
Bed spacing
Learning from deaths
Patient safety and safeguarding / vulnerable patients surveillance report
Quarterly integrated safeguarding report
School immunisation business case
Maternity incentive scheme
Community Diagnostic Hub
Musculoskeletal contract management
Infection Prevention Control report
Serious incidents including maternity serious incidents
Recovery and renewal
Emergency Department primary care service
Covid vaccination program summary
Care Quality Commission quality improvement plan

People

CARE value awards
Responsibility allowance
Workforce planning for a potential third wave
Urology staffing business case
Freedom to Speak Up Report
Trauma and Orthopaedic staffing business case
Oncology staffing business case
Cellular Pathology staffing business case
Exclusions
Annual workforce equalities report 2020-2021
Public and patient Public Sector Equality Duty
Agency spend review and actions
Trust wide pay dates
Publishing facility time
Junior doctor workforce modelling
Health Education England
Learning lessons to improve our people practice
Quarterly education update report
Guardian of safer working hours annual report
Specialty doctor contract reform and Specialist Grade

Money

Covid-19 cost-tracking
Business case prioritisation
Finance Strategy – Drivers of deficit
Cath Lab X-Ray system contract
Updated Draft Financial Plan 2021/22
Charitable Funds Fundraising Strategy
Purchase Order approval

Strategy, Estates & Commercial

Strategic delivery programme
Private Finance Initiative commercial options
Fire safety annual report
Extension of lease
Health and safety annual report
Video consultation
GP IT Support
Energy infrastructure project
Outline Business Case tender
Wycombe Hospital Strategic Outline Case
Strategy delivery plan
Private Finance Initiative contracts
Proposed ICS structure for digital diagnostics
IT Capital infrastructure year 2 business case
BHT Strategy 2025 and staff engagement
Operating Plan narratives (ICS and BHT)
Property services quarterly report
Ophthalmology private patients
Audiology Any Qualified Provider contract

Governance

Caldicott and information governance
System governance – delivering the priorities
Ward to board reporting framework
Board Assurance Framework
Risk management software business case
Compliance with legislation
Corporate risk register
Summary of internal audit

The following policies were approved:

- BHT Pol 144 – Incident Response Policy
- BHT Pol 225 – Prevent Policy
- BHT Pol 125 – Records Management Policy
- BHT Pol 135 – Monitoring Compliance with Legislation Policy
- BHT Pol 071 – Injectables Policy v9.0
- BHT Pol 242 – Organ & Tissue Donation Policy v2.0
- BHT Pol 071 – Medicines Policy v7.0
- BHT Pol 211 – Handling Reported Information Security Incidents Policy
- Policy for the Prevention and Management of COVID-19
- Agile Working Policy
- BHT Pol 138 – Water Safety Policy v3.1
- BHT Pol 267 Homeworking Policy
- BHT Pol 032 - Standards of Behaviour & Conduct Policy & Procedure
- BHT Pol 246 - Innovation & Intellectual Property Policy

Transformation Board

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

Urgent and emergency care transformation
Quality Improvement huddles evaluation
High-level financial strategy
Transformation and efficiency update
Temporary staffing
Planned Care programme
Key strategic priorities and milestones
Quality Improvement projects on a page:

- Hypobox Project
- MatNeoSIP Poster
- Quality Improvement Poster Perceptorship
- Machine learning model
- Polypharmacy
- Speech and Language Therapy Voice pathway
- Stroke Physiotherapy

Performance: June 2021 in numbers



A&E attendances

8,820
June 2021

Number of people arriving in May: 8,151



Emergency admissions

3,700
June 2021

The number of patients admitted to a hospital bed May 2021: 3,720



Planned procedures

4,202
June 2021
(3,543 – May 2021)

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



Training modules delivered

10,082

11,035 (May 2021)

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



1.4%

Crude mortality in June 2021 - deaths expressed as % of the number of admissions
(1.4% May 2021)



A&E patients seen within 4 hour target
80.3%

Percentage of A&E patients seen within 4 hour national target in June 2021 (82.4% in May 2021)



Friends & family test approval
26.3%

Percentage of patients who would be likely or extremely likely to recommend our services to their friends & family in May 2021 (27% in Apr 2021 – 1 month in arrears)



Referral to treatment

52.3%

52.3% (May 2021)

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



Total Falls

60 – June 2021
0 causing severe harm

(51 – May 2021, 0 severe)

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



Cancer 2 week wait for referral
97.4% May
(98% Apr 2021)

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



Cardiac arrests

6 – June 2021
(2 – May 2021)

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



Joiners total: 134

Nursing: 33
Clinicians: 9

Health care assistants: 22
Administrative: 22 Support: 32
Allied health professional: 16

Leavers total: 162

Number of staff who joined/left in May and June 2021

Meeting: Trust Board Meeting in Public

28 July 2021

Agenda item	Integrated Performance Report	
Board Lead	Dan Gibbs	
Type name of author	Wendy Pocknell	
Attachments	None	
Purpose	Information	
Previously considered	<ul style="list-style-type: none"> • 20/07/2021 EMC - Agenda.16 • 20/07/2021 F&BPC - Agenda.5 • 21/07/2021 QCGC - Agenda.5 	

Executive Summary

- Performance update against national targets and standards, and introduction of harm assessment management. Additions and amendments this month:
 - Integration of recovery metrics into performance
 - Clinical harm metrics updated
 - A&E exceptions segmented
 - Outpatient disruption criteria revised for accuracy

- In progress:
 - Expand data to 3 months for comparison
 - Summary of clinical contact of long waiting patients
 - Triangulation of Community metrics

- Spotlight Reporting for key domains

- Detailed response to workforce challenges

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

Decision	The Board is requested to consider performance and virus risk impact		
Relevant strategic priority			
Quality ☒	People ☒	Money ☒	

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

Integrated Performance Report

June 2021

CQC rating (June 2019)

-

GOOD

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Integrated Performance Report

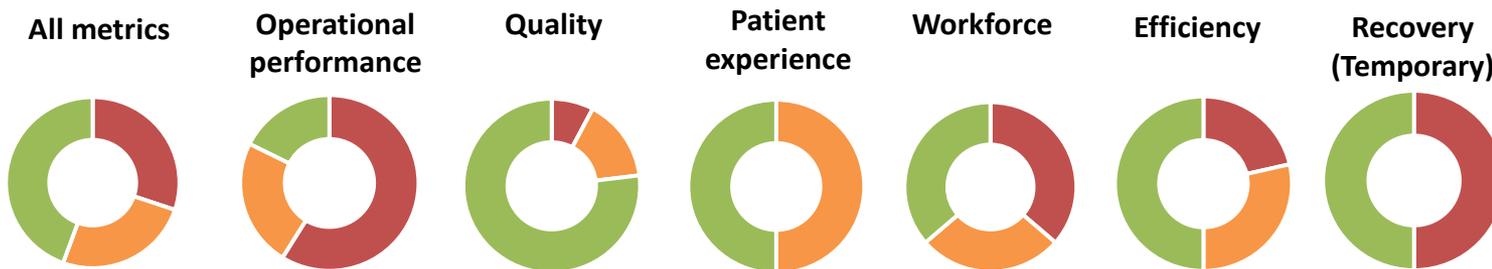
Contents

Section

- | | |
|-----------------------------|------------------------------------|
| 1. Executive Summary | 8. Workforce |
| 2. Domain Spotlight Reports | 9. Efficiency and use of resources |
| 3. Strategic Measures | 10. COVID Recovery |
| 4. Demand Trends | 11. Finance |
| 5. Operational Performance | 12. Appendix: Report Structure |
| 1. RTT | 13. Appendix: Tables of Metrics |
| 2. A&E | |
| 3. Cancer | |
| 4. Diagnostics | |
| 5. Community | |
| 6. Harm Review | |
| 6. Quality and Safety | |
| 7. Patient Experience | |

Executive Summary

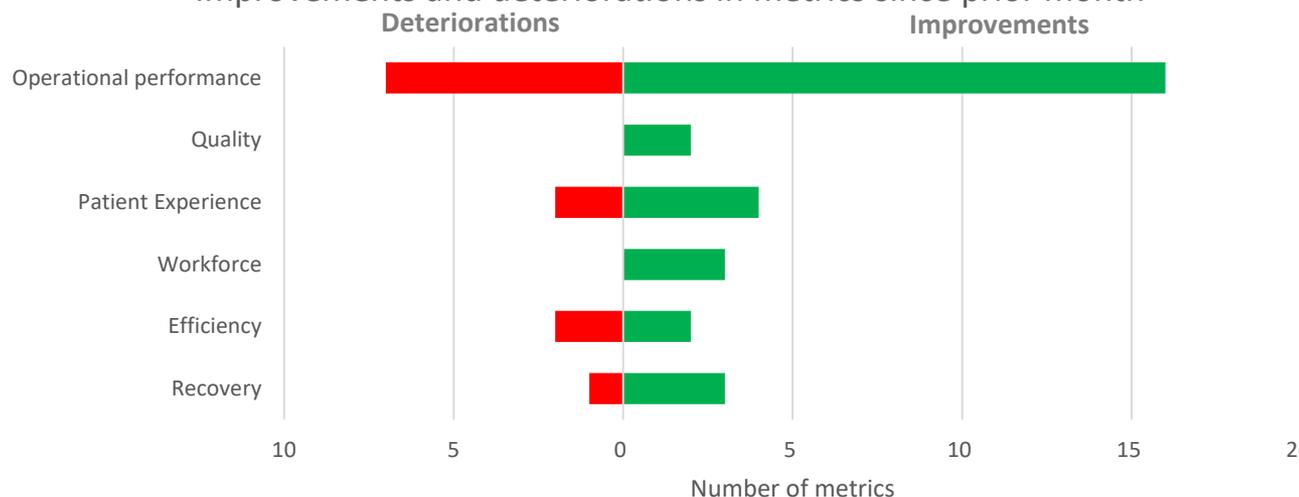
Summary of RAG ratings for latest reporting period:



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

Prior month comparison:

Improvements and deteriorations in metrics since prior month



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

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Operational Performance

Spotlight Report from Chief Operating Officer

June has been an exceptionally busy month at the Trust – urgent and emergency care has remained significantly challenged. The Trust is partnering with The Royal Berkshire Hospitals NHS Foundation Trust's emergency department to provide support for our clinical teams on their recovery journey. We have also instigated a number of actions to improve pathways for minor and non-admitted care including working with our local GP federation, FedBucks to develop a new urgent treatment centre model at Stoke Mandeville Hospital. Elsewhere, we have been busy preparing for the anticipated surge in demand for both adults and children presenting with respiratory symptoms. Both demand curves are expected to peak in September. We are introducing a nurse and therapist-led inpatient model at Chartridge Ward to alleviate pressure on the Stoke Mandeville site. Additionally, ward 9 is to be allocated to children's services as escalation space until the new development is completed. Unfortunately, there is a high probability we will need to use St. George's ward in the NSIC for the peak to support adult demand. We are working through this with our commissioners.

Our recovery of elective services continues. Whilst we remain a regional outlier, we are improving our position on long waiters. July will see our independent sector contracts begin to kick in and now there is clarity on elective recovery fund arrangements for the second half of the year, work is underway to continue dropping the backlog significantly. Diagnostics has been exceptionally challenged but we have seen a herculean effort in ultrasound to clear around 900 patients to bring booking times back down to 5 weeks. DEXA scanning is moving back on track now the machine is repaired. Endoscopy, however, remains a significant challenge. We are working with NHS partners and local and national independent providers to increase capacity. For July we are predicting a reduction to 20% of all patients waiting > 6 weeks with further improvements in August.

Quality & Safety

Spotlight Report from Medical Director and Chief Nurse

- Quality Account published on June 30th , with focus on response to the COVID-19 pandemic and the maintenance of high quality care for our patients.
- Chief Nurse Office fully recruited to with a Director of Midwifery and second Deputy Chief Nurse
- Named Nurse for Childrens' Safeguarding appointed to commence September 2021. This will support increased demands on Safeguarding team which emerged during pandemic and continues.
- Work is continuing to deliver improvements in ED for all aspects of patient experience. An external review of Emergency Department by NHSE/I identified positive practice but with clear guidance on improving front door triage system which is being implemented.
- Deputy Head of Nursing appointed as lead nurse, for operational oversight nursing issues and patient experience in ED.
- Gap analysis completed in IPC for training and policy (links to approximately 15 policies), linking with the ICP, developed into annual plan and strategy for approval in July.
- Chief Nurse Learning event – open to all – now established monthly, with first event discussing a Serious Incident with focus on WHO checklist and everyone having a voice in surgical teams
- Dr. Belinda Dewar delivered two weeks of training on Appreciative Inquiry to a range of teams and met with Executives. The methodology of Appreciative Inquiry supports Safety II principles

Patient Experience

Spotlight Report from Medical Director and Chief Nurse

Approval ratings for both Emergency Department and inpatient care have fallen.

Key areas for concern for patients in A&E include: waiting times, staff attitude and behaviour and ED environment. The patient experience team are working with A&E to incorporate patient experience improvement actions into the wider A&E improvement plan and will continue to support the A&E team in achieving these.

Inpatient approval ratings have also fallen. The policy on visiting will be changing in July to allow for more flexibility around appointment times and increasing the number of people that can be designated as visitors to two.

Maternity approval ratings have increased, this is likely to have been impacted by changes to allow partners to attend all appointments and an increase in the number of birth partners, previous restrictions had been a source of concerns and complaints

Complaint numbers are down in June. The top three subjects of complaints were: treatment and procedure, behaviour & attitude of staff and communication with patient/family/friends. Queries to PALs increased in June, the top three subjects of queries were general information, delays and cancellations and communication.

Workforce

Spotlight Report from Director of Workforce

COVID-19 vaccination programme

Our internal vaccination programme for this stage has now ended. We completed our second dose clinics (for Astra Zeneca vaccines) on 30 June; Pfizer second doses were completed by 25 April. From 1 July, colleagues book vaccines through the national booking system. Uptake of the vaccine first dose is 89% and second dose is currently 85%. Uptake from colleagues from minority ethnic backgrounds is 87% first dose, 82% second dose. The lowest uptake is from colleagues of black/black British ethnicity. We have started planning for the Flu and Covid-19 vaccine boosters for Autumn 2021.

Absence levels

Absence levels are increasing; numbers of colleagues absent because of a positive COVID-19 test remain at a low level (average daily absences have been at c8 since the start of May). However, numbers of colleagues isolating has risen since the start of June from c8 per day to c46 per day.

Thrive@BHT

Delivery of the key strands of our people programme Thrive@BHT has started well. Our brochure, setting out our offer has been sent out and we are seeing good uptake of our offerings. c400 people have enrolled on Peak 1 of our three Peaks Management programme. This comprises 10 modules delivered across 6 days, including Managing inclusivity, REACT mental health and wellbeing conversations. Our occupational health, wellbeing and leadership & OD teams are providing support and interventions to teams and individuals, proactively as well as responding to referrals for stress.

Statutory Training

Compliance levels are increasing; two clinical divisions have met the target of 90%. Support is in place as part of our THRIVE@BHT programme to support further compliance.

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Finance

Spotlight Report from Director of Finance

- 1. 2021/22 I&E month 3 year to date (YTD) headline position of break even** in line with the provisional annual budget agreed by Board in April 2021. This is supported by £16.1m of non-recurrent Block top-up, Covid-19 income and Elective Recovery funding, this income has been accrued based on the latest guidance from NHSE/I.
- 2. Reported position year to date includes £1.5m of Covid-19 related incremental expenditure and £6.3m Covid-19 income.** Covid-19 expenditure has fallen to £0.3m in month 3, down from £0.4m in month 2.
- 3. Full year forecast of £22.3m deficit in line with plan.** The plan and forecast includes H1 income and expenditure related to the delivery of additional activity that would qualify for Elective Recovery Funding (ERF). The H1 ERF income forecast of £11m has not been updated to reflect guidance issued by NHSE/I on 9th July, which indicates that the activity threshold will be increased from 85% to 95% with effect from 1st July 2021. This is expected to reduce ERF income in H1. NHSE/I is planning to release financial guidance for H2 in September 2021. This is a draft full year plan and it remains subject to final review and approval by the Board.

Demand Trends

Metric	Latest reporting period	Previous reporting period	Reporting period	Movement since last month	RAG	12-month trend
A&E						
A&E attendances	8,820	8,151	Jun-21	↑		
<i>Total number of A&E attendances at Stoke Mandeville Hospital</i>						
CSRU attendances	450	485	Jun-21	↓		
<i>Total number of attendances at the Cardiac and Stroke Unit, Wycombe Hospital</i>						
CAT clinic activity	156	139	Jun-21	↑		
<i># of Patient contacts at the Community Assessment and Treatment Service</i>						
Cancer						
Cancer - 2 week wait referrals	1,734	1,810	May-21	↓		
<i># of urgent 2 week wait cancer referrals received.</i>						

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Demand Trends

Metric	Latest reporting period	Previous reporting period	Reporting period	Movement since last month	RAG	12-month trend
RTT						
GP referrals	7,784	7,572	Jun-21	↑		
<i># of GP referrals received in month</i>						
Community						
Total referrals	7,538	6,900	Jun-21	↑		
<i># of patients referred to Community Services (all)</i>						
Covid Referrals	1	7	Jun-21	↓		
<i># of suspected COVID 19 patients referred to Community Services (all)</i>						
Non Covid Referrals	7,537	6,893	Jun-21	↑		
<i># of non COVID 19 patients referred to Community Services (all)</i>						

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Operational Performance Overview

Summary of RAG ratings:



Summary of metrics:

Metric	Target	Latest reporting period	Previous reporting period	Reporting period	MoM mvmt G = Improvement R = Deterioration	RAG	SPC threshold breach	Exception report
A&E								
A&E - 4 hour performance	95%	80.3%	82.4%	Jun-21	↓	Red		✓
A&E - Child under age one - triage in 15 mins	95%	81.6%	85.7%	Jun-21	↓	Red		✓
A&E - Patients over 12 hours in A&E	0	298	234	Jun-21	↑	Orange		✓
A&E - Delayed ambulance handovers	0	182	84	Jun-21	↑	Red		✓
A&E - Patients returning within 72 hours		4.5%	4.5%	Jun-21	→	Grey		
Cancer								
Cancer - 2ww - first appt within 2 weeks	93%	97.4%	98.0%	May-21	↓	Green		
Cancer - 2ww - treatment within 62 days	85%	80.1%	82.7%	May-21	↓	Orange		✓
Cancer - 2ww - 28 day faster diagnosis	75%	77.3%	73.3%	May-21	↑	Green		
Cancer - screening - treatment within 62 days	90%	81.3%	100.0%	May-21	↓	Orange		✓
Cancer - 31 days to first treatment	100%	100.0%	97.6%	May-21	↑	Green		
Cancer - 104 day waits	0	2	5	May-21	↓	Orange		

[Link to appendix](#)

Constitutional targets are highlighted blue

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Operational Performance Overview

Summary of metrics:

Metric	Target	Latest reporting period	Previous reporting period	Reporting period	MoM mvmt G = Improvement R = Deterioration	RAG	SPC threshold breach	Exception report
RTT & Elective Recovery								
RTT - Open Pathway performance	92%	52.3%	52.2%	Jun-21	↑			
RTT - Number of open pathways	31,024	35,385	35,155	Jun-21	↑		×	
Waiting list size at pre COVID levels (baseline is 19/20)		120%	119%	May-21	↑		×	
RTT - Average weeks wait on waiting list	20/21 19/20	26 19	26 16	May-21	→			
RTT - Patients open pathways over 52 weeks	0	5,086	5,472	Jun-21	↓			
RTT - Patients open pathways over 26 weeks	0	12,675	12,550	Jun-21	↑			
Activity to pre COVID levels - Elective/Daycase (baseline is	90%	96.5%	81.2%	Jun-21	↑			
Activity to pre COVID levels - Outpatients	90%	109.4%	101.2%	Jun-21	↑			
Transition to virtual appointments	30%	26.3%	28.8%	Jun-21	↓		×	
RTT - Diagnostic waits under 6 weeks	99%	72.9%	64.8%	Jun-21	↑			

[Link to appendix](#)

Constitutional targets are highlighted blue

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Operational Performance Overview



Summary of metrics:

Metric	Target	Latest reporting period	Previous reporting period	Reporting period	MoM mvmt G = Improvement R = Deterioration	RAG	SPC threshold breach	Exception report
Community								
% of EHCP completed in 6 weeks		44.1%	51.0%	May-21	↓			✓
% of births offered a face to face appointment with a Health Visitor within 14 days		72.6%	80.0%	Jun-21	↓		✗	✓
% of LAC seen within 20 days (in county)				Apr-21	→			
% of LAC seen within 20 days (out of county)				Apr-21	→			

[Link to appendix](#)

Constitutional targets are highlighted blue

Operational Performance Overview

Summary of metrics:

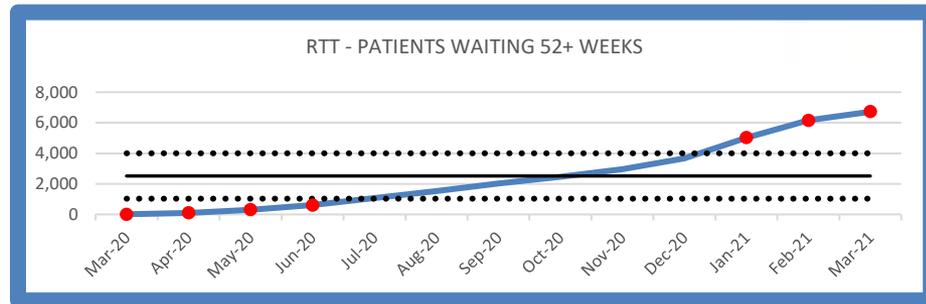
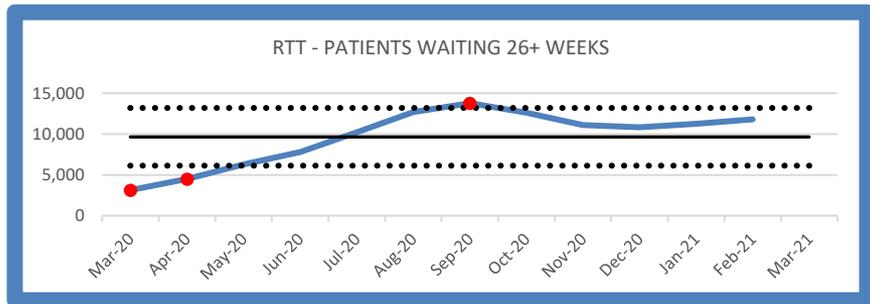
Metric	Target	Latest reporting period	Previous reporting period	Reporting period	Direction = MoM mvmt Green = Improvement Red = Deterioration	RAG	SPC threshold breach	Exception report
Harm review								
Cancer - COVID delays		16	15	May-21	↑			
Elective referrals		21,988	18,496	Jun-21	↑			
Clinical Harm assessment - category P1 waiters		0	2	Jun-21	↓			
Clinical Harm assessment - category P2 waiters		335	285	Jun-21	↑			✓
Other Operational								
Reablement - median urgent response time (hours)	8	1.5	2.0	Jun-21	↓			
District Nursing - median urgent response time (hours)	8	1	2	Jun-21	↓		×	
Average bed occupancy (G&A)		91.8%	92.5%	Jun-21	↓			
Emergency readmission within 30 days	5%	7.7%	8.2%	May-21	↓			
Patients with expected discharge date		70.0%	70.6%	Jun-21	↓		×	
Neck of femur fracture to theatre in 36 hours		74%	82%	May-21	↓			✓
% of G&A beds occupied by MFFD		7.7%	8.7%	Jun-21	↓			
Average LOS after MFFD		6.2	6.1	Jun-21	↑			

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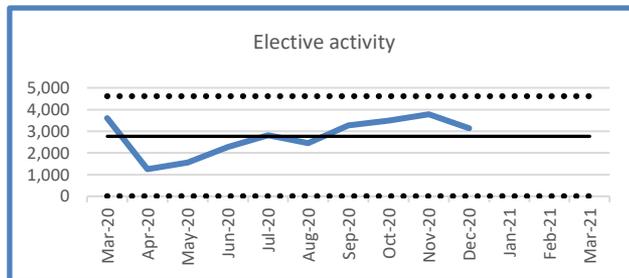
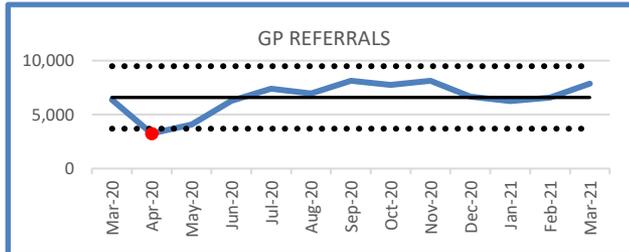
every time

Operational performance

RTT



Breakdown of waiting list	Booked	Not booked	Total
>=105 weeks	15	77	92
53-104 weeks	567	4460	5027
41-52 weeks	231	2361	2592
27-40 weeks	626	4291	4917
18-26 weeks	624	4683	5307
Total	2063	15872	17935



	Patient choice
>=105 weeks	43%
53-104 weeks	17%

Performance commentary

The number of long waiting patients is improving, with more being treated in BHT and private facilities. There are several patients reluctant to accept appointments for treatment and the impact of delay is reassessed when contacted by clinicians.

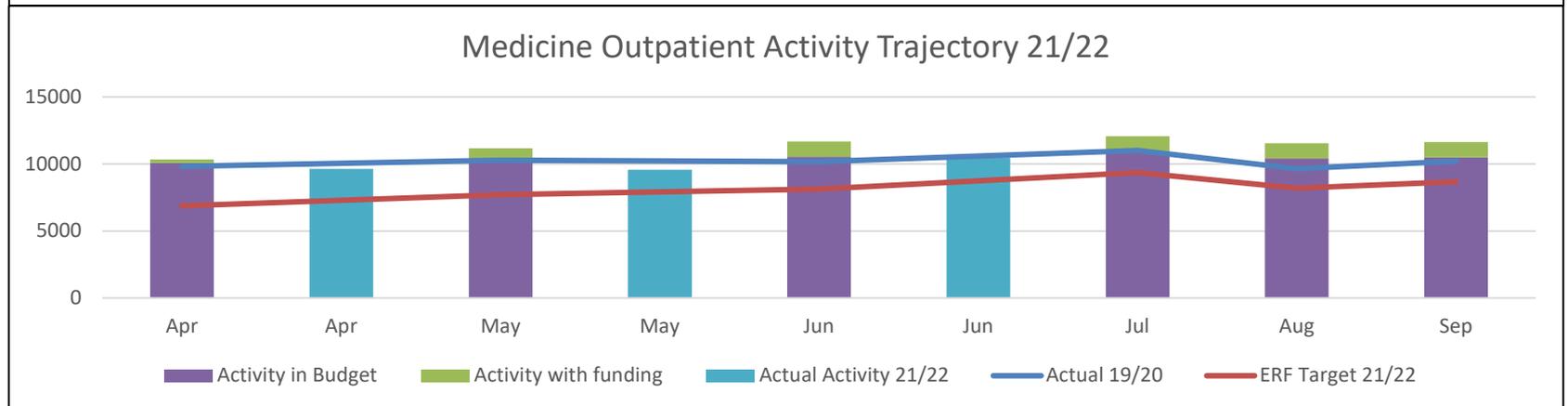
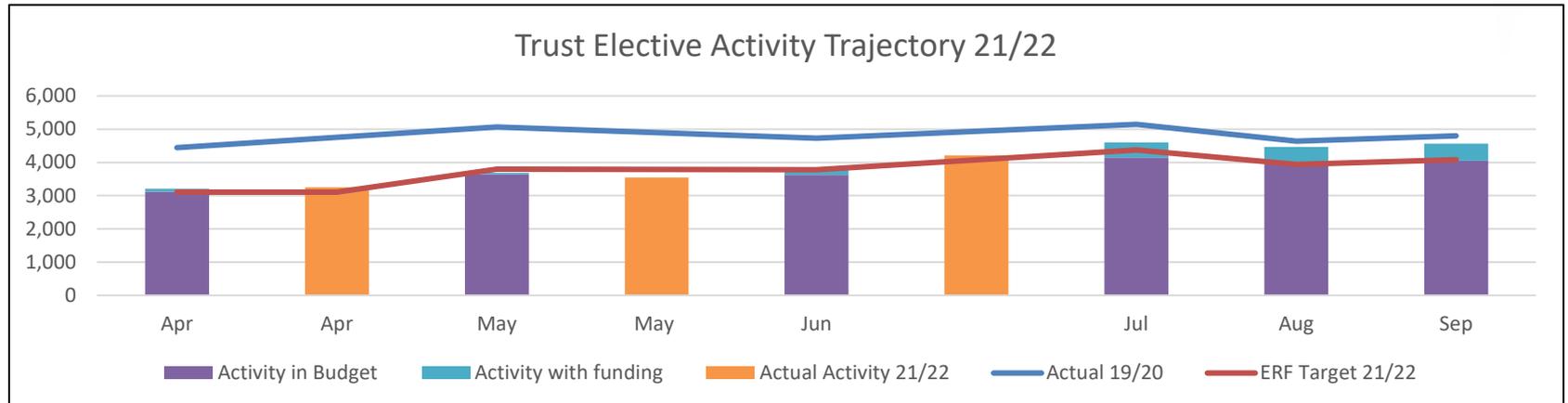
The rise in patients waiting over 26 weeks is monitored as capacity continues to be used for cancer and urgent patients as appropriate.

Patients on waiting lists have been contacted recently and this will form part of ongoing communication with our patients

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Operational performance

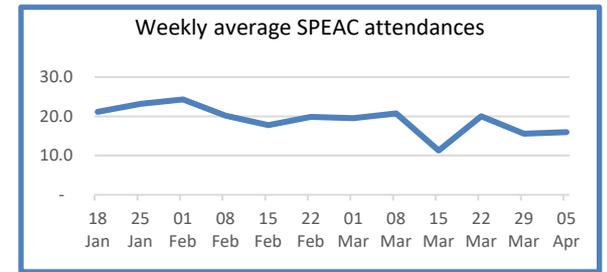
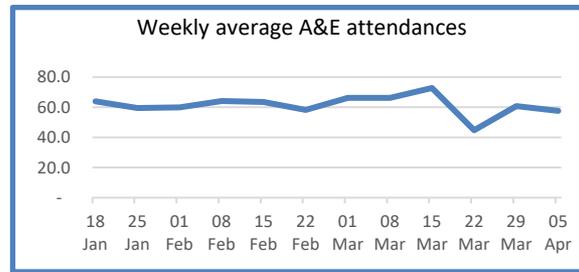
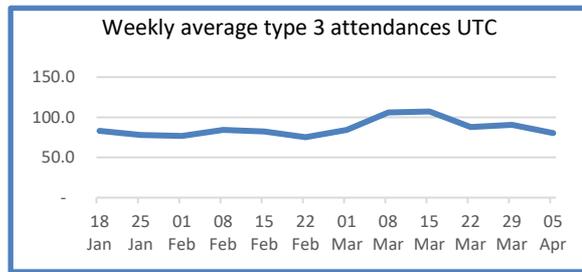
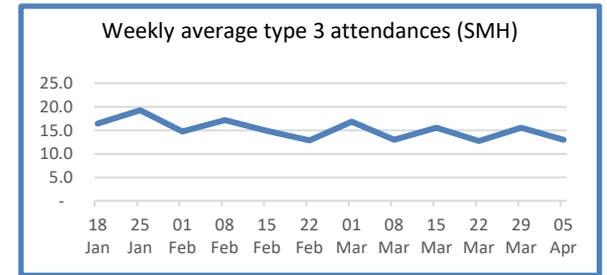
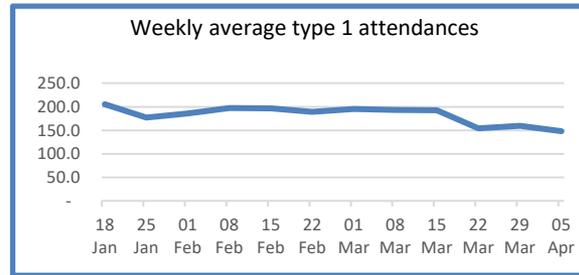
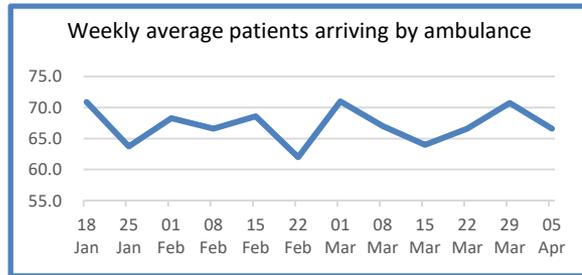
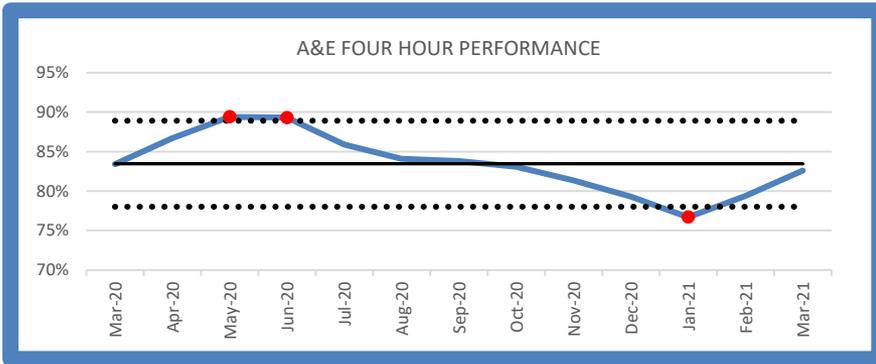
RTT – Recovery Trajectory



Narrative
 Outpatient and day case activity continues to increase within infection control guidance, this is expected to continue over the summer months and assist with recovering the waiting list position.

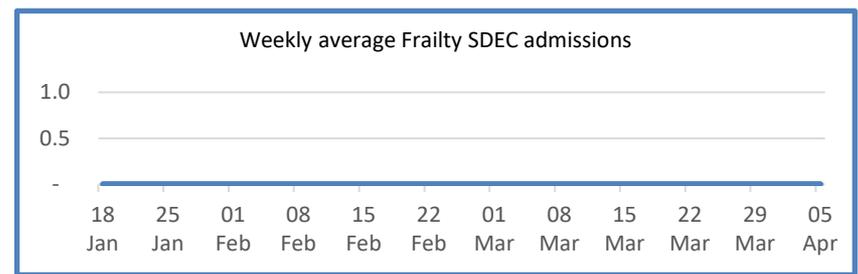
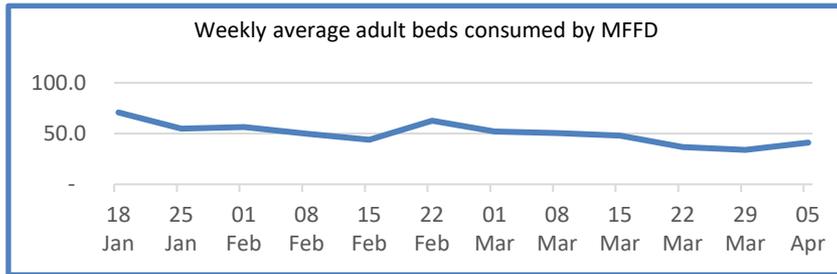
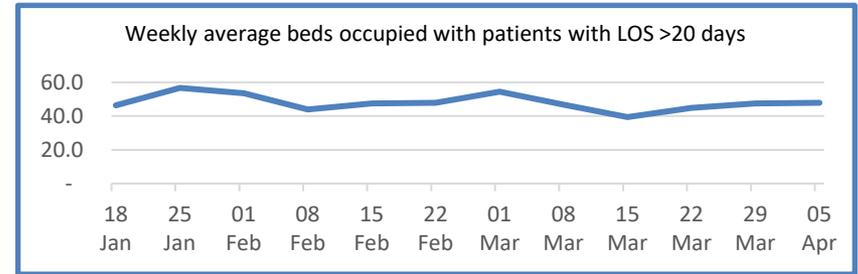
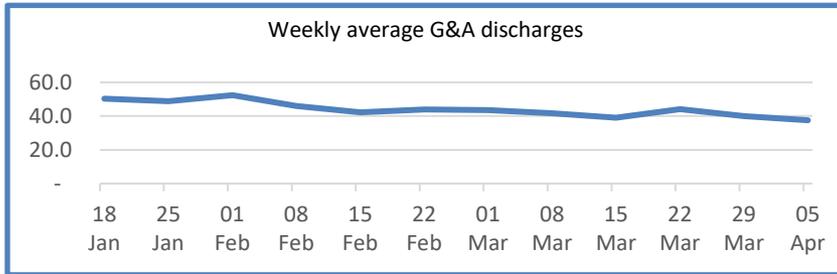
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Operational performance A&E



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Operational performance A&E



Performance commentary

Attendances at pre-covid levels , with high numbers of children presenting and those who cannot get prompt access to primary care . In order to reduce waiting times and improve patient experience a system of clinical triage was introduced in month in order to direct to appropriate area or reassure and sent home with advice. Further plans include GP presence at the front door from mid July.

The 3 x weekly LLOS meetings continue however the non medically optimised numbers remain high.

Overall bed capacity has not been a challenge in month however it is acknowledged continued focus is required on patient clinical management plans and discharge planning , the latter ensuring timely referrals. The recording of EDDs has improved .

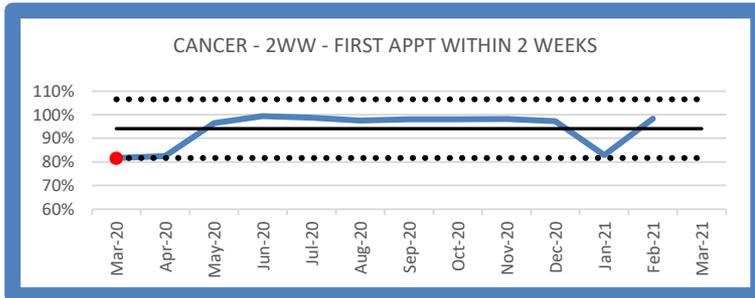
The expansion of the clinical site team commenced this month with 3 new members joining, this will help to support flow across the Trust.

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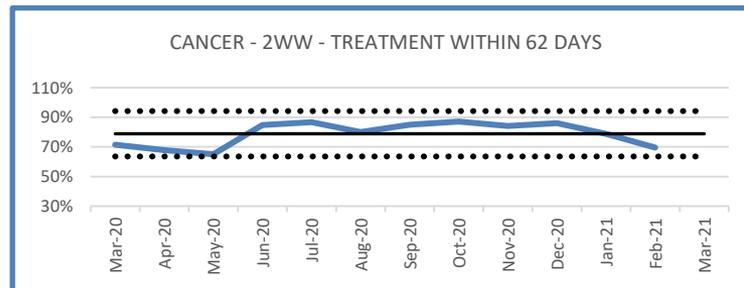
Operational performance

Cancer



Breakdown of waiting list:

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



Performance commentary

Successes

Despite pressures surrounding capacity, the trust continues to perform well and has continued compliance across 2WW, 31-day and 28 Faster Diagnosis standards.

Despite remaining non-compliant with the 62-day standard:

- BHT finished in 3rd position within the Alliance for the month of May 2021
- BHT placed 47th out of 141 treating providers nationally

Emerging Risks

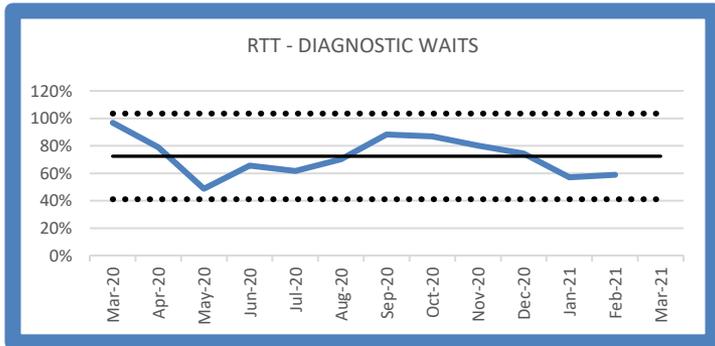
- This is the 5th consecutive month the trust has been non-compliant for the 62-day standard, although recovery has improved since January, this remains our most challenged pathway with several bottlenecks affecting patients.
- The number of 2WW GP referrals continued to rise above baseline during the month of May. This is indicative of the trend seen since COVID-19 restrictions have been lifted, with more patients presenting symptoms in primary care. It is likely that the number of referrals will continue to rise over the coming summer months.
- Daily cancer huddles continue to take place with service areas, encouraging polling within 10 days, failure to do so significantly increases the risk of becoming non-compliant with both 2WW and 28 day Faster Diagnosis standards.

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Operational performance

Diagnostics



Diagnostic waiting time performance has been driven adverse by three significant challenges:

- 1) DEXA scanner was inoperable – machine has been repaired. Waiting patients reviewed as low risk by CMO. Additional capacity has been identified.
- 2) Non-obstetric ultrasound – extreme staffing issues during wave 2 created a significant backlog. Locum recruitment has occurred and >900 patients were cleared in late June. Recovery continues.
- 3) Endoscopy – focus on P2 and cancer during wave 2 has led to backlog growth. Gutcare are providing insourcing support to the Trust. Change to use of lateral flow for preassessment has helped. Booking capacity remains a significant risk – extra support being sourced.

Modality	Service	Activity		Waiting List		
		Total tests / procedures latest month	Total tests / procedures previous month	< 6 Weeks	> 6 Weeks	Total WL
Imaging	Magnetic Resonance Imaging	1,892	1,865	909	61	970
	Computed Tomography	4,057	3,663	592	18	610
	Non-obstetric ultrasound	4,067	3,613	913	66	979
	Plain film	0	0	0	0	0
	DEXA Scan	50	113	172	340	512
Physiological Measurement	Audiology - Audiology	380	417	241	0	241
	Cardiology - echocardiography	462	357	704	192	896
	Cardiology - electrophysiology	0	0	0	0	0
	Neurophysiology - peripheral neurophysiology	0	0	0	0	0
	Respiratory physiology - sleep studies	0	0	22	0	22
	Urodynamics - pressures & flows	0	0	7	79	86
Endoscopy	Colonoscopy	266	183	220	335	555
	Flexi sigmoidoscopy	116	101	69	147	216
	Cystoscopy	223	257	332	0	332
	Gastroscopy	326	245	202	388	590
Total		11,839	10,814	4,383	1,626	6,009

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

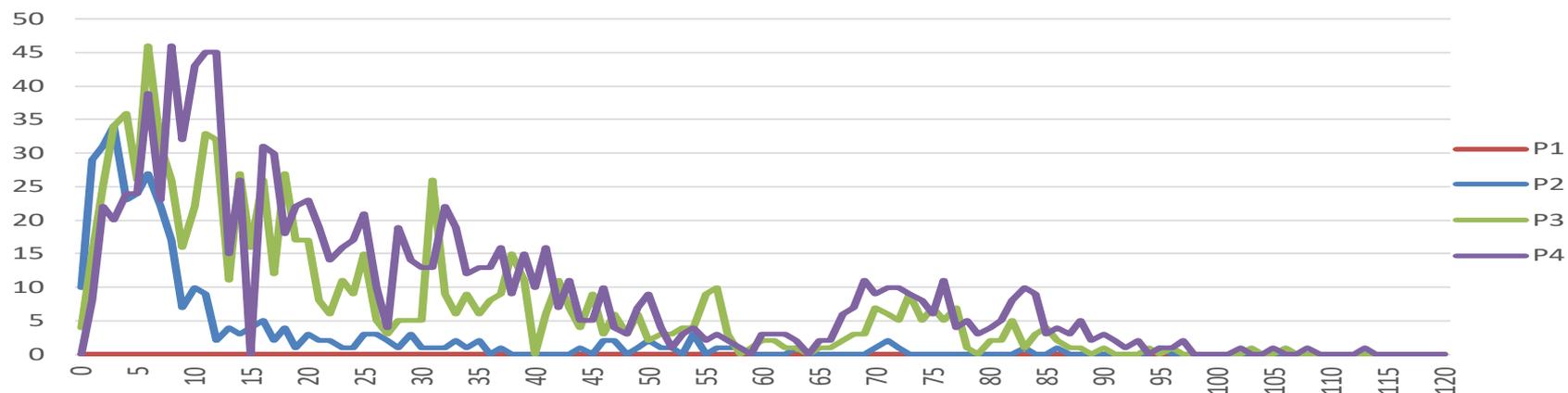
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Operational performance

Harm review

Patient wait and harm assessment



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

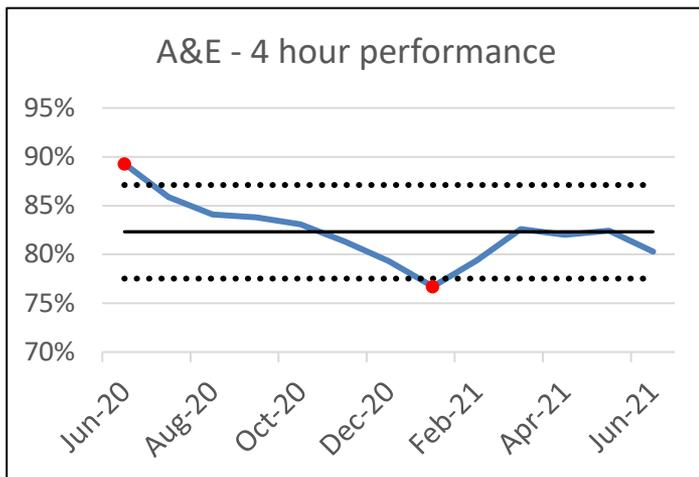
Narrative

Patients prioritised as P1 continue to be treated immediately and no patients are waiting. BHT have made progress in ensuring patients categorised as P2 are offered appointments within 4 weeks.

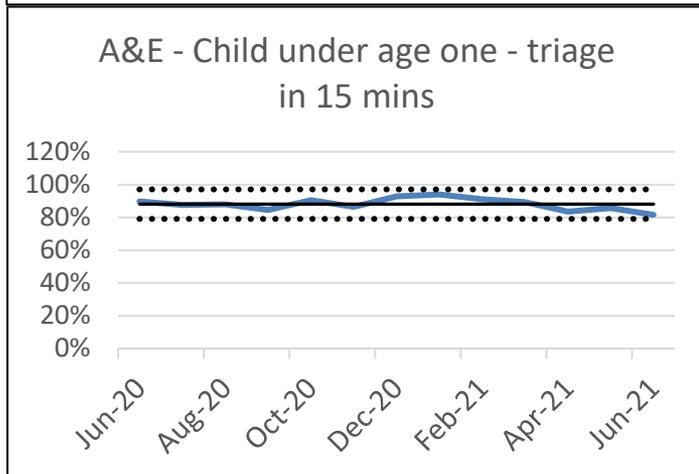
Capacity will continue to be offered to patients at highest risk of clinical harm.

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Performance Exceptions



Risk	Resolution Action	Improvement timeline	Owner
Compliance with the 4 hour standard has dropped. This position has been driven mostly by significant increases of minors type care	Engaging independent GP provider to increase GPs by 3 in ED 14-2200, to see at least 60 patients per day	End July 2021	Director of Transformation, UEC
	Developing SMH UTC concept with Fedbucks	End Sept 2021	Director of Urgent Care



Risk	Resolution Action	Improvement timeline	Owner
Delaying patients for assessment and treatment	Review of pathway and streaming process – minors/GP/PDU streaming Analysis of staff in process, to get navigator until midnight	July 2021	Director of Urgent care

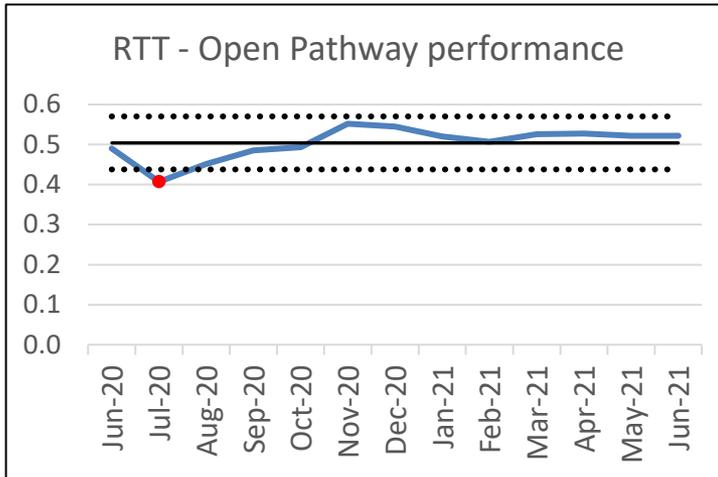
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Performance Exceptions

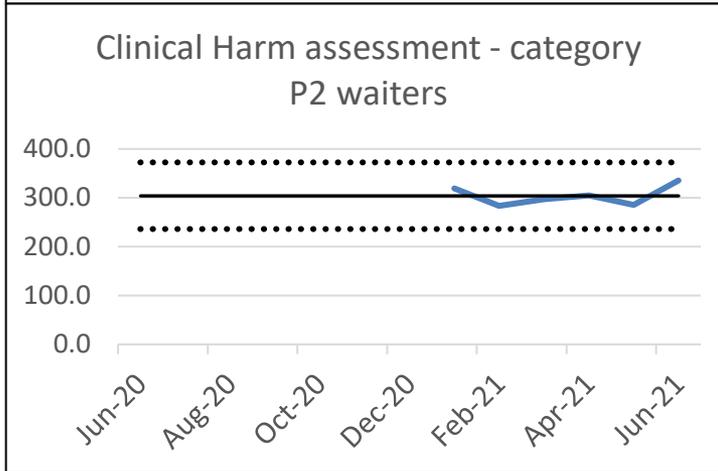
A&E - Patients over 12 hours in A&E	Risk	Resolution Action	Improvement timeline	Owner
<p>A&E - Delayed ambulance handovers</p>	<p>Risk</p> <p>Increased demand has led to increased delays</p>	<p>Resolution Action</p> <p>Nurse-led RAT model – increasing capacity for rapid turnaround.</p> <p>In-department paramedic HALO to release crews.</p>	<p>Improvement timeline</p> <p>End August</p>	<p>Owner</p> <p>Director of Transformation, UEC</p>
	<p>Risk</p> <p>Patients with extended length of stay in ED are at greater risk of harm</p>	<p>Resolution Action</p> <p>Continued review of patients and monitoring shift. Whilst the overall number has increased, it has stayed below previous levels</p>	<p>Improvement timeline</p> <p>Improvements to be seen by end July 2021</p>	<p>Owner</p> <p>Director of Transformation, UEC</p>

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Performance Exceptions



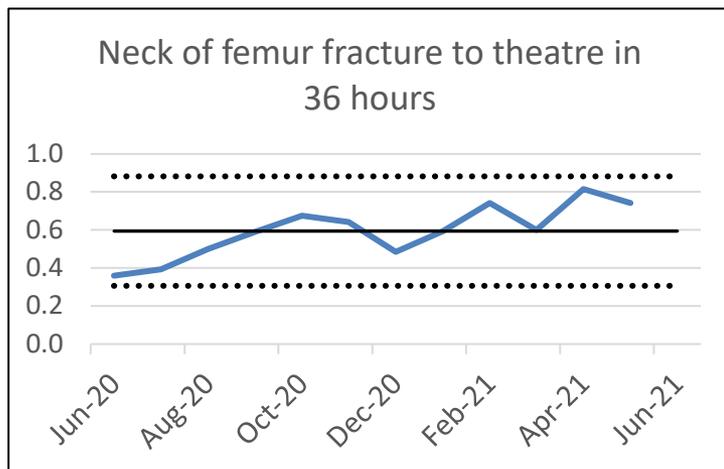
Risk	Resolution Action	Improvement timeline	Owner
More patients added to wait list without adequate capacity to see and treat	All referrals assessed at the point of receipt. Advice and Guidance given where appropriate to ensure only those requiring appointments added to waiting list	Ongoing – actions provide appropriate management of waiting list but growth also dependent on GP referrals	Divisional Directors Director of Performance and Planning



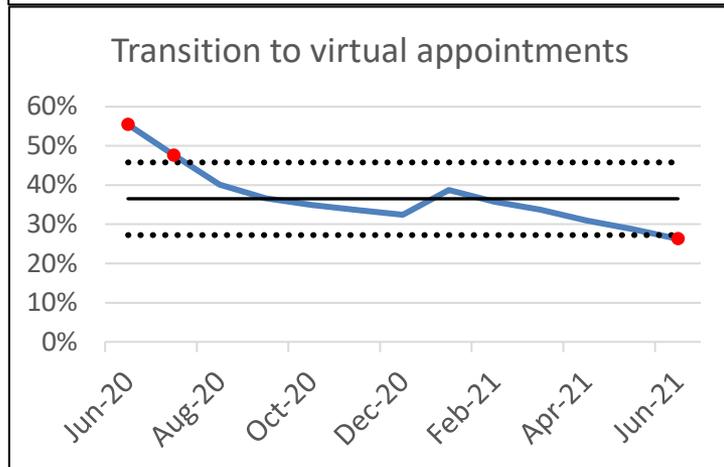
Risk	Resolution Action	Improvement timeline	Owner
Patients with risk of clinical harm continue to be delayed	Patients prioritised early on their care pathway. Agreed actions to offer P2 patients' appointments within 4 weeks of decision to treat	End July 2021	Divisional Directors Director of Performance and Planning

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Performance Exceptions



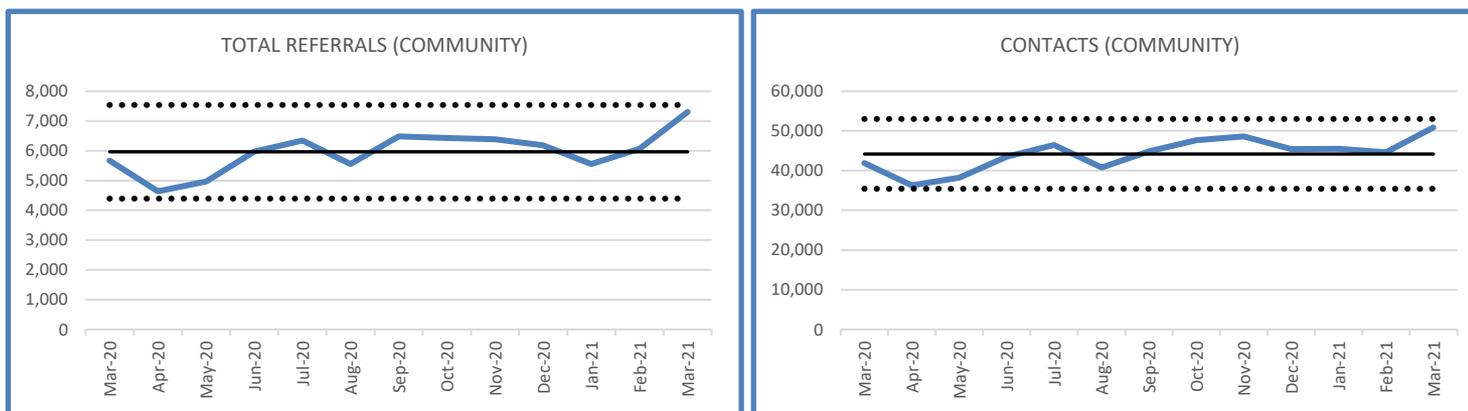
Risk	Resolution Action	Improvement timeline	Owner
<p>There is a risk of increased mortality if hip fracture patients do not have their surgery within 36 hours of Admission</p> <p>Higher priority cases caused delays over 36 hours</p>	<p>High visibility in Ed/T&O wards to ensure all preop investigations are completed in a timely manner</p> <p>Highlight breach times, influencing changes to list order to ensure patients reach theatre within 36 hours.</p> <p>Implement revised hip fracture pathway book</p>	<p>Patients to surgery within 36 hours:</p> <p>Ongoing monitoring of the standard to ensure month on month improvement</p>	<p>Hip Fracture Nurse and Trauma Lead</p>



Risk	Resolution Action	Improvement timeline	Owner
<p>BHT does not meet national expectation to deliver 25% of outpatient appointments as virtual</p>	<p>Addressed at Divisional level – and speciality.</p> <p>Ensure patients benefit from increased number of virtual appointments where appropriate.</p>	<p>End August 2021</p>	<p>Divisional Directors</p>

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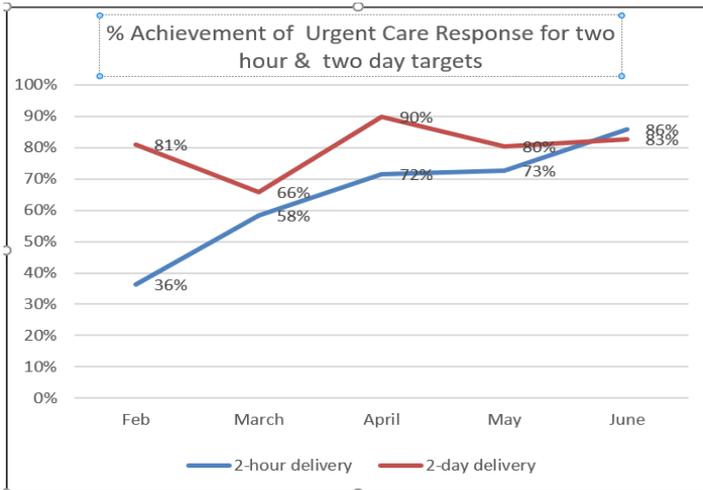
Operational performance Community



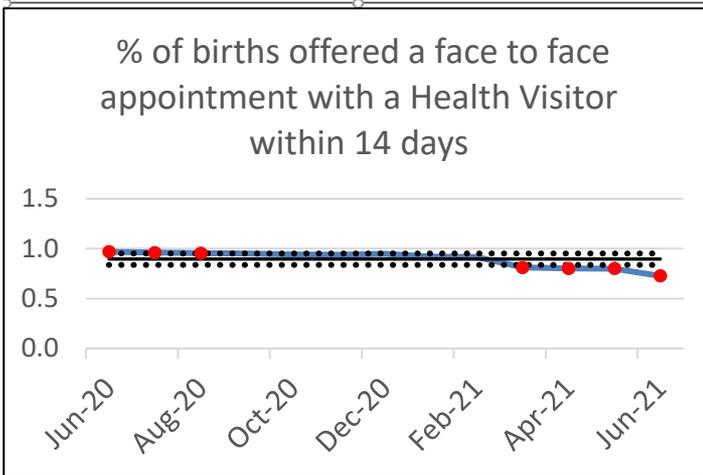
Referrals for community services have increased in the last year but contacts have been less. The District Nursing service averages around 1800 referrals a month with c1900 contacts. In March, some of the previously closed services re-opened which is reflected in the increasing number of contacts. The teams are focusing on reviewing waiting lists and trying to see the long waiting patients – virtually as well as face to face

Clarification is required into exactly which services are included within this data and the source ie RIO/Medway as these services stretch across all the Divisions eg Cardiology, CYP, BIRS etc. This will be done before the next IPR report is published.

Community Performance Exceptions



Risk	Resolution Action	Improvement timeline	Owner
Recruitment of staff to enable and sustain 80% delivery at two hrs and two days by October	Use of locums and bank to support 8am-8pm requirement until recruitment is completed	1 st October 2021	IECC
	Collaborative working with single point of access team, continued stakeholder engagement and establish clear referral pathways and criteria	1 st October 2021	IECC
Too high or too low demand for the Urgent Care Response			



Risk	Resolution Action	Improvement timeline	Owner
Mid point review not carried out consistently	Reviewing process for booking appointments and management of meetings	August 2021	Deputy Divisional Director Community Paediatrics
	Staff levels and digitisation review		

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Quality & Safety Overview

Summary of RAG ratings: Summary of metrics:



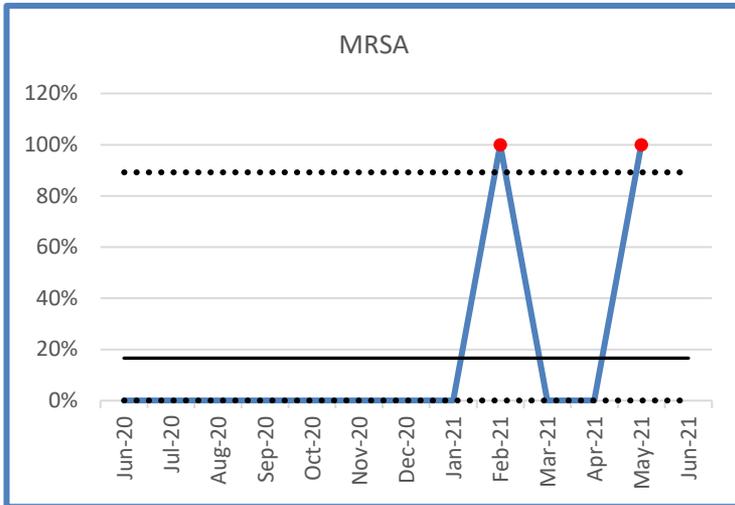
Metric	Target	Latest reporting period	Previous reporting period	Reporting period	MoM mvmt G = Improvement R = Deterioration	RAG
MRSA	0	1	0	May-21	↑	Red
Clostridioides Difficile (C Diff)	0	4	6	May-21	↓	Green
Never Events	0	0	0	Jun-21	→	Green
Falls causing severe harm	0	0	0	Jun-21	→	Green
Medication errors causing severe harm	0	0	0	Jun-21	→	Green
Line infections	0	0	-	May-21	→	Green
Failures to isolate		11	6	May-21	↑	Grey
Crude mortality (rolling 12 months)		1.4%	1.4%	Jun-21	→	Grey
Hospital Standardised Mortality Ratio (HSMR) (rolling 12 months)		-	-	Apr-21	→	Grey
Medical Examiner screens selected for further review		9.8%	13.0%	Jun-21	↓	Orange
Sepsis Compliance - Suspicion to needle time (STNT) within one hour	80.0%	74.0%	73.0%	May-21	↑	Grey
Extended perinatal mortality (per 1000 cases)		5	5	Apr-21	↓	Green
Stillborn 24 weeks or later (per 1000 cases)		4	4	Apr-21	↓	Orange
Avoidable cardiac arrests	0	6	2	Jun-21	↑	Orange
VTE assessment	95.0%	96.0%	96.2%	May-21	↓	Grey
Pressure ulcers - deep tissue damage				Apr-21	→	Grey
Safeguarding training (C&YP Level 2)		83.8%	84.0%	Jun-21	↓	Orange
A&E - median time to triage (minutes)		17	15	Jun-21	↑	Orange

[Link to appendix](#)

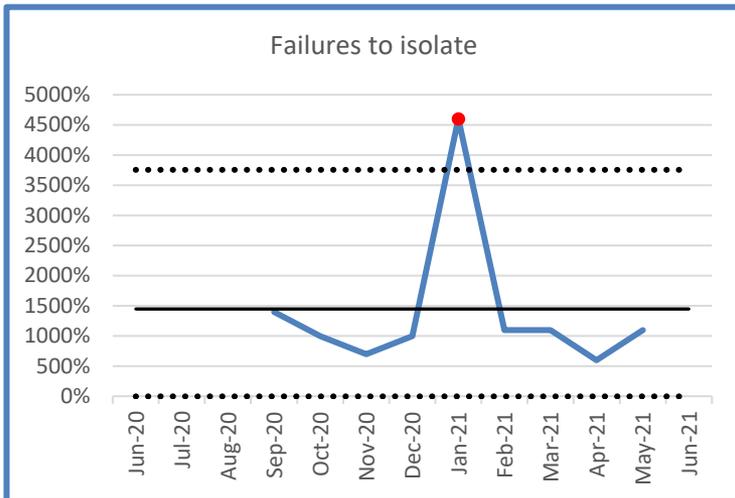
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Quality & Safety Exceptions

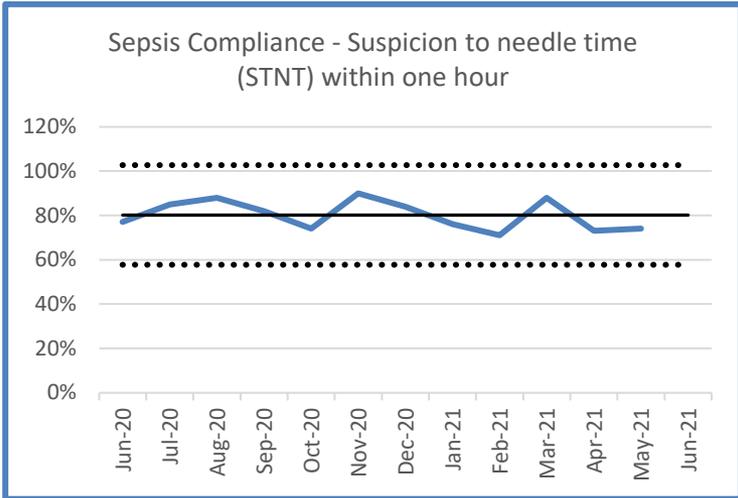


Risk	Resolution Action	Improvement timeline	Owner
Risk of increased length of stay, and 50% increased risk of morbidity and mortality from contracting healthcare associated MRSA bacteraemia. Risk for any patient of significant harm and delayed recovery.	Full investigation completed which has identified significant changes in practice required, guided by the creation/update of 2 x documents - in line with national guidance i) MRSA - new policy to link with Surgical Site Infection ii) INVASIVE DEVICES – new policy to standardise practice	22 nd July Trustwide Infection Control Committee to ratify the MRSA Policy and guideline IPC have requested an IPC specific TPSG meeting – August date– to be confirmed	Head of Nursing for Infection Prevention and Control



Risk	Resolution Action	Improvement timeline	Owner
Aware of need to isolate patients but unable to do so when clinically indicated due to prioritisation of patients with greater clinical need (primarily those with COVID). Number of side rooms is insufficient for demand and some side rooms - where available- have inadequate facilities (such as lack of ensuite facilities).	Mitigating actions include : Cross contamination reduction measures ie focus on increased cleaning frequency, hand hygiene, changing PPE between patients. Infection clean requested on discharge/ transfer. Daily site mtg is forum for raising failure to isolate cases. Long term plan would be to increase side room facility.	End of Quarter 2 for improvements from mitigation Increase in side room availability is a long term plan as part of trust strategy .	Head of Nursing for Infection Prevention and Control, working with Estates Team

Quality & Safety Exceptions



Risk	Resolution Action	Improvement timeline	Owner
Significant harm to patients including death from delays in sepsis treatment, and potentially significantly increased length of stay.	<p>Increased awareness and training in ED to support sepsis recognition and timely treatment</p> <p>Introduction of Eobs and Sepsis screen within ED</p> <p>Align STNT compliance to ED performance and system pressures</p>	<p>Monthly ED training commenced June 21- ongoing</p> <p>Monthly attendance at ED clinical governance June 21- ongoing 22nd June - complete</p> <p>June 21 – complete Positive correlation between 4hr DTA performance but not statistically significant</p>	<p>Nurse Consultant Critical Care</p> <p><u>with support from</u> Sepsis Outreach sister and IT Clinical Programme Team</p>

Patient Experience Overview

Summary of RAG ratings:

Summary of metrics:



Metric	Target	Latest reporting period	Previous reporting period	Reporting period	MoM mvmt G = Improvement R = Deterioration	RAG	SPC threshold breach	Exception report
New complaints		46	56	Jun-21	↓	Grey		
Complaints - still outstanding after 90 days	0	0	3	Jun-21	↓	Green		
Complaints - response within 25 days	85.0%			Apr-21	→	Grey		
Compliments - total received		386	269	May-21	↑	Grey		
Patients discharged before noon		17.1%	18.9%	Jun-21	↓	Grey		
Outstanding patient safety alerts	0	0	0	Jun-21	→	Green		
12 hour trolley waits in A&E	0	0	0	Jun-21	→	Green		
Friends & Family - overall response rate		26.3%	27.0%	May-21	↓	Grey		
Friends & Family - Inpatient - positive response	95.0%	91.8%	92.3%	May-21	↓	Orange		
Friends & Family - A&E - positive response	95.0%	81.0%	82.3%	May-21	↓	Orange		
Friends & Family - Maternity - positive response	95.0%	85.9%	78.8%	May-21	↑	Orange		

[Link to appendix](#)

Constitutional targets are highlighted blue

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Workforce Overview

Summary of RAG ratings:

Summary of metrics:



Metric	Target	Latest reporting period	Previous reporting period	Reporting period	MoM mvmt G = Improvement R = Deterioration	RAG	SPC threshold breach	Exception report
Substantive								
Staff Turnover	12.0%	12.9%	12.3%	Jun-21	↑	Orange		✓
Sickness	3.5%	3.4%	3.2%	Jun-21	↑	Green		
Nursing vacancy rate	10.0%	15.8%	15.9%	Jun-21	↓	Red		
Wards with 30%+ nursing vacancies	0	12	12	Jun-21	→	Red	✗	✓
Statutory training	90.0%	87.5%	86.6%	Jun-21	↑	Orange	✗	
Occupational Health referrals - stress	20	94	113	Jun-21	↓	Red		
Temporary								
Temporary staff - % spend	10.0%	16.0%		Jun-21	→	Red	✗	✓
Temporary staff (all nursing) - shifts requested	6,000	5,304	5,271	Jun-21	↑	Green		
Temporary staff (all nursing) - shifts breaching Agency Cap		79	63	Jun-21	↑	Green		
Nursing - Bank fill rate		49.3%	55.3%	Jun-21	↓	Grey		
Average time to replace vacancy (days)	56	48	43	Jun-21	↑	Green		
Equality & Diversity								
Relative likelihood of White staff being appointed from shortlisting compared to BAME staff		1.28	1.98	20/21	↓	Grey		
Relative likelihood of Disabled staff being appointed from Shortlisting compared to non-Disabled staff		1.27	1.06	20/21	↑	Grey		

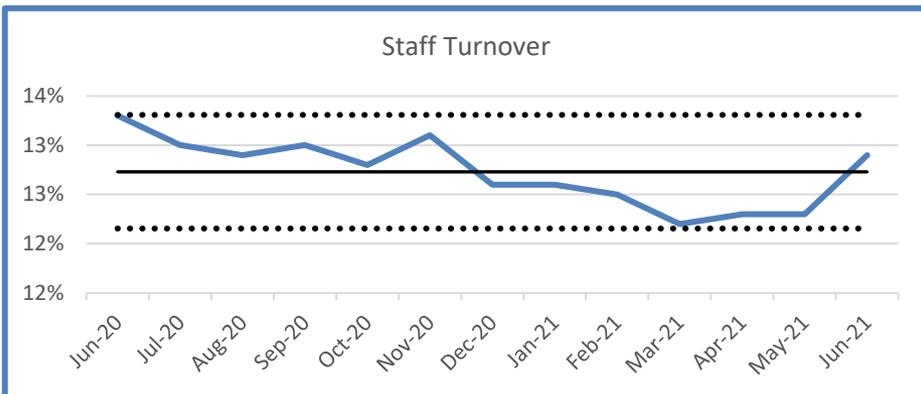
[Link to appendix](#)

Constitutional targets are highlighted blue

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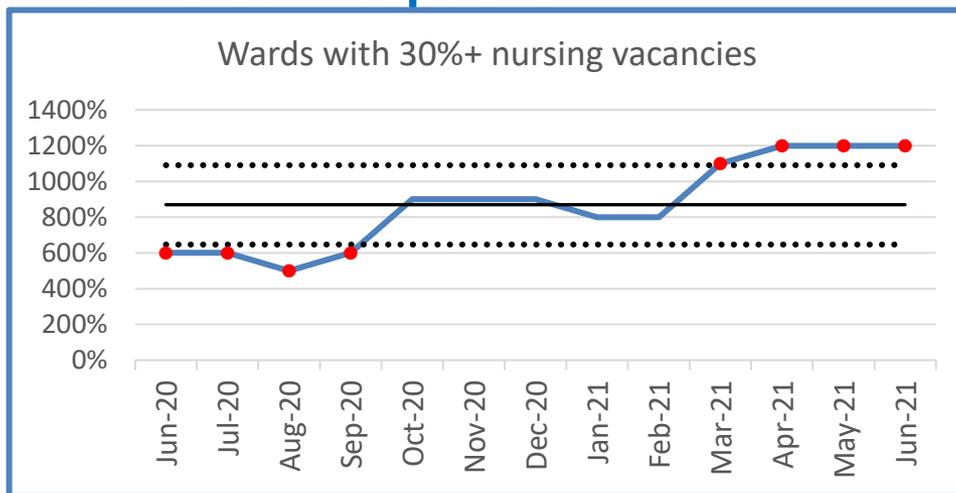
every time

Workforce Exceptions



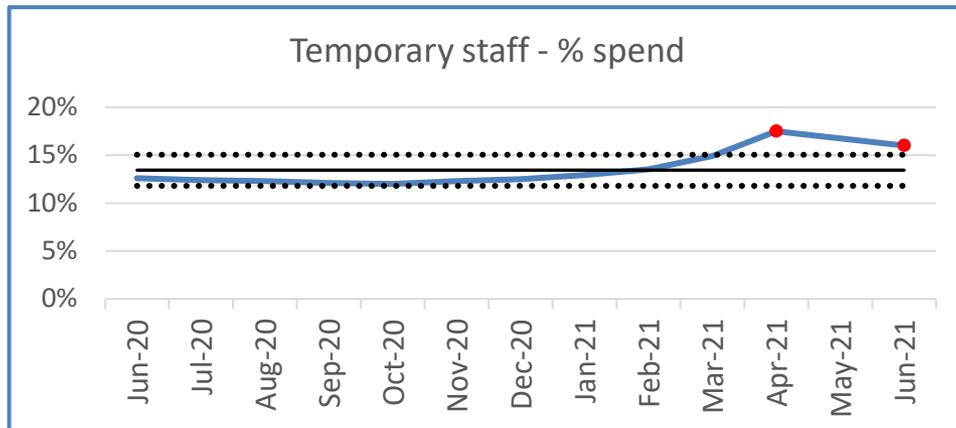
Risk	Resolution Action	Improvement timeline	Owner
High turnover, could result in a shortage substantive staff, which results in high reliance on temporary staffing (Bank and Agency) in some areas which could impact on the quality of patient care and the Trust financial position.	<p>There were increases in turnover of 3% in Prof & Tech and Healthcare Science staff groups. Targeted actions in place include:</p> <p>Pathology apprenticeship scheme: 8 Medical Laboratory Assistants starting a 20-month course.</p> <p>Radiology: Offers made to five individuals from recruitment drive in Portugal. Potential start date of Sept 2021</p> <p>There were increases in turnover of c1% in allied health professionals and 0.5% in nursing.</p> <p>Analysis shows the need for early awareness of intention to leave to address issues in a timely way. Actions in place are:</p> <ol style="list-style-type: none"> 1. A centralised in box for resignations, so early action can be taken to discuss opportunities, education, HR, coaching and wellbeing support, to potentially reverse their decision. 2. Proactively promote internal opportunities and initiatives that address main themes – flexible working, interpersonal relationships support and career pathways. 	<p>We have established a Retention steering group with a multi disciplinary team approach in the people directorate. Actions are to be completed by end August</p> <p>Further quantitative and qualitative analysis from those actions is being collated and reviewed weekly and will drive further initiatives and priorities for September and October.</p>	Chief People Officer

Workforce Exceptions



Risk	Resolution Action	Improvement timeline	Owner
A shortage of substantive nursing staff, which results in high reliance on temporary staffing (Bank and Agency) in some areas which could impact on the quality of patient care and the Trust financial position.	<p>Recruitment of international non-EU nurses: Five cohorts (63 individuals) have arrived to date from March to May 21. Since April, 159 appointments have been made. Targeted training and induction is in place. The pass rate for OSCE is 100% as at end of June 21.</p> <p>Recruitment of UK university graduates: We have offered out jobs to all 90 students that will be graduating. 47 have accepted, 38 are considering the offer and 5 have declined.</p> <p>We continue to promote nurse apprenticeships. This f/y year 38 Trust employees will start nurse apprenticeship programmes; up from 30 in 20-21.</p>	<p>We are on track to meet our target to recruit and relocate 222 nurses between March 21 to March 22. Average time to arrive from appointment is 12 weeks. Average time from arrival to taking the first OSCE (Objective Structured Clinical Examination) is 8 weeks. This strand will impact overall vacancy rate by up to 1% per month from September 2021.</p> <p>Recruiting our target will impact overall vacancy rate by a further 1% from October 2021.</p> <p>24 individuals are due to complete nurse/nurse associate apprenticeship programmes this f/y.</p>	Chief People Officer

Workforce Exceptions



Risk	Resolution Action	Improvement timeline	Owner
A high level of temporary staffing spend could impact on the quality of patient care and impacts on the Trust financial position.	<p>Key drivers of temporary staffing spend (Bank, Agency, Locum) are seen in all staff groups. Resolution actions are:</p> <ul style="list-style-type: none"> • Nurse recruitment (see previous slide for detail) • Healthcare support worker recruitment: we continue to reduce our vacancy rate, drawing on the national programme. However, we are seeing increased demand for 1 to 1 care of patients. • Radiology: agency staff are currently supporting the operations of mobile scanning units. Overseas recruitment will be key in the medium term; longer term pathways supported by apprenticeships will provide a more resilient staffing model. • Medical staff: We continue to have an increase in temporary medical staff to meet demand. • IT services: the roll-out of our IT programme continues. Our aim is to move away from temporary staffing. 	<p>Monthly impact of international recruits reduction in vacancy rate by up to 1% per month from September 2021.</p> <p>Targeted actions re 1:1 care demand planned (end July 21)</p> <p>5 international radiologists in pre-employment now</p> <p>Weekly agency 'Line of Work' reviews in place to minimise agency costs.</p> <p>Fortnightly UK recruitment workstream deep dives to drive substantive recruitment in hot spot areas.</p>	Chief People Officer

Efficiency Overview

Summary of RAG ratings: Summary of metrics:



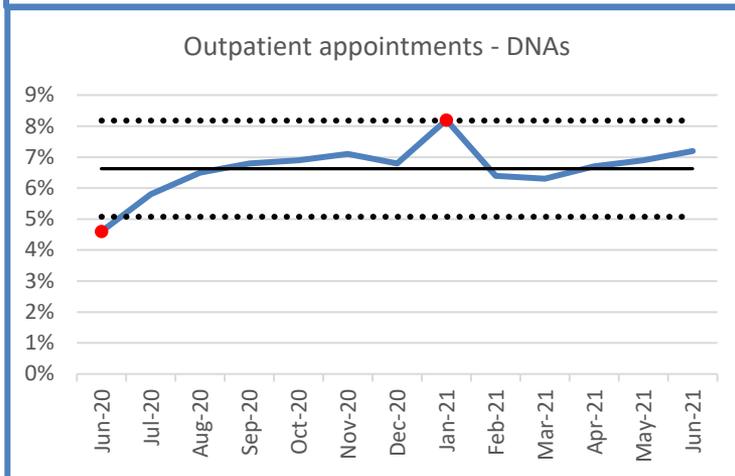
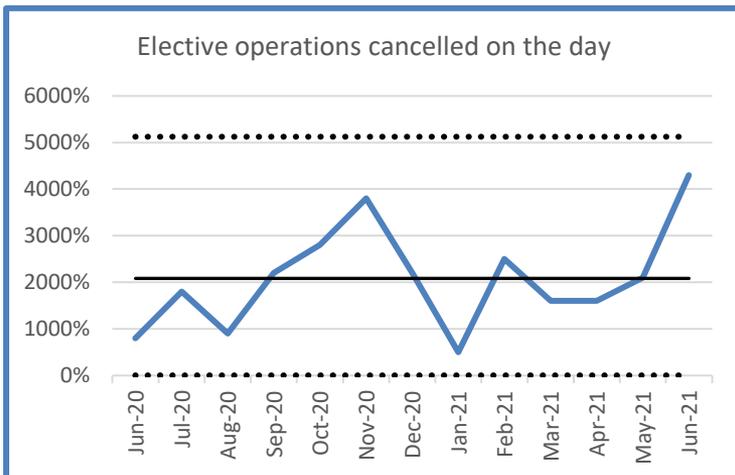
Metric	Target	Latest reporting period	Previous reporting period	Reporting period	MoM mvmt G = Improvement R = Deterioration	RAG	SPC threshold breach	Exception report
Theatres/Other								
Theatre utilisation	85.0%	89.6%	89.9%	May-21	↓	Green		
Clinical coding within target	95.0%	92.7%	97.1%	May-21	↓	Orange		
Coding depth - avg no. of diagnosis codes per FCE - Elective	5.2	4.1	3.9	May-21	↑	Red		
Coding depth - avg no. of diagnosis codes per FCE - Non Elective	5.4	5.7	5.7	May-21	→	Green	×	
Coding depth - % of R codes in primary diagnosis (per FCE)	25.0%	12.9%	13.8%	May-21	↓	Grey		
Receipts without a purchase order	250	160	314	May-21	↓	Green		
Elective operations cancelled on the day	20	43	21	Jun-21	↑	Red		✓
Outpatients								
Outpatient appointments - DNAs	<5%	7.2%	6.9%	Jun-21	↑	Orange		✓
Outpatient appointments - not cashed up	2.0%	2.7%	2.7%	Jun-21	→	Orange		
Outpatient letters to GPs within 14 days	90.0%	72.4%	78.8%	Jun-21	↓	Orange		✓
Outpatient appointment disruption	15.0%	10.3%	9.7%	Jun-21	↑	Green	×	
Flow								
Stranded patients at 7 days		281	271	Jun-21	↑	Grey		✓
LoS > 21 days - patients in acute hospitals	80	52	50	Jun-21	↑	Green		
LoS > 21 days - patients in community hospitals	18	15	16	Jun-21	↓	Green		
SMH - Average medical length of stay (days)	6.5	7.4	6.9	Jun-21	↑	Orange		✓
Community Hosps - Average length of stay (days)	28	23	24	Jun-21	↓	Green		
Investment Case Performance								
Ageing Well step up activity				Apr-21	→	Grey		
Aylesbury post code over 75 ED admission rate				Apr-21	→	Grey		
Ageing Well step down activity				Apr-21	→	Grey		
Frailty SDEC activity		186	167	Jun-21	↑	Green		

[Link to appendix](#)

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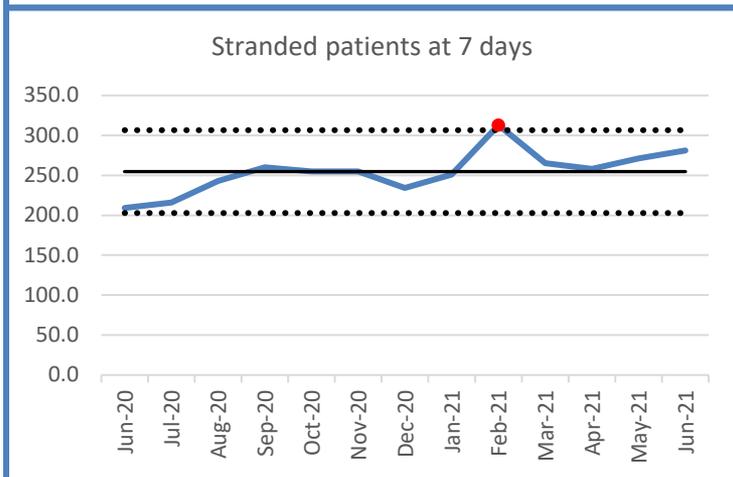
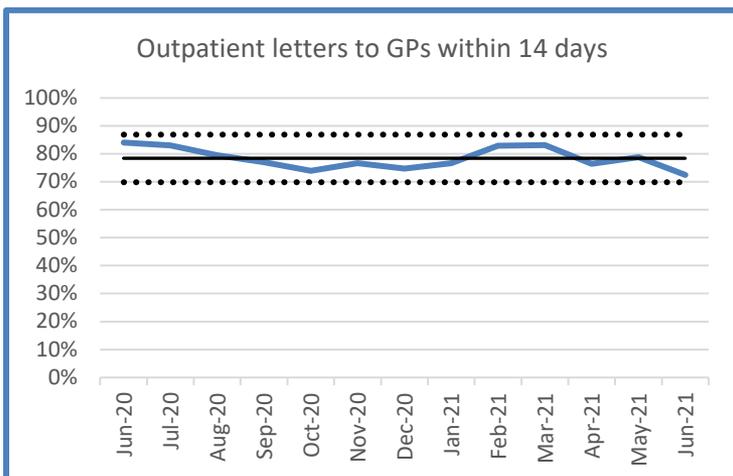
Efficiency Exceptions



Risk	Resolution Action	Improvement timeline	Owner
<p>Patients unable to be treated on expected day</p> <p>- Rise due to 24 Covid results unavailable</p>	<p>Ensure patients are tested at appropriate time/prior to admission date</p> <p>Small number due to equipment unavailability – to be checked at theatre scheduling meeting</p>	August 2021	Divisional Director for Surgery
Risk	Resolution Action	Improvement timeline	Owner

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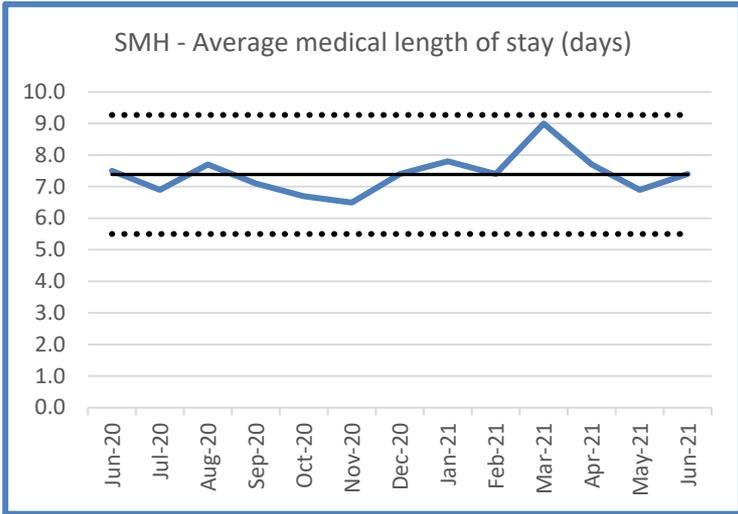
Efficiency Exceptions



Risk	Resolution Action	Improvement timeline	Owner
Patient clinical communication is delayed and actions to GPs not communicated quickly.	Specialty level under review. Outpatient letters under review.	End September 2021	Divisional Directors
Risk	Resolution Action	Improvement timeline	Owner
Extended numbers of stranded patients limit flow	Increased purchase of D2A capacity. Daily reviews of long stayers.	End July 2021 In progress	Director of Urgent Care Director of Patient Flow

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Efficiency Exceptions



Risk	Resolution Action	Improvement timeline	Owner
Increased length of stay inhibits flow	Extension of supernumerary ward manager pilot and red to green programme on wards.	End July 2021	Head of Nursing, Integrated Medicine
	Review of Medical Staffing against RCP guidelines	End August	Chief Medical Officer

Finance: income and expenditure

Key Highlights

The Trust reports a break-even position year to date (YTD) in line with plan.

- The plan used in this report is based on NHSE/I planning guidance issued at the end of March 2021 which covers guidance for the first six months of the year (referred to as H1). NHSE/I has issued providers with pre-populated plans for H1 based on a continuation of the emergency financial regime. In calculating the Trust's income and expenditure, NHSE/I has applied a simple high level methodology of Q3 (2020/21) multiplied by 2. The ICS has confirmed the H1 settlement includes Covid-19 funding of £12.4m. NHSE/I's expectation is that this funding settlement will allow the ICS, commissioners and providers to deliver break even for this period. The plan for the second half of the year currently (referred to as H2) indicates a £22.3m deficit. The H2 plan is subject to final approval by the Trust Board and agreement with BOB ICS and NHSE/I.
- The plan has been adjusted this month to reflect income and expenditure relating to Elective Recovery Fund (ERF) activity totalling £11m. The YTD position assumes £5.8m income relating to ERF monies.
- The plan assumes a £16m efficiency plan will be delivered. This plan is phased equally throughout the year.
- Covid-19 expenditure totals £0.3m in month 3, £1.5m YTD and is reported within the overall expenditure position for this financial year at divisional level. Income to cover Covid-19 expenditure is assumed to be within the block values received and is reported within contract income in the table below.
- YTD pay costs total £80.1m, £4.9m adverse to plan. Key drivers of this adverse position include medical staffing spend and shortfalls in CIP delivery due to the plan being phased equally across the year.
- YTD non-pay costs total £44.2m, £4.9m favourable to plan. Key drivers of this underspend include drugs and clinical supply expenditure being lower than plan.
- The non-recurrent I&E adjustment removes the benefit of H1 Block income top-up, Covid-19, ERF funding receivable from NHSE/I and Bucks CCG and other non-recurrent items. This would result in an underlying normalised deficit of £70.6m for the full year.

Trust I&E Performance (£M)

(£m)	In Mth Plan	In Mth Actuals	In Mth Variance	YTD Mth Plan	YTD Actuals	YTD Variance	Annual Plan	Forecast
Contract Income	46.2	42.8	(3.4)	127.6	126.4	(1.2)	477.3	477.3
Other income	2.3	1.9	(0.5)	7.0	6.3	(0.7)	27.9	27.9
Total income	48.5	44.6	(3.9)	134.6	132.7	(1.9)	505.2	505.2
Pay	(25.8)	(26.5)	(0.7)	(75.2)	(80.1)	(4.9)	(298.7)	(298.7)
Non-pay	(19.3)	(15.3)	3.9	(49.1)	(44.2)	4.9	(187.6)	(187.6)
Total operating expenditure	(45.1)	(41.8)	3.3	(124.3)	(124.3)	0.0	(486.3)	(486.3)
EBITDA	3.4	2.8	(0.6)	10.3	8.4	(1.9)	19.0	19.0
Non Operating Expenditure	(3.4)	(2.8)	0.6	(10.3)	(8.4)	1.9	(41.3)	(41.3)
Retained Surplus / (Deficit)	(0.0)	(0.0)	(0.0)	0.0	0.0	0.0	(22.3)	(22.3)
Non Recurrent I&E	(5.4)	(5.4)	0.0	(16.1)	(16.1)	0.0	(48.3)	(48.3)
Normalised I&E Surplus / (Deficit)	(5.4)	(5.4)	(0.0)	(16.1)	(16.1)	0.0	(70.6)	(70.6)

Divisional I&E Performance (£M)

Division / (£m)	YTD Variance against Plan	Outturn Plan	Finance YTD Sector Rating	Current Month Run Rate		
				M01	M02	M03
Integrated Medicine	(0.6)	(85.5)	3	(7.2)	(7.5)	(7.4)
Integrated Elderly Care	(0.5)	(41.5)	3	(3.5)	(3.6)	(3.5)
Surgery And Critical Care	(0.5)	(100.7)	3	(8.1)	(9.2)	(8.8)
Women and Children	(0.2)	(44.7)	3	(3.7)	(3.8)	(3.8)
Specialist Services	0.5	(78.3)	3	(6.2)	(6.6)	(6.3)
Total Clinical Divisions	(1.4)	(350.7)		(28.7)	(30.8)	(29.9)
Chief Executive	0.2	(3.8)	3	(0.2)	(0.2)	(0.2)
Chief Operating Off-Management	(0.5)	(4.0)	3	(0.4)	(0.4)	(0.6)
Corporate Services	(4.4)	1.2	N/A	(0.1)	(2.0)	(2.0)
Commercial Director Mgmt	(0.3)	1.0	3	(0.0)	(0.0)	0.0
Finance Dept.	0.2	(6.8)	3	(0.7)	(0.7)	(0.2)
Information Technology	(1.2)	(10.1)	3	(1.1)	(1.1)	(1.4)
Performance and Delivery	(0.0)	(4.1)	3	(0.3)	(0.4)	(0.4)
Property Services	0.0	(55.6)	3	(4.8)	(4.6)	(4.5)
Human Resources	(0.9)	4.0	3	0.5	(0.4)	(0.0)
Medical Director	0.1	(0.5)	3	(0.0)	0.0	(0.0)
Nursing Director	(0.1)	(16.4)	3	(1.4)	(1.4)	(1.4)
PDC And Depreciation	3.0	(35.6)	N/A	(2.7)	(1.8)	(2.3)
Covid-19 Division	0.0	0.0	N/A	(0.8)	0.8	0.0
Strategy And Business Dev.	0.0	(0.2)	3	(0.0)	(0.0)	(0.0)
Total Corporate	(3.9)	(130.9)		(12.2)	(12.2)	(13.0)
Contract Income	(1.2)	477.3		40.8	42.9	42.7
Provisions	6.1	(18.0)		0.0	0.0	0.0
Donated Asset Reporting Adj	0.4	0.0		0.2	0.1	0.1
Retained Surplus / (Deficit)	0.0	(22.3)		0.0	0.0	(0.0)

Communications and engagement JUNE 2021

Comms in numbers

Channel	Measurement	MAY	JUNE
Staff	BHT today	19	22
Press	Enquiries	8	3
	Statements issued	2	4
	Press releases	1	5
Twitter	New followers	84	70
	Tweets	100	79
	Retweets	118	172
	Likes	1.2k	660
	Replies	108	49
Facebook	Followers	6378	6433
	Posts	17	39
	Shares	138	185
	Likes	1784	1328
	Comments	131	112
Videos - YouTube	Created by Comms	2	11
	Published	23	18
	Channel views	13070	12115
Website	Users	57299	47638
Patient engagement	events	2 (21 att.)	8 (49 att.)
	CAP	1 (10 att.)	0

Media roundup:

- Wendover News: [Work begins on Nightingale's Rainbow](#) (Also covered by Living Magazine & InYourArea.co.uk)
- Bucks Herald: [Aylesbury and Buckinghamshire NHS Heroes celebrated in for herculean efforts against Covid](#)
- Buckingham & Winslow Advertiser:
 - [More than 1,000 extra patients on treatment waiting list at Buckinghamshire Healthcare Trust](#)
 - [Temporary move for maternity services at Stoke Mandeville Hospital](#) (Also covered by Greatest Hits)
- Bucks Herald: [Rise in visits to A&E at Bucks hospitals](#)
- BFP: [New 'energy centre' at Wycombe Hospital will see some staff parking lost permanently](#)

Key activities:

Events

- 2 Rainbow Badge training sessions
- Hosted 2nd Public, Patient Equality, Diversity and Inclusion group meeting
- 4 Meetings about TRiM launch within the Trust
- 2 virtual sessions on Teaching QSIR

Digital and social media:

- Volunteers week (1-7 June) - Video from Bridget O'Kelly, sharing why our volunteers volunteer
 - Supported World Orthoptic Day (7 June)
 - Supported the Bucks Council Euros domestic abuse campaign (ongoing in to July)
 - Pride month - Illuminated buildings, Neil Macdonald and Dan Gibbs video, Hattie raising Pride flag at SMH
 - Beat the heat messaging
- ### Internal:
- Staff Euros decoration competition
 - Comms for Agile working

Campaigns and Media:

- Social media and press release for NHS Big Tea
- Community nursing awareness week: 'Grow your career' social media staff story campaign
- Organised filming schedule for school careers videos: 17 career interviews plus 4 in situ locations
- Community nursing recruitment video storyboarding
- Drafting BHT Today stakeholder newsletter
- Supported HSJ awards submissions

Social media:

Buckinghamshire Healthcare NHS Trust
29 June · 🌐

An opportunity for a hairdresser to work within Stoke Mandeville Hospital. See ad below.
Interested? Send a CV to Jo.latter@nhs.net before Friday 9 July.

Fantastic opportunity for a qualified hairdresser

Are you caring and friendly? Do you like working independently? Do you want to be part of something new and exciting? Do you have at least a NVQ/SVQ Level 2 and ideally 5 years' experience? If the answer is YES!, this could be the perfect job for you.

Jobs are based new salon at Stoke Mandeville Hospital, providing a professional cutting, colouring and styling service for our male and female patients, visitors and staff. Build your own portfolio of clients. Negotiable working hours. Competitive salary package incl bonus.

Send your CV to Jo.latter@nhs.net by Friday 9 July or call 01296 316976 for more details.

re Healthcare NHS Trust @BucksHealth... · Jun 22 · ...
...tribution that Windrush generation descendants... today - particularly to the #NHS.
@karenabonner2, herself 'a proud product' of Windrush, ... colleagues on behalf of us all.
#WindrushDay #BHTFamily

Three generations of nurses

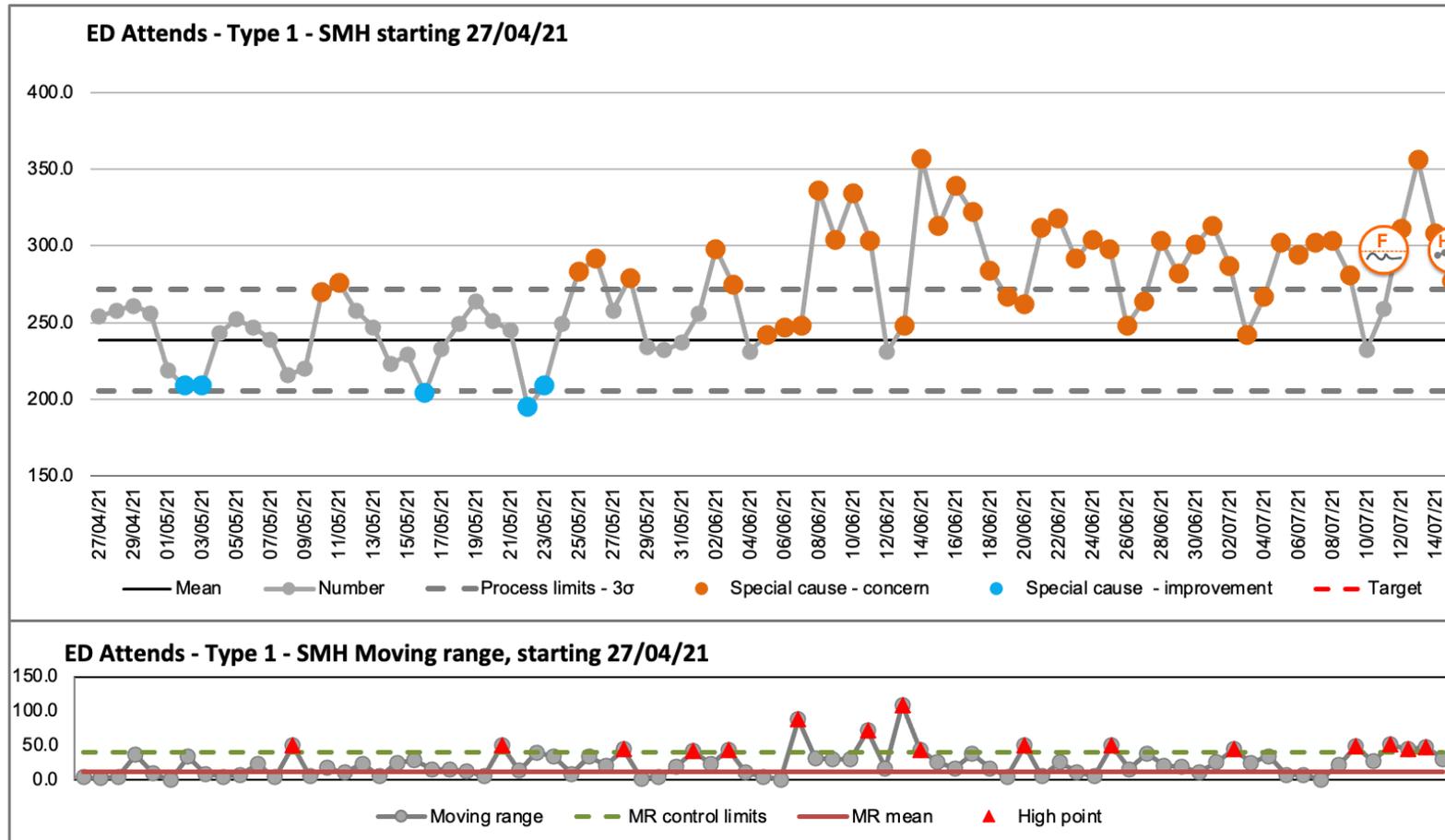
On 1 July, the country will be celebrating Thank You Day - and we couldn't think of a better family than this one to show our gratitude for...

Stoke Mandeville Hospital
Emergency Care Metrics

Executive Management Committee – 16th July 2021



ED Type 1 Attends



Attends stabilising.

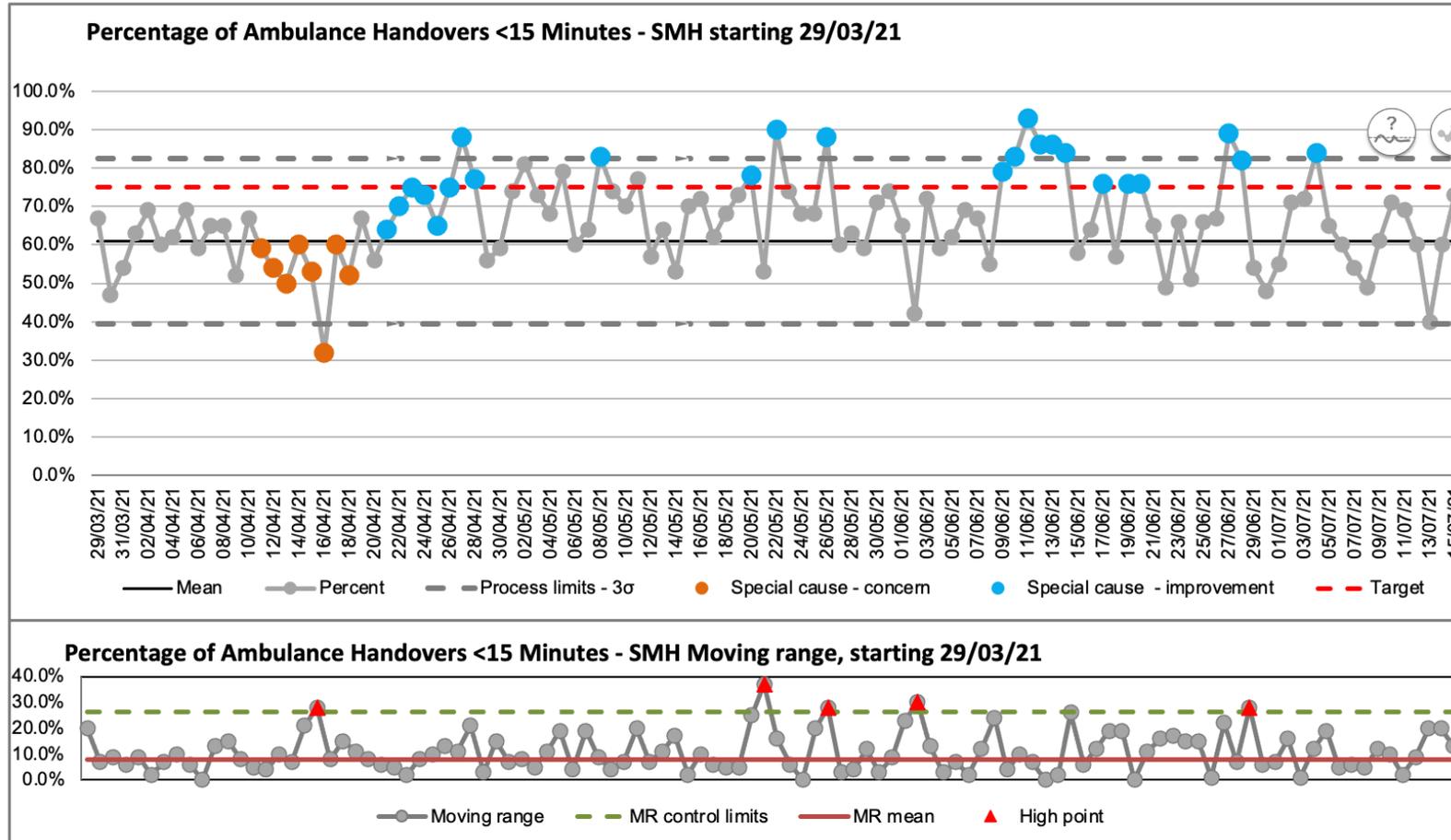
Occasional peaks – 356 on Tuesday, 23% above the established average

7 Day Rolling Average (Aim 280)

Down is good

24/06	1/07	8/07	15/07
291	287	285	289
↓	↓	↓	↑

Trust Percentage Of Ambulance Handovers Within 15 Minutes



Small deterioration.

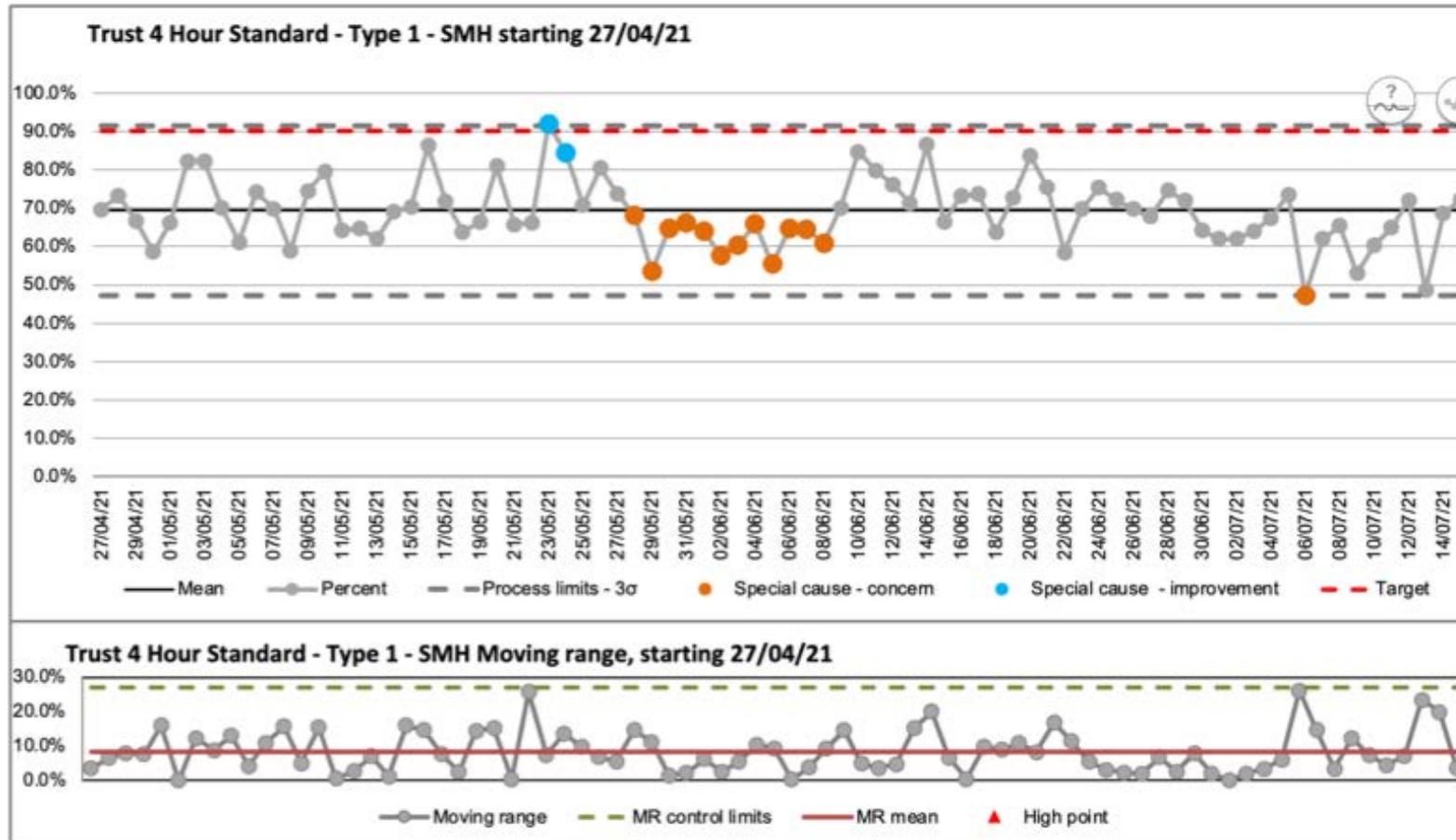
Still some occasional very long waits hidden in the average.

7 Day Rolling Average (Aim 75%)

Up is good

17/06	24/06	1/07	8/07
63%	66%	65%	62%
↓	↑	↓	↓

Trust Four Hour Standard – Type 1



Stabilised trajectory.

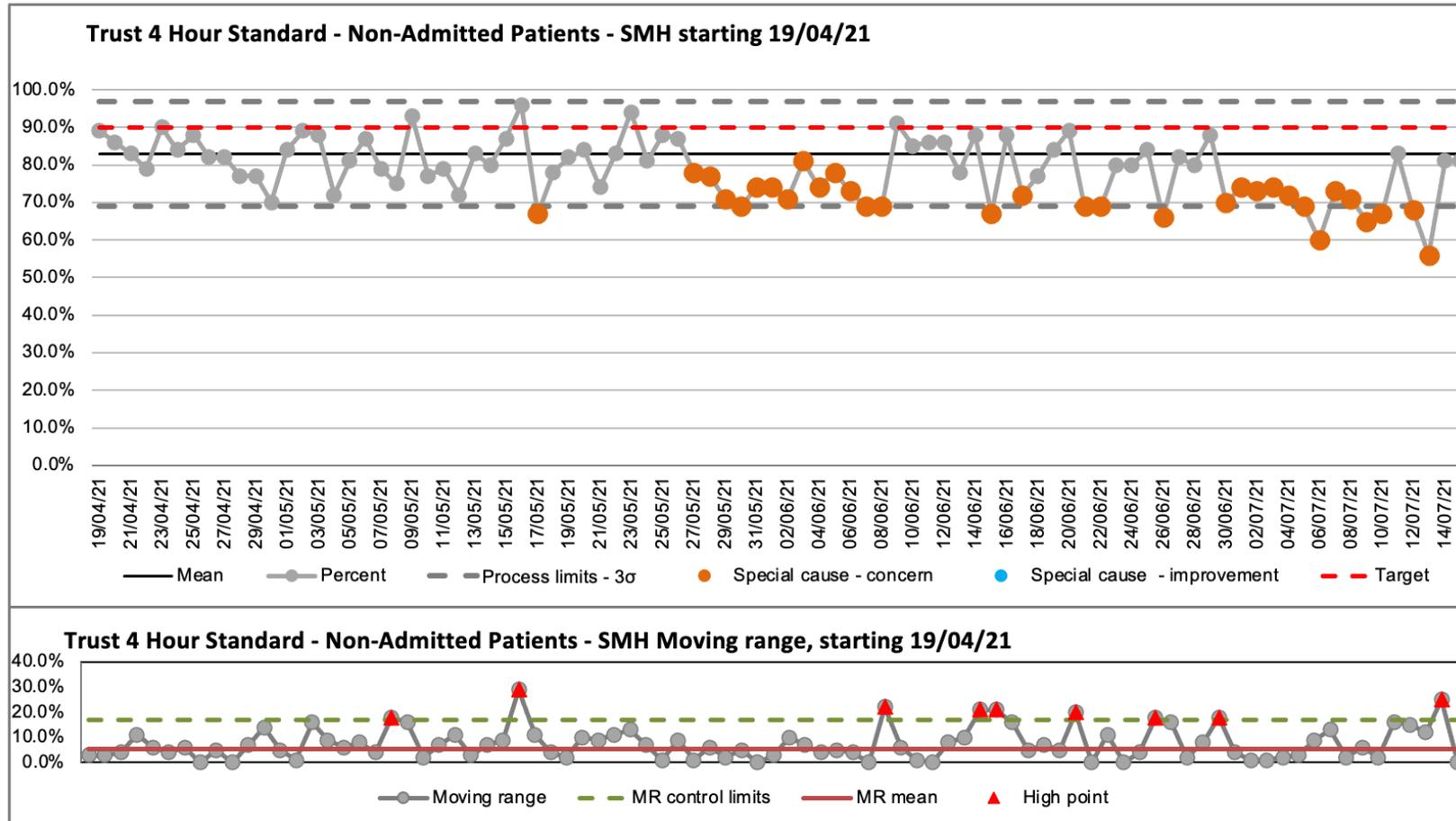
Very poor performance two Tuesdays in a row.

7 Day Rolling Average (Aim 90%)

Up is good

24/06	1/07	8/07	15/07
71%	70%	63%	63%
↓	↓	↓	↔

Trust Four Hour Standard – Non-admitted



Work underway to establish UTC by September.

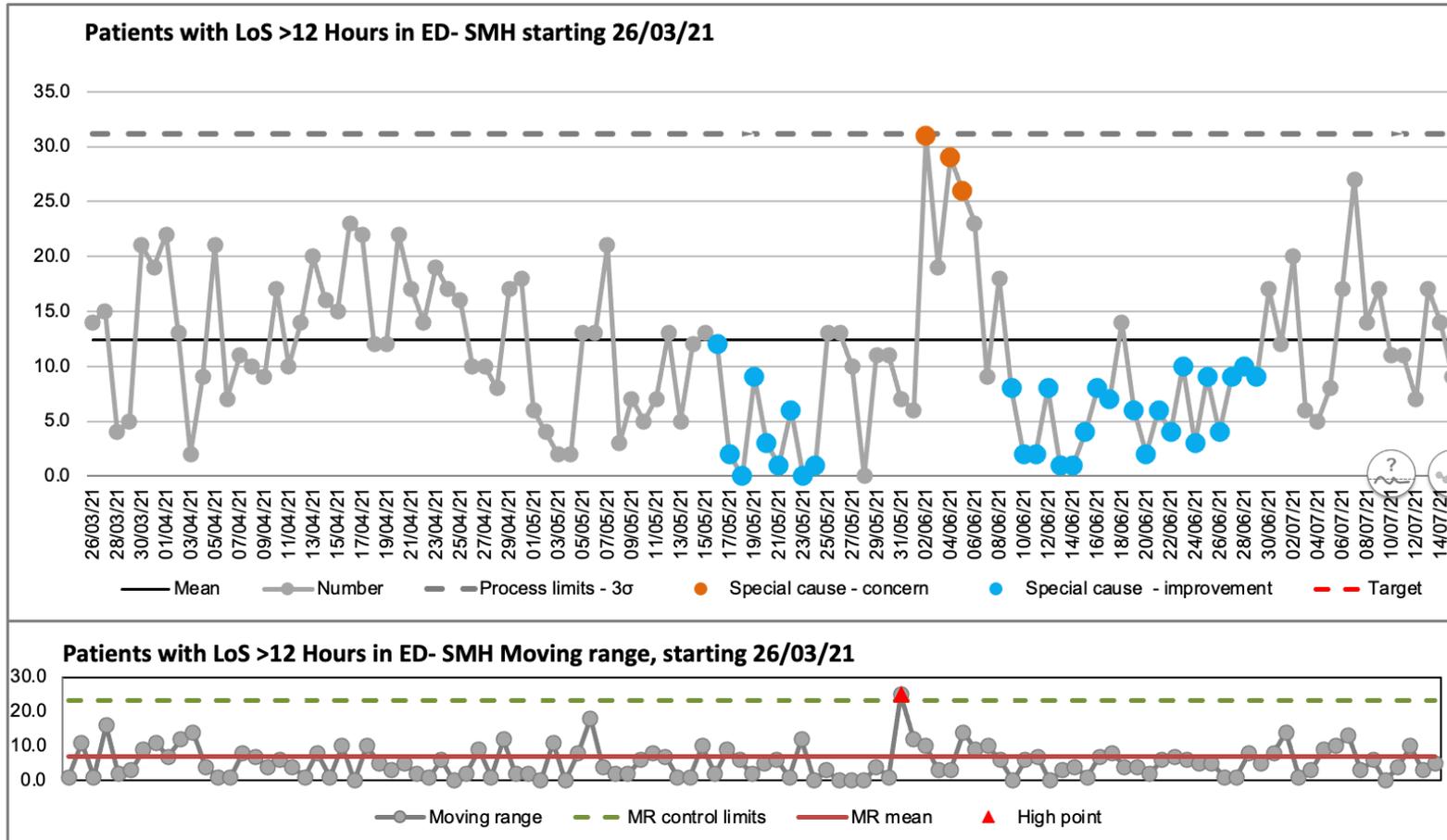
Small improvement to the average.
Past 48 hours much bigger improvement.
Essex GPs due to start next week.

7 Day Rolling Average (Aim 90%)

Up is good

24/06	1/07	8/07	15/07
78%	78%	70%	72%
↓	—	↓	↑

Trust 12 Hour Stays In ED



Small improvement this week.

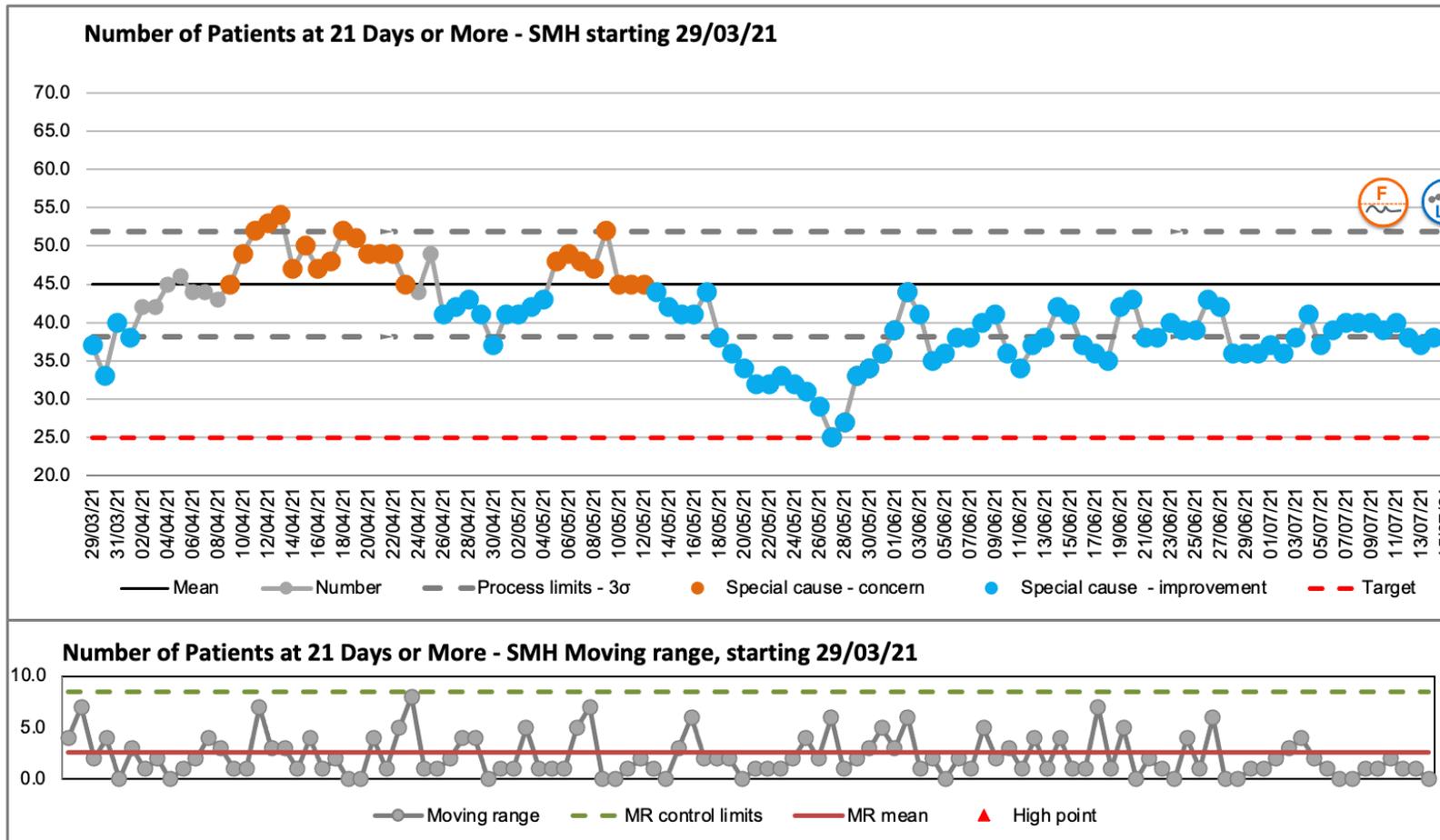
Bed occupancy increasing.
Overall workload increasing.
Some challenges on Covid pathway.

7 Day Rolling Average (Aim Zero)

Down is good

24/06	1/07	8/07	13/07
6	9	14	12
↓	↑	↑	↓

Trust 21 Day Lengths Of Stay



Sustained level.

Needs work to drive down again to 25.

7 Day Rolling Average (Aim 25)

Down is good

24/06	1/07	8/07	13/07
39	38	38	38
↑	↓	▬	▬

Meeting: Trust Board Meeting in Public

28 July 2021

Agenda item	Operating guidance and recovery - briefing for July
Board Lead	D.H.R. Gibbs – Chief Operating Officer
Type name of Author	Matan Czaczkes and Isobel Day
Attachments	(21-07-09) July Op guidance briefing v0.5 (MCz)
Purpose	Approval
Previously considered	EMC - 13.07.2021 F&BPC – 13.07.2021

Executive Summary

The purpose of this paper is to provide the executive team an update on, and assurance of, work to deliver the requirements of the operational planning guidance, with a focus around delivering the elective care elements. To date the BHT has completed 63% (12/19) of operational planning guidance requirements and 72% (26/36) of gateway criteria requirements relating to acute trusts. Requirements still in progress are not yet due.

Elective activity recovery is being tracked to provide assurance. Activity value has increased month on month since April. In June the Trust delivered approximately 105% of 19/20 outpatients and 85% of 19/20 electives. Elective activity has exceeded planned trajectories for June. Future activity may be impacted by the 3rd wave of Covid and winter pressures.

Activity planning for H2 has begun, with the aim of signing off divisional trajectories by 12/09/21. Approval for this timeline is being sought from the executive team.

On 9th of July revised rules governing ERF funding allocation were issued, with the key change being the increase of the ERF threshold from 85% to 95% in H1. Early indications suggest that the Trust trajectory of £7.7m ERF funding income for H1 remains valid. An initial analysis has been conducted based on this new information and early recommendation proposed. EMC are invited to review and agree the recommendations.

The Trust has been successful in bringing down the total number long waiters, with 52 week breach total numbers dropping by an average of 492 per month - now down 1476 from the peak in March. However, 104+ week wait numbers continue to rise and are an area of concern. Unbooked P2s at 4+ weeks also remain high and continued focus on this area is advised.

Work to deliver the national diagnostic validation exercise requirement is ongoing. The July milestone requirement for submitting identified diagnostic modality (endoscopy) validations will be achieved. However, additional assurance is required on plans to meet up-coming national deadlines.

A new planned care programme board is proposed. The board will provide assurance of the in-year delivery of the operating planning requirements, assure against recovery of activity and oversee the required service transformation to deliver the clinical strategy for planned care. Detailed scope and high-level milestones are set out. This has been approved separately in transformation board

The urgent care position in relation to the four-hour target remains challenge. A recovery programme for urgent care has been developed and is being managed by the operational teams. Information relating to this programme is included in this paper due to it's potential impact on elective recovery.

Decision		The executive team are invited to: <ul style="list-style-type: none"> • note progress on operational planning guidance requirements • Approve proposed H2 activity planning timetable • Consider and respond to proposed ERF rule change responses 	
Relevant Strategic Priority			
Quality ☒		People ☒	
		Money ☒	
Implications / Impact			
Patient Safety		Yes – impact on long waits and clinically urgent management.	
Risk: link to Board Assurance Framework (BAF)/Risk Register		1.2 Developing as a learning organisation	
Financial		Yes – Impact on ERF funding	
Compliance CQC Standards Person-centred Care		Yes - requirement to ensure that the potential impact of delay does not cause harm to patients.	
Partnership: consultation / communication		Yes - requirement to engage with staff and partners	
Equality		Yes - requirement to ensure health inequalities are identified and addressed	
Quality Impact Assessment [QIA] completion required?		No	

Operating guidance and recovery

Briefing for July

Isobel Day
Matan Czaczkes
July 2021

Contents

6

- Delivering elective activity recovery

14

- The Elective Recovery Fund (ERF) update

18

- Planned care performance and clinical harm management

24

- Planned care transformation

33

- Recovering cancer performance

35

- Urgent and emergency care recovery

Executive summary

To date the BHT has completed 63% (12/19) of operational planning guidance requirements and 72% (26/36) of gateway criteria requirements relating to acute trusts. Requirements still in progress are not yet due.

Activity value has increased month on month since April. In June the Trust delivered approximately 105% of 19/20 outpatients and 85% of 19/20 electives.

Activity planning for H2 has begun, with the aim of signing off divisional trajectories by 12/09/21. Approval for this timeline is being sought from the executive team.

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The Trust has been successful in bringing down the total number long waiters- down 1476 from the peak in March. However, 104+ week wait numbers continue to rise and are an area of concern. Unbooked P2s at 4+ weeks also remain high and continued focus on this area is advised.

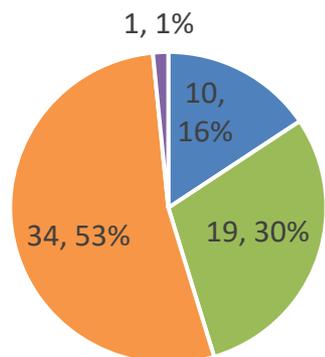
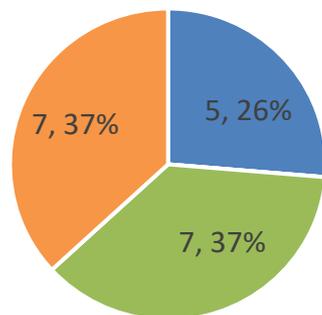
The urgent care position in relation to the four-hour target remains challenge. A recovery programme for urgent care has been developed and is being managed by the operational teams. Information relating to this programme is included in this paper due to it's potential impact on elective recovery.

Tracking progress on operation guidance requirements

The recovery and renewal board provides assurance against compliance with the operational planning guidance at place. The charts below set out current compliance against the individual guidance requirements. The first sets out only those relevant to BHT. This is a subset of the second, which shows status of Buckinghamshire as a whole. Colleagues from both BHT and BCCG are involved in updating this tracker on behalf of the ICP.

BHT compliance

ICS wide compliance



■ Done and assured
■ In progress

■ Complete - assurance required
■ Up to date and ongoing

Operational planning guidance

The planning guidance sets out the high level requirements below. This report focuses predominantly on C1 – elective care

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



Planning guidance - elective care requirements

The focus of this paper is to provide assurance around delivering the elective care elements of the operational planning guidance. As the operational planning guidance evolves and is clarified by NHSE the criteria for assessment change, e.g. the addition of the diagnostics validation requirement. This can result in action compliance changing status.

The ERF requirements, including activity recovery and gateway criteria, form part of the elective care requirements. Details of the elective care requirements are set out in detail below.

Ref	Letter ref	Requirement	Current status
15	C1	Draw up elective and diagnostic delivery plans	Done and assured
16	C1	Increase elective capacity safely	Done and assured
17	C1	prioritise the clinically most urgent patients,	In progress
18	C1	review and validation of the waiting list	In progress
20	C1	Plan to address the longest waiters and ensure health inequalities	In progress
24	C1	Outpatient transformation, - avoid low clinical value	In progress
25	C1	A&G mobilisation	Done and assured
26	C1	PIFU mobilisation	In progress
27	C1	Virtual OPD	Done and assured
29	C2	Cancer treatment to Feb 20 levels	Done and assured
30	C2	Make up first treatment shortfall	In progress
31	C2	Draw up a single cancer delivery plan	Complete - assurance required
32	C2	Meet the new Faster Diagnosis Standard	Complete - assurance required

Delivering elective activity recovery

Ref	Letter ref	Requirement	Current status
15	C1	Draw up elective and diagnostic delivery plans	Done and assured
16	C1	Increase elective capacity safely	Done and assured
17	C1	prioritise the clinically most urgent patients,	In progress
18	C1	review and validation of the waiting list	In progress
20	C1	Plan to address the longest waiters and ensure health inequalities	In progress
24	C1	Outpatient transformation, - avoid low clinical value	In progress
25	C1	A&G mobilisation	Done and assured
26	C1	PIFU mobilisation	In progress
27	C1	Virtual OPD	Done and assured
29	C2	Cancer treatment to Feb 20 levels	Done and assured
30	C2	Make up first treatment shortfall	In progress
31	C2	Draw up a single cancer delivery plan	Complete - assurance required
32	C2	Meet the new Faster Diagnosis Standard	Complete - assurance required

Bar indicates relevant operational planning guidance action reference

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Elective activity compared to 19/20

All services have now restarted and are building up activity levels, which are being monitored daily. It is important to note that June figures have not been fully cashed up, so the numbers below are indicative and may *increase*. Nevertheless, as things stand **taken as a whole, June has seen an increase in elective activity over May.**

April

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

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

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

May

Outpatient	
19/20	34200
21/22	34870
Monitor	102.0%

Day case	
19/20	4146
21/22	3223
Monitor	77.7%

Electives	
19/20	430
21/22	347
Monitor	80.7%

June

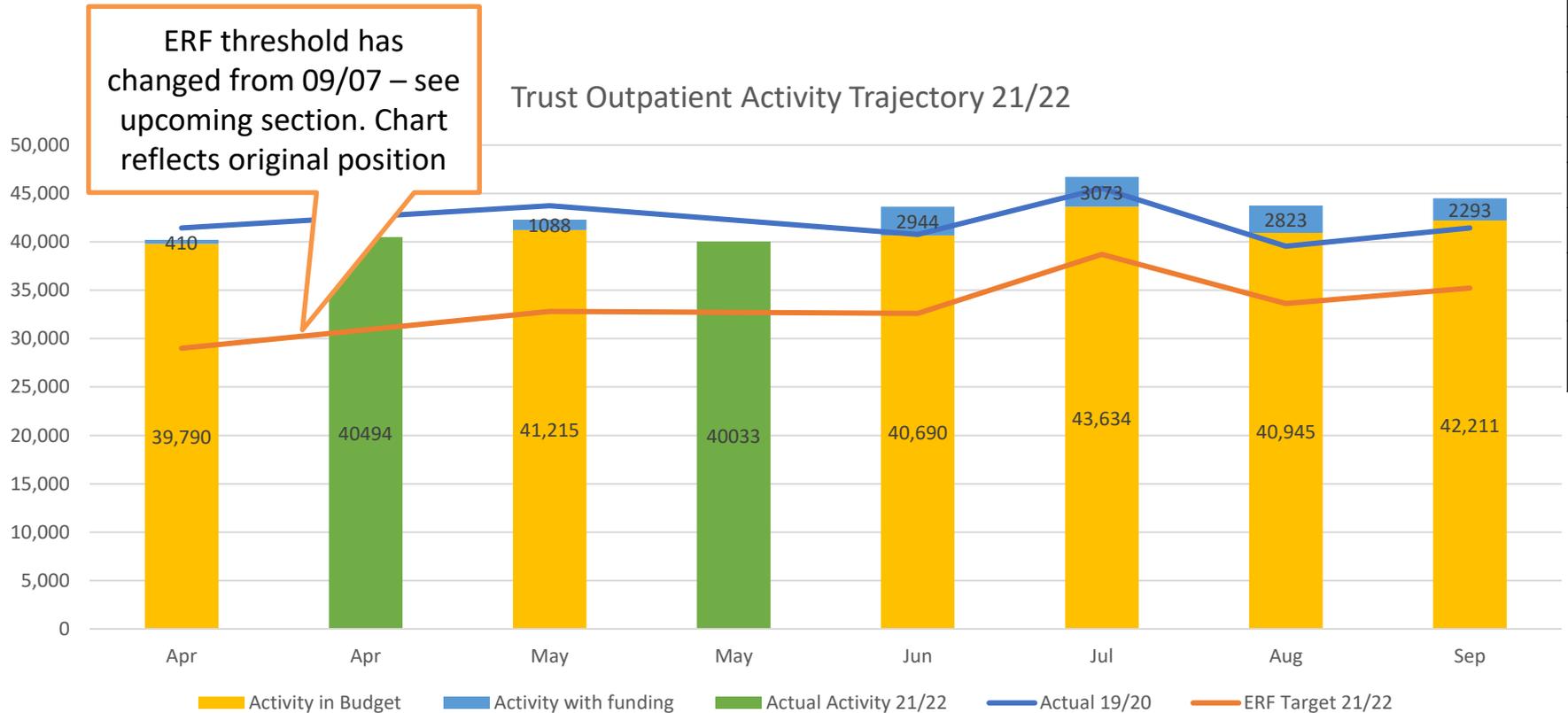
OUTPATIENTS	
2019/20	35334
2021/22	37390
Monitor	105.8%

DAYCASE	
2019/20	4255
2021/22	3757
Monitor	88.3%

ELECTIVE	
2019/20	495
2021/22	388
Monitor	78.4%

Outpatient Recovery plans

Using service level ERF plans a trust-wide activity trajectory can be set out for the first half of the year. This is divided into elective and outpatient activity to allow analysis given the differences in volume and value. Divisional and SDU are charts available on request.

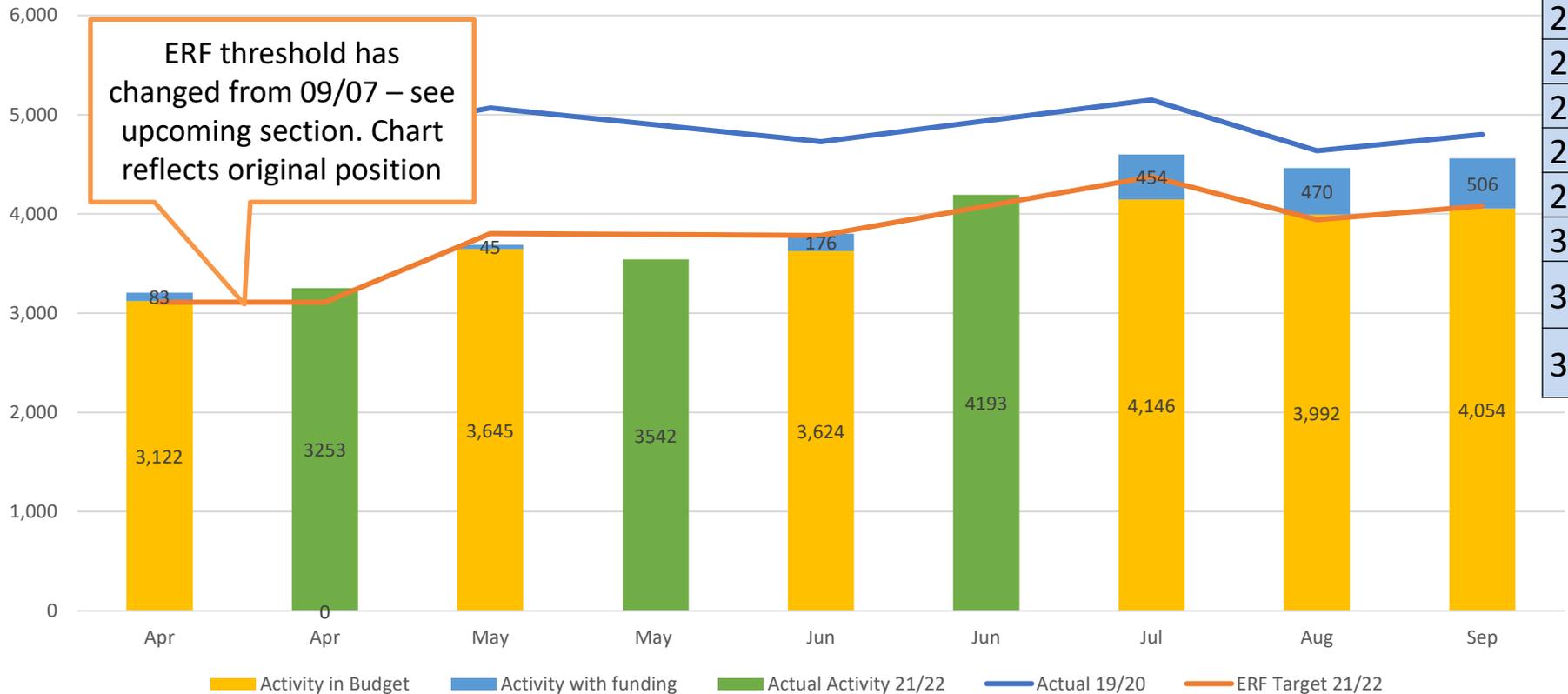


Apr (actual)	May (actual)	June (actual but not fully cashed up)	Jul	Aug	Sep
40,494	40,033	37,390	46,707	43,768	44,504

Elective Recovery plans

Elective activity in June has increased over original plan.

Trust Elective Activity Trajectory 21/22

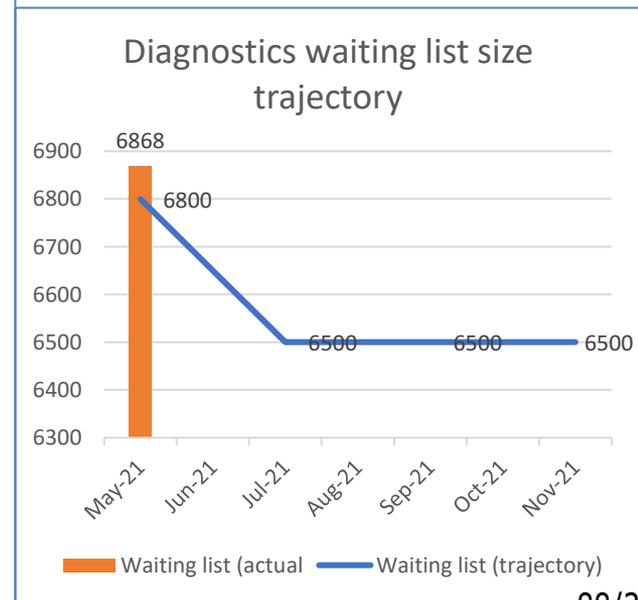
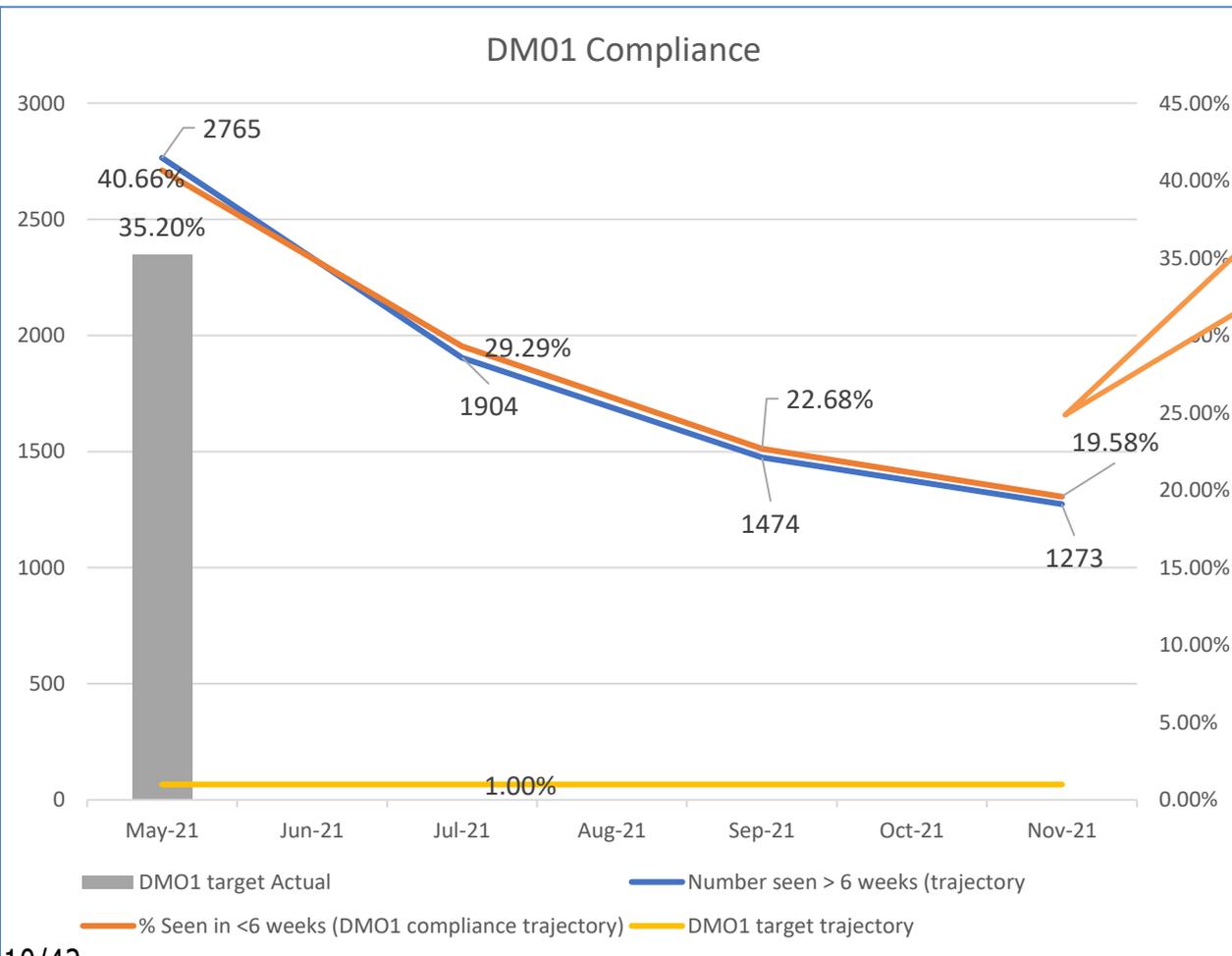


Apr (actual)	May (actual)	June (actual)	Jul	Aug	Sep
3,253	3,542	4,193	4,600	4,462	4,560

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Diagnostic recovery trajectories

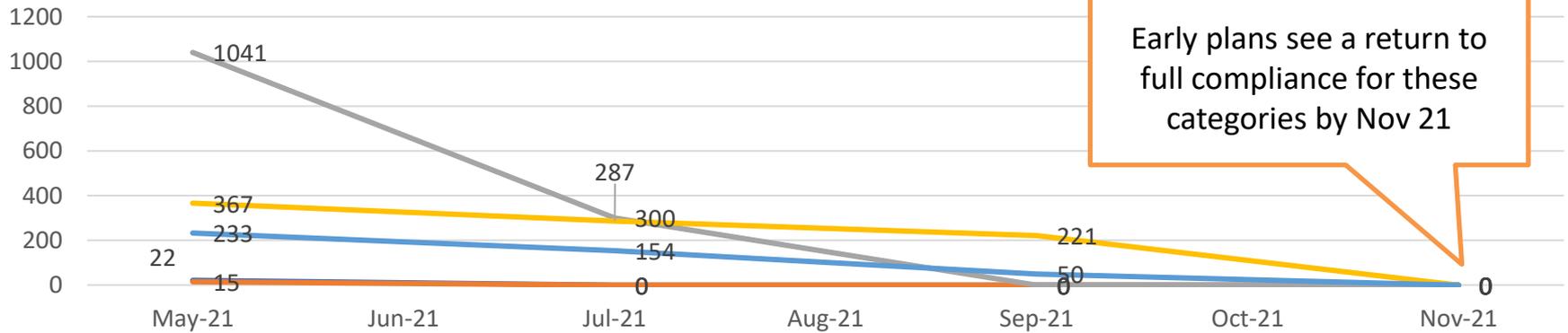
Draft diagnostic activity and recovery trajectories have been developed. The proposed trajectories have been developed with operational teams but require validation. The charts below sets out the total size of the diagnostic waiting list and performance against the DMO01 compliance. The national target is that less then 1% of patients wait longer than six weeks.



Diagnostic recovery trajectories by category

The charts below sets out the proposed trajectory for improving DMO1 compliance across the 10 diagnostic categories. Please note that endoscopy activity is also included in day case reporting

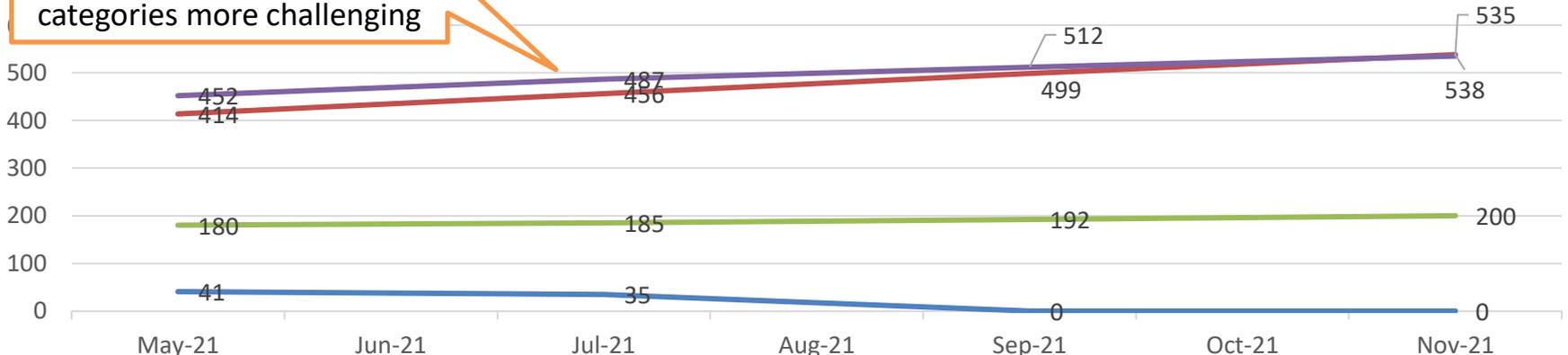
DMO1 diagnostics 6> week waits (Excludes endoscopic)



Early plans see a return to full compliance for these categories by Nov 21

Requirements around IPC, POA and staff availability make recovering these categories more challenging

Endoscopic DM01 diagnostics 6> week waits



Activity planning for H2 (post September)

National guidance for the second half of the year (H2) around activity expectations and supporting financial mechanisms (such as the ERF) are yet to be released.

However, it is likely that activity expectations are likely to begin at the September ERF thresholds of 95%. In view to this, activity recovery trajectory planning for H2 has begun with SDUs. The table below sets out proposed timelines for this process.

Milestone	Target date
SDU level activity baseline and planning tools developed and shared	09/07/21
Draft H2 plans developed and signed off by division	26/07/21
Check and challenge sessions held to ensure viability ambition	16/08/21
Divisional plans signed off by EMC	07/09/21
Trust plans signed off by F&BP	21/09/21

The same methodology used to generate H1 trajectories will be used for H2, with the exception that the 'check and challenge' function will be carried out within the newly set up planned care transformation programme (see upcoming section of this report)

Potential 3rd wave impact on elective recovery

The winter and 3rd wave escalation plan seeks to minimise the impact on elective care across the Trust. However, should additional capacity be required this may impact the ability to deliver routine work. Given the importance of maintaining the elective program, a number of actions are being implemented:

Reduce baseline bed occupancy

- Though length of stay has decreased this now needs to be translated into reduced bed occupancy. LOS efforts should be refocused on this

Additional escalation options

- Additional escalation options must be worked up to be ready should data show that the trend is towards these more challenging scenarios. Focus should be away from stoke site

Strengthen discharge

- Given the high non-Covid bed demand and bedding these could negatively impact bed occupancy. Discharge to assess beds must be protected where possible.

The Elective Recovery Fund (ERF) update

Ref	Letter ref	Requirement	Current status
15	C1	Draw up elective and diagnostic delivery plans	Done and assured
16	C1	Increase elective capacity safely	Done and assured
17	C1	prioritise the clinically most urgent patients,	In progress
18	C1	review and validation of the waiting list	In progress
20	C1	Plan to address the longest waiters and ensure health inequalities	In progress
24	C1	Outpatient transformation, - avoid low clinical value	In progress
25	C1	A&G mobilisation	Done and assured
26	C1	PIFU mobilisation	In progress
27	C1	Virtual OPD	Done and assured
29	C2	Cancer treatment to Feb 20 levels	Done and assured
30	C2	Make up first treatment shortfall	In progress
31	C2	Draw up a single cancer delivery plan	Complete - assurance required
32	C2	Meet the new Faster Diagnosis Standard	Complete - assurance required

Updated ERF rules - analysis



On 9th of July revised rules governing ERF funding allocation were issued. An initial analysis has been conducted based on this new information, but further work with wider colleagues will be required to review the recommendations. Initial analysis is set out below.

Key changes

- From July ERF additional tariff payment threshold has been raised from 85% to 95%
- From July ERF 120% tariff payment threshold raised from 85% to 100%
- Quantitative Gateway analysis will not be used to determine payments in H1 but are likely to be reintroduced in H2
- The April ERF payments to the systems are expected on 15 July

Early analysis

- Indicative financial models have been rerun based on this new guidance - see next slide
- Total ERF expected earning from trust activity is now between £5.7m and £8m
- A large majority of ERF the income from a BHT perspective will have already been earned in Q1
- Even with the planned investment, Q2 is not expected to earn significant additional ERF
- This analysis does not take into account the ICS wide position

Updated ERF rules – early recommendations

Based on early analysis, a number of early recommendations for discussion are set out below. It will be important to triangulate these with recommendations from wider colleagues, especially those in finance. The tables right are early indications only and require validation from the finance teams

Draft revised ERF income expectations

New best case	Expected ERF earning
April	£ 2,512,349.52
May	£ 2,316,874.38
June	£ 2,099,845.91
July	£ -
August	£ 676,030.33
Septs	£ 374,053.30
Total	£ 7,979,153.44

New worst case	Expected ERF earning
April	£ 2,512,349.52
May	£ 2,316,874.38
June	£ 649,119.94
July	£ -
August	£ -
Septs	£ -
Total	£ 5,478,343.84

Early recommendations

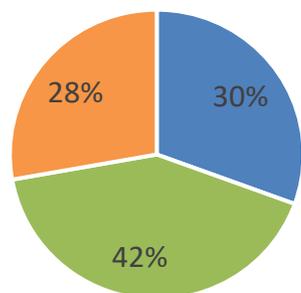
- The Trust trajectory of £7.7m ERF funding income for H1 remains valid
- No further investment in delivery of additional should be made until further analysis is completed
- Focus should be on increasing efficiency *within* budget.
- Planned Care Transformation programme and Outpatient Transformation should focus on genuine achievable in-quarter productivity gains e.g. strengthening RAS and A&G, introducing 'safe discharge by default' methodology
- Services should ensure that activity investment already committed delivers in H1
- H2 activity planning should aim for 100%+, at expected baseline of 95%
- A similar offer of ERF funding in H2 to services as in H1 should be made, but with target of over 95%
- Focus should remain on reducing long waiters by booking patients in the right order to continue to tackle long waits and clinical harms in Q2
- Focus on achieving the ERF gateways should moved from H1 to H2, unless they are expected to directly deliver efficiencies
- Continue discussion with BOB ICS is required for clarity around system ERF approach, including methodology for allocating ERF income

Achieving the gateway criteria

Table below sets out the high-level status of the gateway criteria in Buckinghamshire. BOB ICS submitted a fully compliant gateway criteria evidence on 14th of June to the region for the first month. The outcome of the NHSE assessment is expected on the 15th of July.

Gateway criteria	Current status
Addressing health inequalities	Work has been commissioned around this criteria. Updated report will be available mid July
Transformation of outpatient services	Trust currently meets criteria for virtual outpatients and A&G, with solid plans to meet PIFU requirements.
Implementing system led elective working	Early discussion in ACW and project Initiation commenced (note: this is the responsibility of the ICS team)
Tackling the longest waits	Plan to tackle the longest waits well underway (see long waiter and clinical harms section below). Currently 200 ahead of trajectory for 52 week waits.
Supporting staff	'Project thrive' is underway with clear plan of action

The charts below shows a local assessment of progress against the Gateway criteria.



Not started	0
Done and assured	11
Complete - assurance required	15
In progress	10

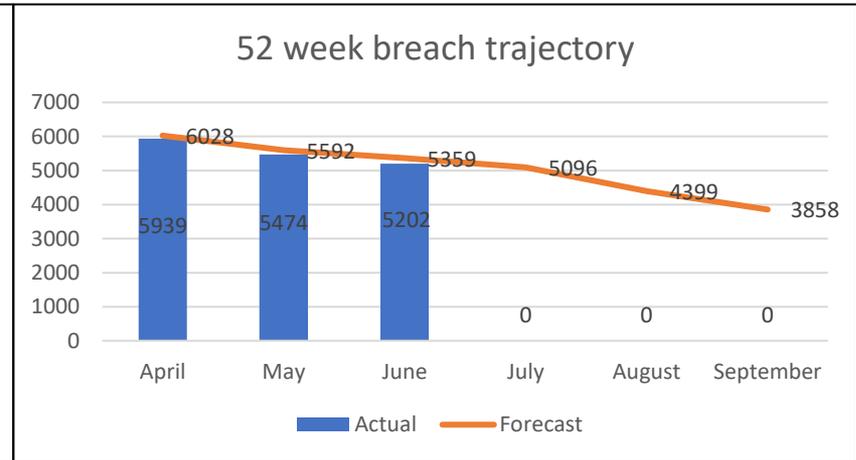
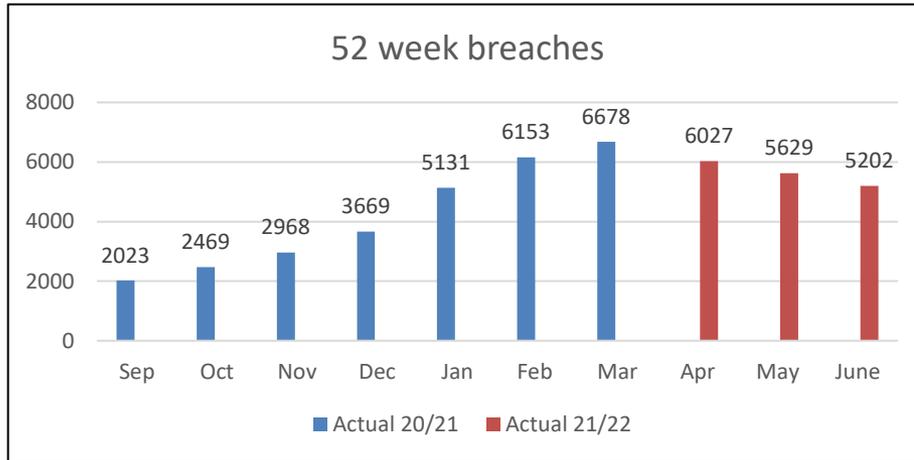
Note that recent guidance from NHSE suggests that systems will not be held to account for gateway achievement in Q2, though a reemphasis will be made on them for H2

Planned care performance and clinical harm management

Ref	Letter ref	Requirement	Current status
15	C1	Draw up elective and diagnostic delivery plans	Done and assured
16	C1	Increase elective capacity safely	Done and assured
17	C1	prioritise the clinically most urgent patients,	In progress
18	C1	review and validation of the waiting list	In progress
20	C1	Plan to address the longest waiters and ensure health inequalities	In progress
24	C1	Outpatient transformation, - avoid low clinical value	In progress
25	C1	A&G mobilisation	Done and assured
26	C1	PIFU mobilisation	In progress
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30	C2	Make up first treatment shortfall	In progress
31	C2	Draw up a single cancer delivery plan	Complete - assurance required
32	C2	Meet the new Faster Diagnosis Standard	Complete - assurance required

Managing risk for patients with long waits

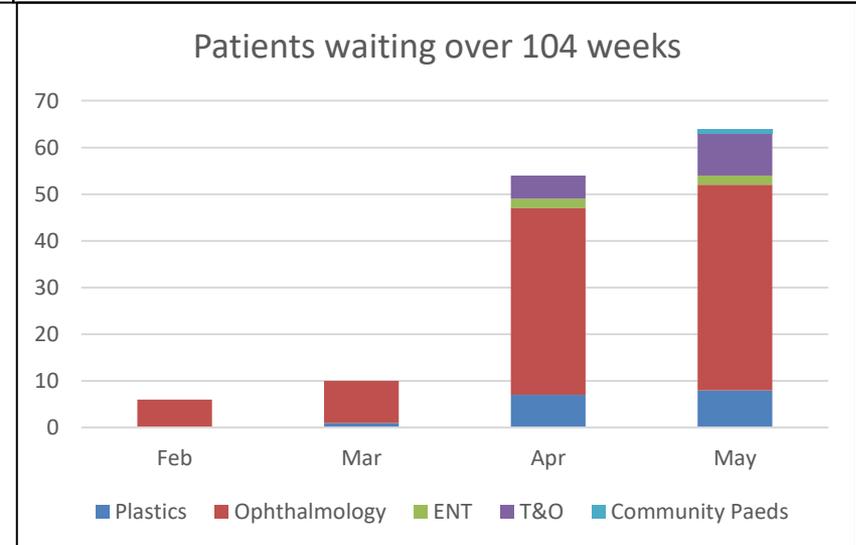
The Trust has been very successful in bringing down the long waiter number, with 52 week breach total numbers dropping by an average of 492 per month - now down 1476 from the peak in March. Actual numbers are tracking slightly ahead of planned trajectory, giving good reason to expect the trend will continue. The numbers below include both admitted and non-admitted long waits.



104+ week wait numbers continue to rise.

Approximately one third of these are P5 & P6 categories (patient choice), and an additional third now have been dated. Work is underway to ensure all non-P5 & P6s are dated.

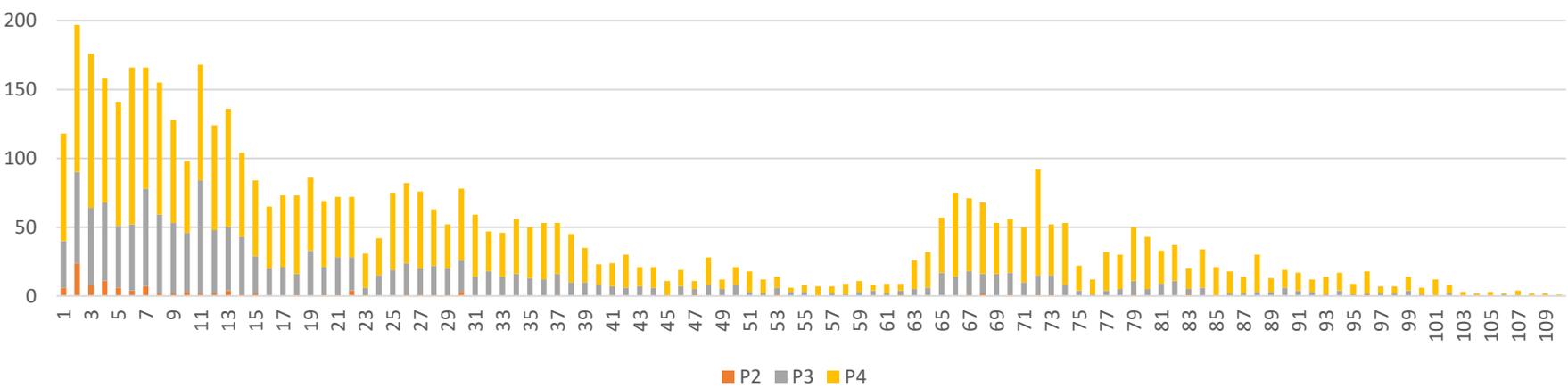
In addition, clinical conversations are being arranged with all 104+ long waiters to encourage appropriate management of P5 & P6s, as well as to determine fitness to remain on the surgical list.



Managing clinically urgent patients

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

Length of wait by P categories (P2 numbers pulled out)



Week	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	22	25	26	27	30	31	34	41	51	71	72	74	Total	
Number of P2 (excludes P5 & P6)	6	22	8	10	5	2	6	2	1	2	1	1	3	1	2	1	1	2	1	1	1	1	1	1	1	1	1	1	85

P2 unbooked numbers have been decreasing but an additional focus is required to bring this number of zero. Many of those unbooked are not fit for surgery.



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Elective recovery context

The Trust is currently reporting as an outlier in terms of long waiters despite good progress at recovering activity levels for both admitted and non-admitted pathways (see activity section). The reasons for this are complex and an external investigation has been commissioned to identify the drivers. Initial analysis suggests that the trust performance is comparatively low for three key reasons:

- **Remained open to referrals:** unlike ICS colleagues, BHT remained open to all referrals throughout all waves of the pandemic. Referrals accepted through the first wave of the pandemic are now at risk of becoming long waiters.
- **Limited IS:** Buckinghamshire has a relatively small number of independent sector providers with limited capacity. Some independent capacity available was used to manage oncology pathways throughout the second wave, which limited the impact of IS on waiting times. Furthermore, the available capacity is not always able to be applied to procedures that will impact on long waiters due to complexity.
- **Constrained finances:** Pre-pandemic the trust was in the process of financial turnaround, limiting resources to target RTT performance

Number of key actions are being pursued to improve the position:



National diagnostics validation requirement



On 10 May 2021 NHSE/I published a requirement that all acute diagnostic procedures (defined as those on the DM01 list) will need to be clinically prioritised. This will help Trusts to actively manage their waiting list and any risks associated with longer waits. The process is similar, but not identical to, the surgical 'P category' prioritisation.

The tables below set out the diagnostic validation categories (D categories), as well as the high-level timeline set by NHSE.

D Categories

D1: Potentially life-threatening or time-critical conditions eg, cancer, cardiac failure, significant bleeding, chest pain, renal failure, vision loss

D2: Potential to cause severe disability or severe reduction to of quality-of-life eg, intractable pain

D3: Chronic complaints that impact on quality of life and may result in mild or moderate disability
Routine patients that would normally be seen within the next 4-6 weeks

D4: Chronic complaints that impact on quality of life and may result in mild or moderate disability -
Routine patients that would normally be seen within the next 6-12 weeks

National requirement	Timescale	other
Agree which diagnostic modalities/waiting lists require review	Monday 7 June 2021 DONE!	15 16 17 18
Commencement of delivery of validation programme	Monday 7 June 2021 DONE!	20 24 25
Inclusion of D code in national waiting list data submission	Friday 30 July 2021 IN PROGRESS	26 27
Completion of diagnostic validation programme for all patients on waiting list	Tuesday 31 August 2021	29 30
Proactive prioritisation of diagnostic referrals	Ongoing	31 32

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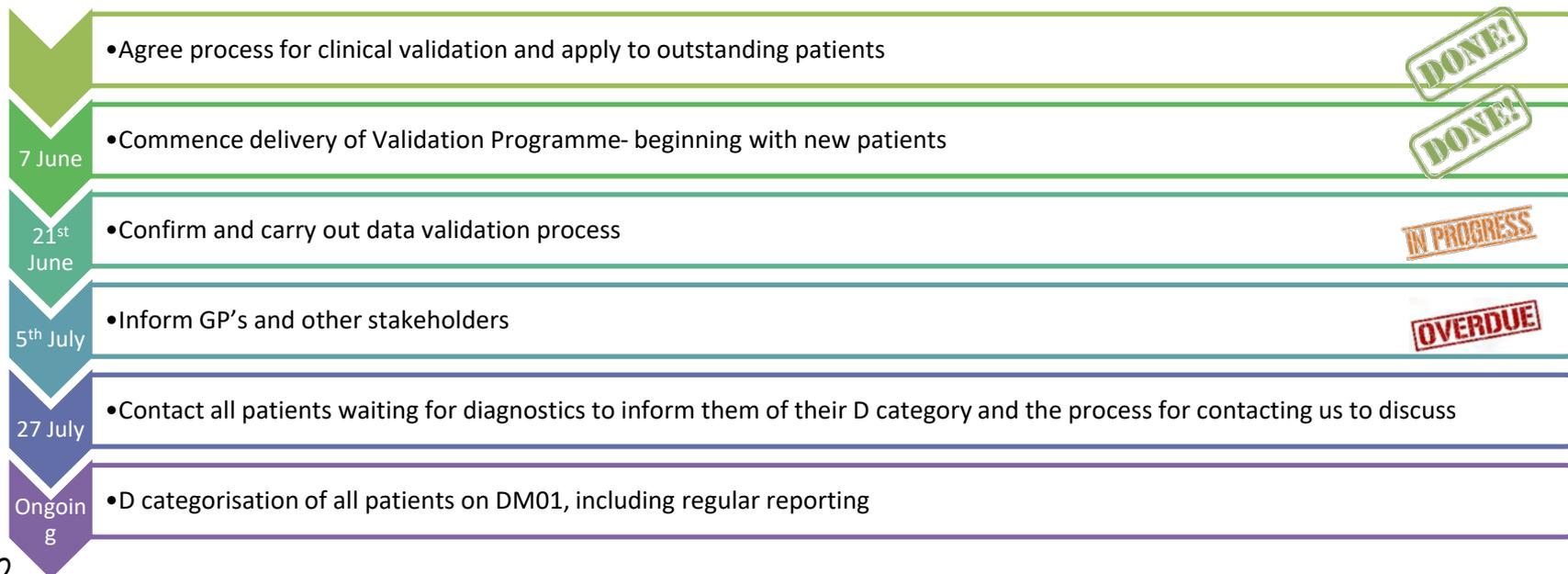
Progress delivering the diagnostics validation requirement

Work to deliver the national diagnostic validation exercise requirement is ongoing. The July milestone requirement for submitting endoscopy validations will be achieved. However, a significant gap remains ahead of delivering a complete diagnostic PTL, including surveillance patients.

Key next steps include:

- Approval of required changes for ICE system
- Agreement of where D categories are recorded so they can be accessed and extracted

Additional assurance is required on plans to meet up coming national deadlines



Planned care transformation

Ref	Letter ref	Requirement	Current status
15	C1	Draw up elective and diagnostic delivery plans	Done and assured
16	C1	Increase elective capacity safely	Done and assured
17	C1	prioritise the clinically most urgent patients,	In progress
18	C1	review and validation of the waiting list	In progress
20	C1	Plan to address the longest waiters and ensure health inequalities	In progress
24	C1	Outpatient transformation, - avoid low clinical value	In progress
25	C1	A&G mobilisation	Done and assured
26	C1	PIFU mobilisation	In progress
27	C1	Virtual OPD	Done and assured
29	C2	Cancer treatment to Feb 20 levels	Done and assured
30	C2	Make up first treatment shortfall	In progress
31	C2	Draw up a single cancer delivery plan	Complete - assurance required
32	C2	Meet the new Faster Diagnosis Standard	Complete - assurance required

Background and purpose of the proposed board

The Trust has recently launched its clinical strategy detailing the aims and objectives of clinical services from 2021 to 2025. In March 2021 the NHSE Operating Planning Guidance was published, which sets the direction of travel for Healthcare services over the coming year, which includes requirements around planned care recovery.

Various elements within the planned care transformation programme have been ongoing for a number of months. The planned care board seeks to bring these together into a single programme with senior oversight, as well as identifying new opportunities.

This paper sets out proposals for a governance structure to deliver the required planned care transformation.

Purpose of the board

The planned care board will provide assurance of the in-year delivery of the operating planning requirements, assure against recovery of activity and oversee the required service transformation to deliver the clinical strategy for planned care.

Part of a wider ICS programme

The BOB ICS has established a governance framework for the delivery of system wide programmes including elective recovery. The proposals in this document are designed to dovetail with the forming ICS proposals and avoid any duplication

Proposal

1) Align existing planned care projects into a single programme structure overseen by the Planned Care Programme Board

2) Clarify governance lines to bring all planned care workstreams into a rational structure and avoid duplication

3) Integrate the BHT planned care programme management with the ICS planned care programmes where appropriate

4) Provide assurance on delivery of the Operational Planning Guidance and clinical strategy requirements related to planned care

5) Ensure that protectivity and efficiencies opportunities are realised in order to first meet activity trajectories requirements and then transform trust wide delivery of care in line with the clinical strategy

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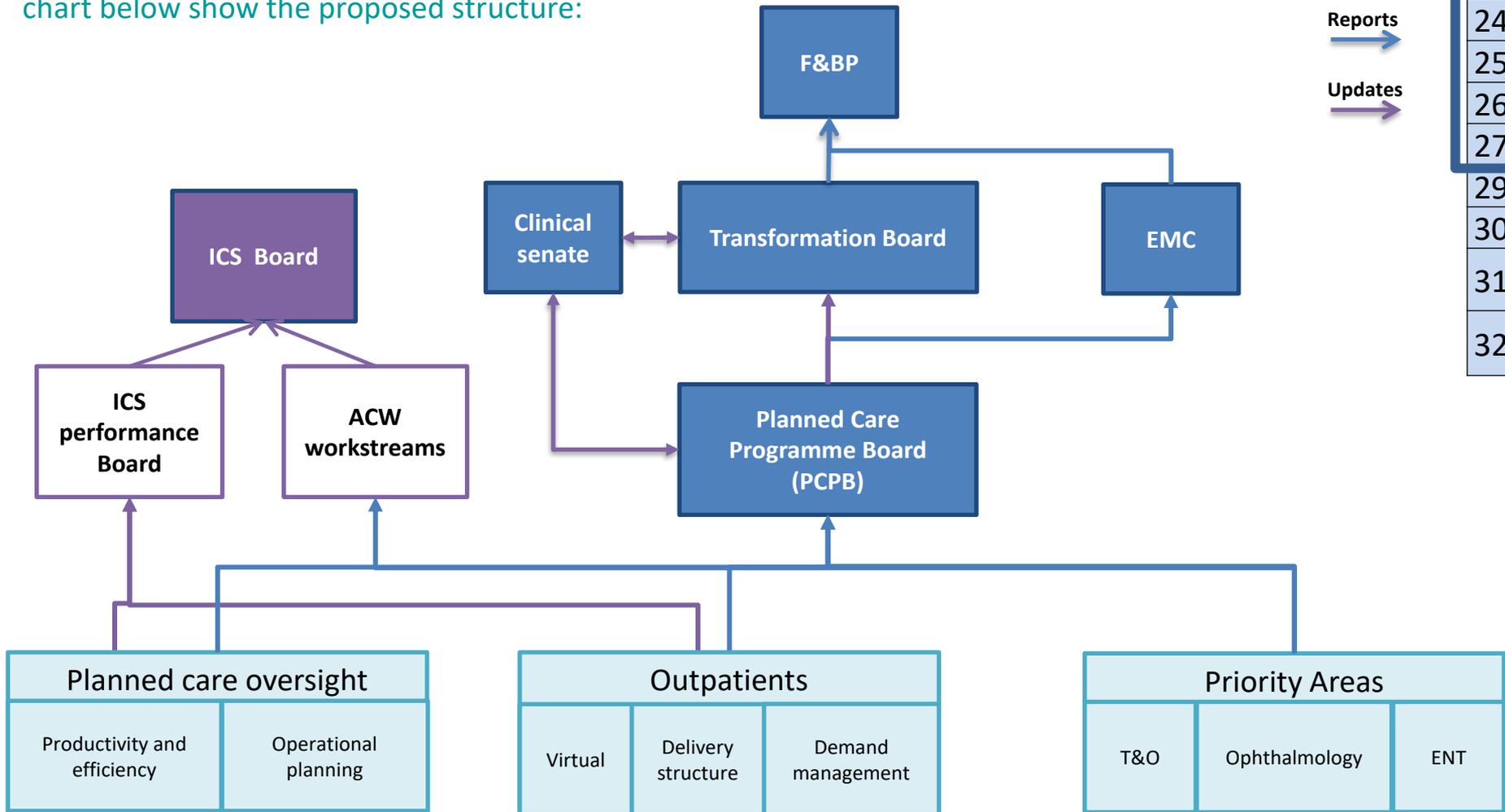
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Proposed governance map

To simplify governance and reduce meeting burden, it is proposed that, though the Planned Care Programme Board (PCPB) will take updates from various groups, these groups will not 'report into' it or direct their work. In this way PCPB is clearly places in an operational assurance and coordination role. The chart below show the proposed structure:

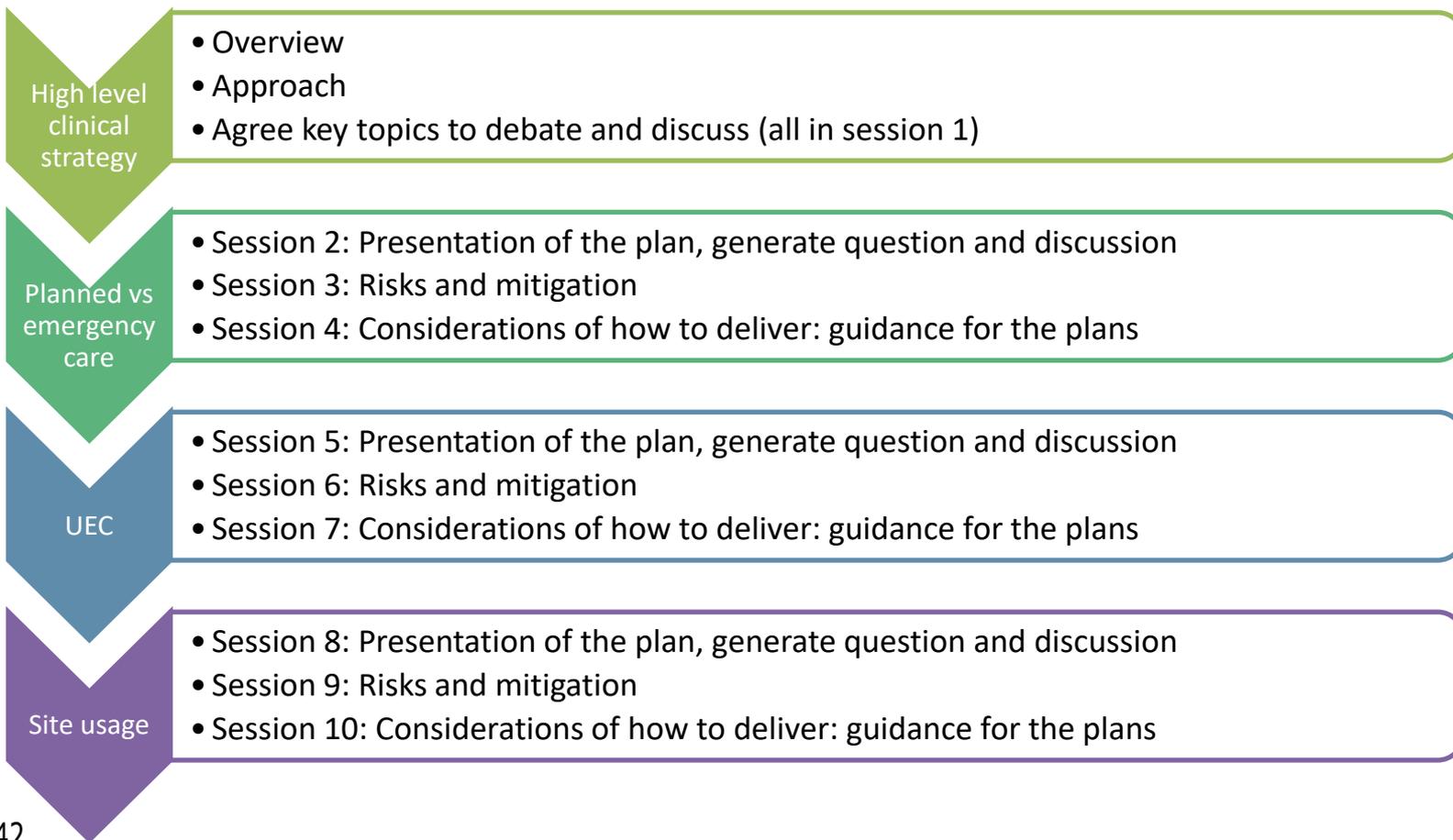


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Clinical leadership

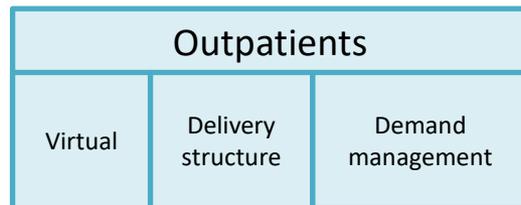
The clinical senate will play a leading role in shaping and assuring the approach taken to planned care transformation. An engagement programme has been developed with the chair of the Clinical Senate to ensure input at the correct decision gateways.

This programme of engagement has been aligned to the key areas of the clinical strategy alongside the strategy team and will form the clinical senate workplan for the year.



Outpatient transformation project

The outpatient transformation project will ensure delivery of the national operating planning guidance and ERF gateway criteria related to OPD – for example virtual appointments, PIFU and advice & guidance. It will also oversee the structural changes to delivery of outpatients within the Trust.



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Milestone	Workstream	Date	Status
PIFU pathway in 3+ major services as required	Demand management (PIFU)	June 2021	Overdue
25% of OPD virtual - achieved and sustained	Virtual appointments	Sept 2021	Done
All non-admitted open pathways clinically prioritised	Delivery structure (Processes)	December 2021	Open
New OPD management model live	Delivery structure (Organisation)	December 2021	Open
12% of all referrals responded by A&G - achieved and sustained and all services offering OPD offering responsive RAS	Demand management (Advice & guidance)	March 2022	Open

Key measure	Target
Number of non-admitted 52 week breaches	below 1,500 by March 2022
Non-admitted activity levels	at least 19/20 levels by Dec 2021
New to FU ratio	increase over 19/20 baseline

Priority Elective Areas

Priority Areas		
T&O	Ophthalmology	ENT

The Priority Elective Areas project will be the local delivery arm of the ICS/ACW programme, engaging with the system work while delivering the required changes locally in BHT. This is expected to include surgical hubs. Once established, each priority area will have its own project group with its own milestones.

Milestone	Date	Status
Agree local leaders and join inaugural ICS programme meeting	June 2021	Done
ICS programme ambition agreed	End July 2021	Open
Local programme developed as part of ICS programme	End August 2021	Open
Programme implémentation along side ICS colleagues	September 2021	Open
Agreed deliverable live - benefit realisation begins	End Q1 2022	Open

Key measure	Target
Number of admitted 52 week breaches	less than 1,000 by 2022
Admitted activity levels	at least 19/20 levels by Dec 2021
Compliance Waited Activity Unit peer group as per GIRFT	Inline with peer group by March 2022

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Planned care oversight

The oversight and assurance arm of the programme will act as a function rather than a project. It will ensure that planned care business cases are reviewed and followed up for ROI, oversee BAU productivity improvement and assure against performance levels

Planned care oversight	
Productivity and efficiency	Operational planning

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Milestone	Workstream	Date	Status
Planned care oversight governance agreed and implemented (July) All current planned care business cases reviewed for ROI System in place to monitor approved business cases (e.g. Endo 7 day working) and to review future business cases (e.g. Robotic surgery)	Productivity & efficiency	August 2021	Open
Elective speciality activity trajectories signed off for H2 2021/22	Operational planning	August 2021	Open
Service level of opportunities from HVLI analysis identified using FourEyes analysis. Also Implementation plans for each opportunities signed off	Productivity & efficiency	October 2021	Open
Process agreed for management of both new EBI referrals and listed EBI procedures	Productivity & efficiency	November 2021	Open
SDU business plans developed and signed off for elective services for FY 2022/23 in line with clinical strategy priorities and operating guidance.	Operational planning	March 2022	Open

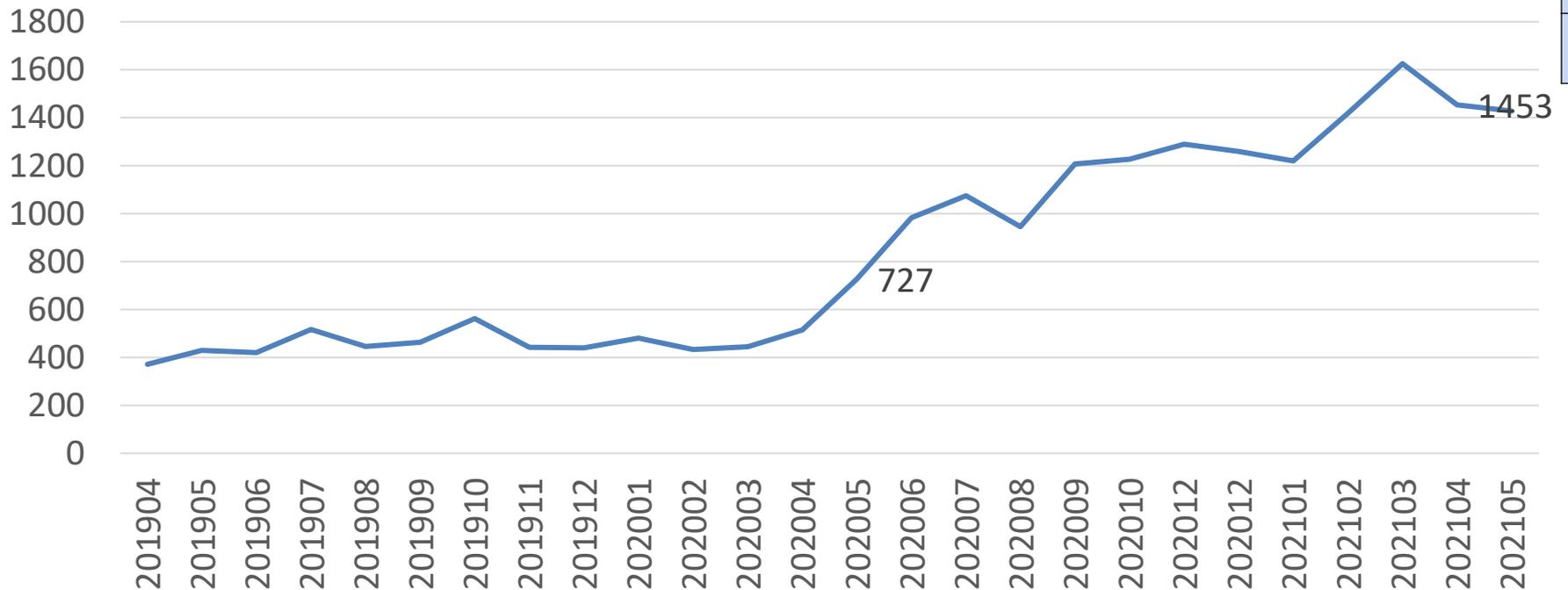
Key measure	Target
Compliant with national guidance related to planned care	12/13 done and assured by March 2022 ERF activity achieved by Sept 2021 100% of local Gateway criteria achieved by Sept 2021
Validation of all patients on PTL in line with prioritisation requirements	95% by December 2021)
Approved and live business cases able to demonstrate a positive return on investment	100% by December 2021

Outpatient transformation and ERF priorities

New guidance on ERF requirements indicates that Advice and guidance, as well as other low-value appointment management interventions, will remain a priority. Minimum baseline standards will be established for outpatient transformation for the second half of the year, based on an increase in the number of Advice and Guidance responses per 100 outpatient first attendances (or equivalent via other triage approaches).

The Trust continues to perform well in term of advice and guidance activity and is well placed to meet the new requirements.

Number of A&G Requests By Month



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Recovering cancer performance

Ref	Letter ref	Requirement	Current status
15	C1	Draw up elective and diagnostic delivery plans	Done and assured
16	C1	Increase elective capacity safely	Done and assured
17	C1	prioritise the clinically most urgent patients,	In progress
18	C1	review and validation of the waiting list	In progress
20	C1	Plan to address the longest waiters and ensure health inequalities	In progress
24	C1	Outpatient transformation, - avoid low clinical value	In progress
25	C1	A&G mobilisation	Done and assured
26	C1	PIFU mobilisation	In progress
27	C1	Virtual OPD	Done and assured
29	C2	Cancer treatment to Feb 20 levels	Done and assured
30	C2	Make up first treatment shortfall	In progress
31	C2	Draw up a single cancer delivery plan	Complete - assurance required
32	C2	Meet the new Faster Diagnosis Standard	Complete - assurance required

Recovering cancer performance

The Trust continues to maintain compliant positions across the majority of cancer targets, exceeding most but slightly under performing in the 62 tumour and screening standards.

Full details of cancer performance and indicators is provided in the Integrated Performance Report (IPR).

Preview Report Type	% Meeting Standard	Target
1.1 - Cancer Two Week Wait	97.40%	93%
1.2 - Breast Symptom Two Week Wait	100.00%	93%
2.1 - 31 Day First Treatment (Tumour)	100.00%	96%
2.8 - 31 Day Subsequent Treatment (Treatment Group)	98.30%	N/A
Drugs	100.00%	98%
Surgery	97.00%	94%
3.1 - Cancer Plan 62 Day Standard (Tumour)	80.60%	85%
3.7 - Cancer Plan 31 Day Rare Cancer Standard	100.00%	90%
4.1 - CRS 62 Day Screening Standard (Tumour)	81.30%	85%
5.1 - CRS 62 Day Upgrade Standard (Tumour)	83.30%	N/A
17.1 - 28 Day FDS Two Week Wait	77.30%	75%
17.2 - 28 Day FDS Breast Symptom Two Week Wait	100.00%	75%
17.3 - 28 Day FDS Screening Referral	82.40%	75%

Urgent and emergency care recovery

Action Ref	Letter Ref	Requirement	Done and assured
54	E2	Promote NHS 111	Up to date and ongoing
55	E2	70% of referred ED patients get booked slot	In progress
56	E2	Direct referral to SDEC	In progress
57	E2	Full SDEC Model	Complete - assurance required
58	E2	Collect Emergency Care Data Set (ECDS)	Complete - assurance required

Urgent & Emergency Care - May 2021

Lead: Caroline Capell

PM: Elaine Baldwin

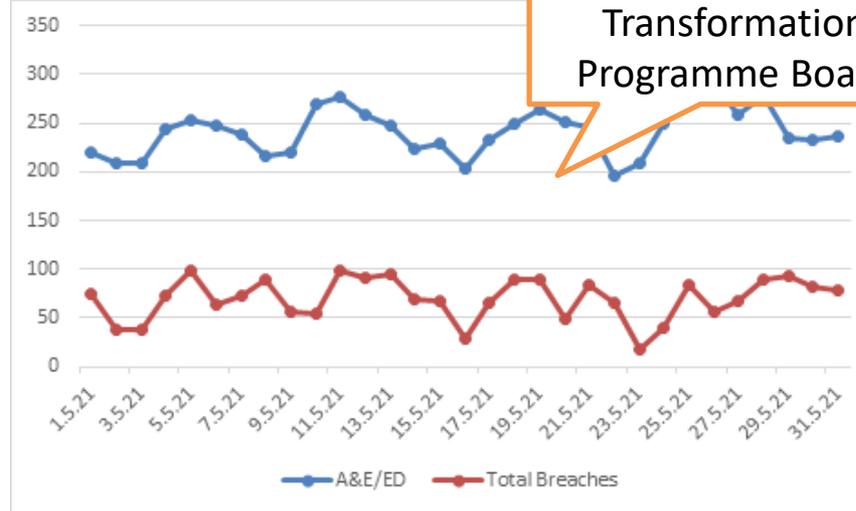
Aim: The people of Buckinghamshire experiencing an urgent or emergency health issue will be assessed quickly and reliably and managed in an appropriate location that is convenient to them. They will be cared for by a clinician that can meet their need, giving clear advice to allow self-care where appropriate and ensure they can return home swiftly and safely following treatment.

Comments: Workstream deliverables are progressing as planned however we are not seeing a consistent impact due to periodic surges in activity but mitigations are being taken forward to address this.

Highlights

- 12hr breaches continue to fall with periodic surges still occurring but the average reduced during May.
- Improvements in ambulance handover with periodic surges still occurring but the average reduced during May.
- HALO recruitment process underway
- Multi agency LLOS reviews supported reduction from 55 to 25 over 21 day LLOS patients. Bank Holiday however impacted performance.
- Frailty pull model developed
- Successful completion of Post Acute pilot and plan in place to address education & training needs following pilot.

ED vs Breach Activity (May 2021)



UEC Highlight provided by Transformation Programme Board

Work stream / initiative	Status (RAG)	Next milestone	Due (Expected)	Risk (and action)	Score (after mitigation)
Pre-Hospital	Green	Children's direct bookings to be piloted in May (delayed due to Adastra issues)	05/07/21	IF Bucks does not continue to meet the national requirement of ED direct bookings 24/7 for all patient cohorts THEN there may be challenges regionally and locally as the only ICP not meeting this deadline.	12
Front Door	Green	Roll out Plan for Consultant Connect	30/06/21		
Ambulation and Acute	Green	Frailty SDEC pull model implemented	15/07/21	IF there is no funding stream agreed for out of hospital discharge capacity for discharges occurring after July 2021 THEN there may not be the ability to proceed with the new models of care.	12
Post-Acute	Red	Develop Business Case for continuation	30/06/21		
Get Me Home	Amber	Develop Integrated Hub proposal	30/06/21	IF there is a third wave of Covid 19 THEN this will impact the recovery and transformation work along with creating staffing and capacity issues.	12
Anticipate not React	Green	Appropriate organisational planning in place for a potential third wave of Covid-19	30/07/21		

Urgent & Emergency Care - May 2021

Lead: Caroline Capell
PM: Elaine Baldwin

Workstream	RAG	Measure	Overall Target	Baseline	Previous Month Actual	This month Target	Actual	
Pre-Hospital	Green	ED attendances (incl. trajectory of 2.5% reduction) Calls to 111 (incl. trajectory of 2.5% increase of 111 Calls)	5750 15900	5895 15550	6824 19560	5750 15900	7471 21975	
Front Door	Green	ED 4 hour breaches average weekly for March (399), April (460), May (499), Baseline 2021 average (Jan-May)	400	440	460	400	499	
Ambulation & Acute	Green	SDEC attendances (incl. trajectory)	1417	383	619	1412	661	
Post-Acute	Red	LOS on admission – 7 days and below, 8-14 days, 14-21 days, 22 days & above (No of patients plotted against month)	Pilot will identify relevant measures going forward					
Get Me Home	Yellow	Total MOFD patients 1) less than 48hrs 2) over 48hrs	10 10 0	55 17 38	57 29 28	10 10 0	55 0 55	
Anticipate not React	Green	1) % ED performance vs trajectory 2) Avoiding Emergency Admissions (incl. SDEC)	95% 2100	80% 2560	82.1% 2922	90% 2400	83.3% 3031	

Mitigation to address performance	
Pre-Hospital	<ul style="list-style-type: none"> Whilst we are using the previous 12 month period for 111 activity and this would have been lower due to Covid pandemic (so may not reflect a normal year) we are working with SCAS to set a realistic baseline and target going forward. Communications plan being put in place with support from the comms team- social media campaign and website links to patient survey – will be rolled out over a 2 month period 111 material has now been delivered and will be timed with the comms plan
Front Door	<ul style="list-style-type: none"> The admitted and non-admitted data has just started to be collated and reviewed. Non-admitted breaches now reviewed daily within the ED team to agree mitigations. The new national guidance for measuring admitted and non admitted attendances will be published shortly. NHSE ED Improvement support in place from 7th April with focus on ED performance and patient flow to improve performance going forward.
Ambulation & Acute	<ul style="list-style-type: none"> Development of SDEC DOS pathways to enable direct bookings Introduction of Pull model from ED (Frailty SDEC) Fortnightly review meetings to assess patient flow
Post-Acute	<ul style="list-style-type: none"> Post acute pilot commencing 19th April for a 6 week period with resource secured. Pilot plan now in place Comms commencing across all BHT sites
Get Me Home	<ul style="list-style-type: none"> Multi agency involvement in 3 time weekly LLOS reviews at BHT Encourage challenge of current bed based model and emphasis towards Home First Planned focus on reducing LOS in D2A beds to support flow and enable system planned reduction in beds as Home First approach develops
Anticipate not React	<ul style="list-style-type: none"> Contingency planning for managing periods of high demand. Continued focus on LLoS patients with system support. Recruitment of HALO to support SMH ED and help improve flow through maximizing the use of alternative settings.

Urgent & Emergency Care - May 2021

Lead: Caroline Capell
PM: Elaine Baldwin

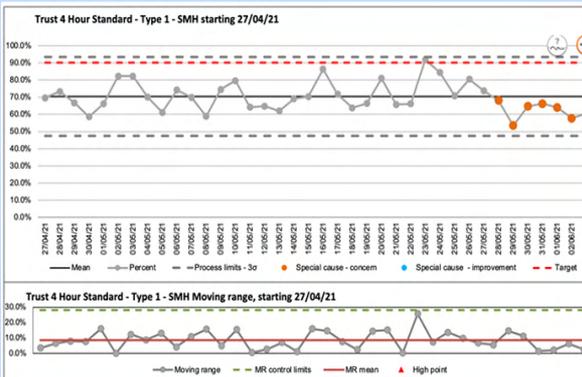
Pre-Hospital

May 2021



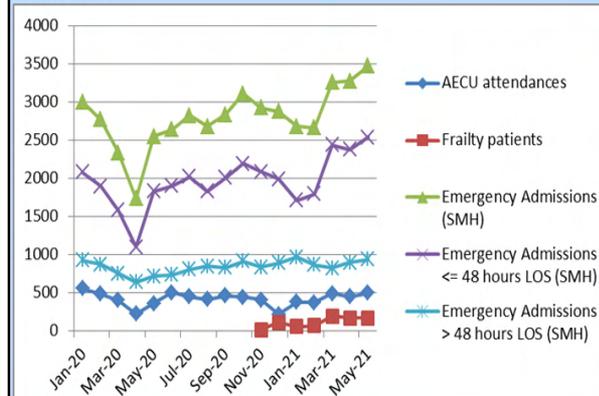
Front Door

CHART 1 - May 2021



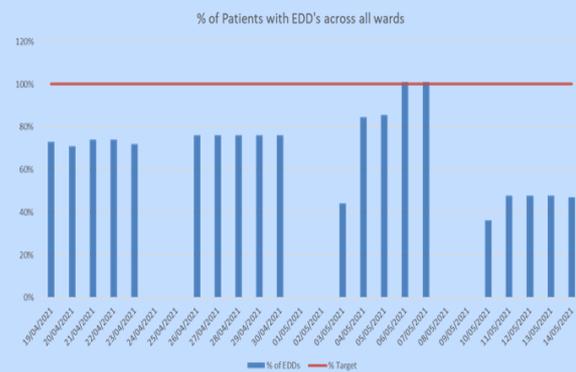
Ambulation and Acute

May 2021



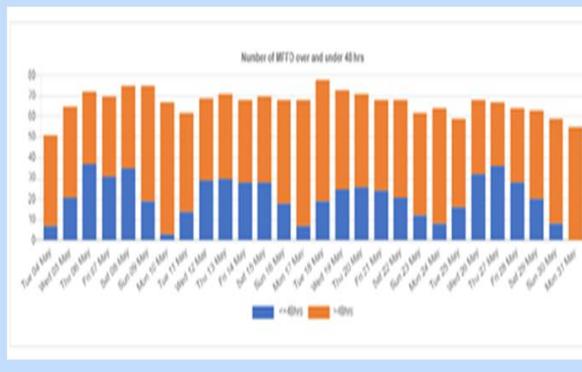
Post-Acute

Pilot Data Weeks 1-4 Patients with EDD's in place



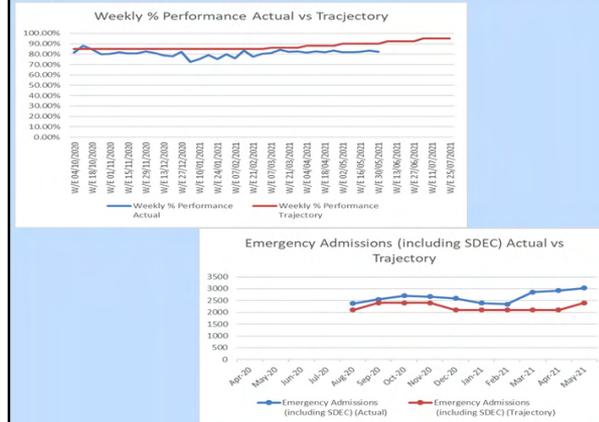
Get Me Home

May 2021 - Graph showing number of MOFD at BHT over and under 48hrs



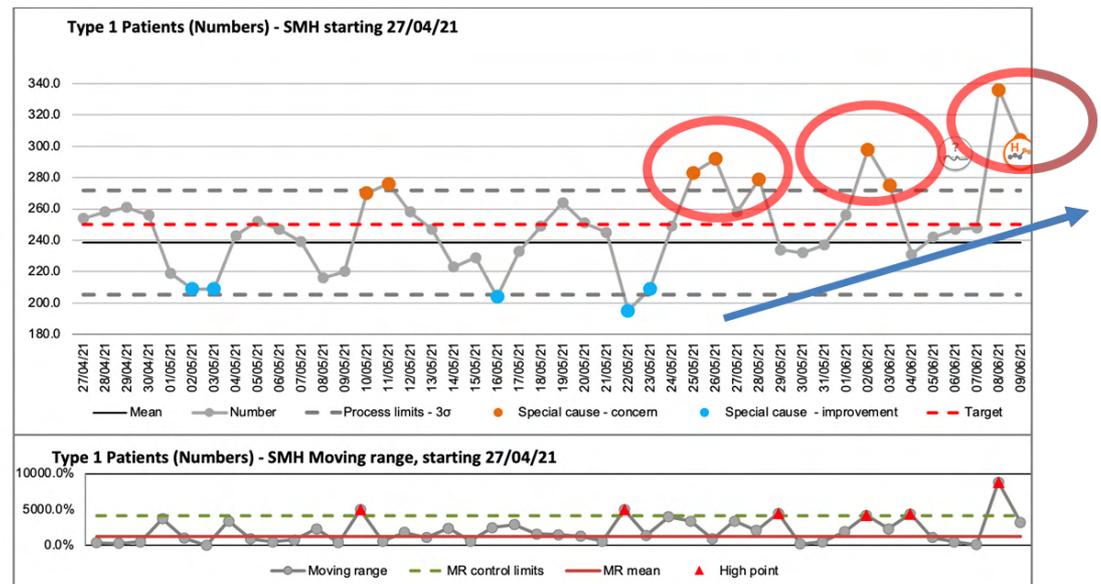
Anticipate not React

May 2021



The challenge for recovering ED performance

- Bed occupancy on the Type 1 site (SMH) remains above 95% despite improvements in length of stay.
- There is a drop in performance and an increase in delays over night
- Clinical and operational leadership capacity needs to improve, as does the collaborative culture in the broader ED service
- These challenges have been exacerbated by a rapidly increasing post-Covid workload
- Stoke site has limited physical capacity in majors and resus: the site has double the admissions per cubical then the national and regional average - 79 admissions per G&A bed compared to 64 regionally



Detailed interventions with clear impact

Below are extracts from the improvement programme plan giving an indication of the actions and expected impact of the interventions in the short, medium and longer term. BHT Has an ED improvement director in place who will oversee the delivery of the programme plan

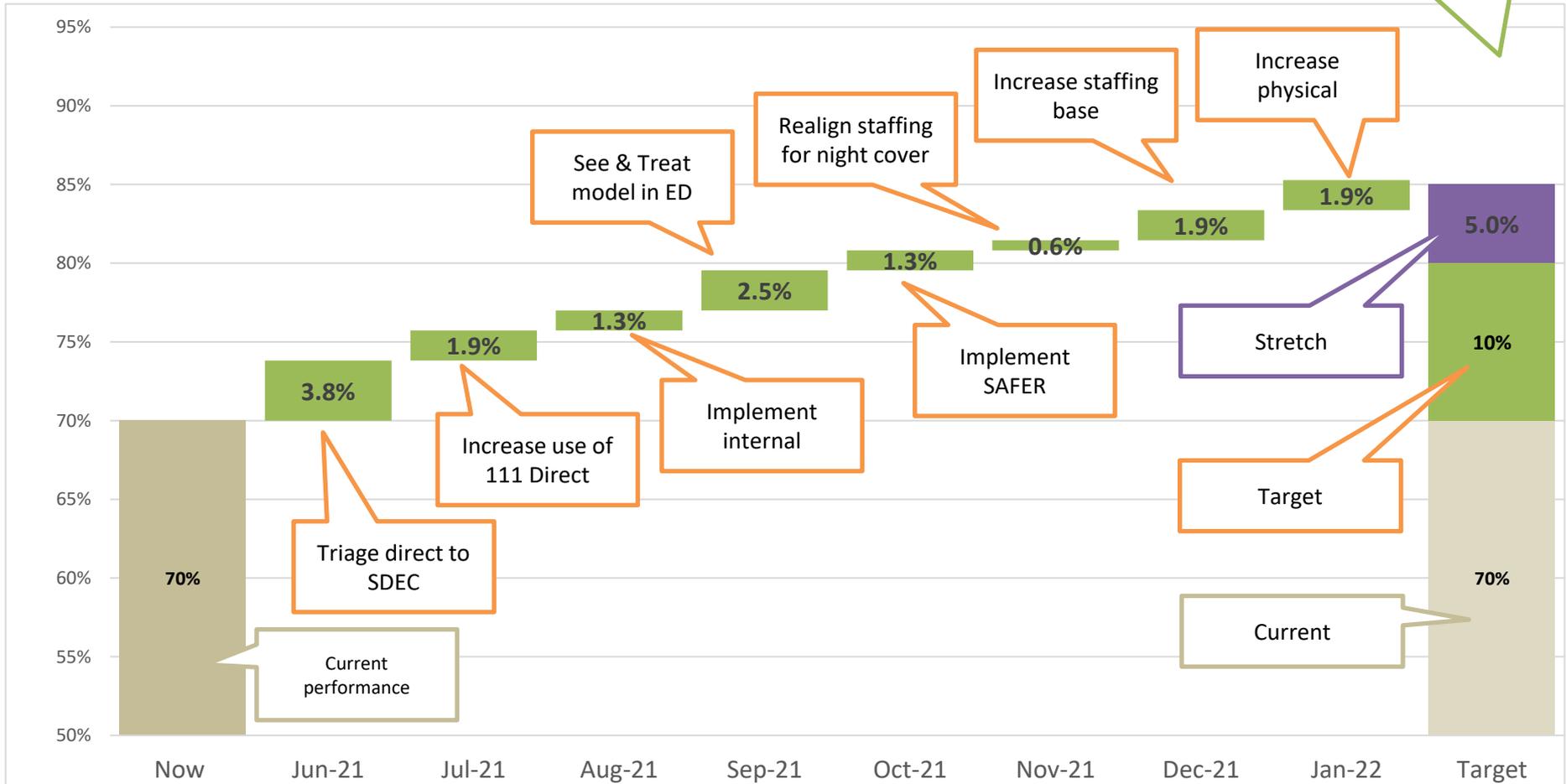
Plan detail, including dates, are being updated locally by the team

Action / Solution	Phase	Target end date	Lead KPI	Expected outcome/Target
Adherence to national best practices for streaming at front door. Protocol known, clear, understood and used. Key areas: acceptance criteria, roles, triggers/pathways	1	05/07/2021	Mean time to see a clinician	<60 minutes
Triage direct to SDEC	1	05/07/2021	Mean time to see a clinician	<60 minutes
Fully articulate, implement and ensure compliance with internal professional standards	2	03/08/2021	Complaint numbers per month	Improvement over baseline by 20%
Ensure understanding, relevance and compliance with full capacity protocol	2	09/08/2021	Mean time from Clinically Ready to Proceed to discharge	<120 minutes
Improvement clinical leadership in department - gain clinical input from regional colleagues	3	30/08/2021	Staff survey results	Improvement over baseline by 20%
IT systems that integrate and show better real-time data – e.g.: the CRS standards. Including access to emergency IT support	3	30/08/2021	Mean time from Clinically Ready to Proceed to discharge	<120 minutes

The above are just 6 examples of a 55 workstream programme beginning this month and ending in December. The full plan is available on request

Expected improvement trajectory

Plan detail, including dates, are being updated locally by the team



Meeting: Trust Board Meeting in Public

28 July 2021

Agenda item	Infection Prevention & Control	
Board Lead	Karen Bonner, Chief Nurse	
Type name of Author	Hannah Bysouth Infection Prevention & Control Head of Nursing,	
Attachments	Refresh of Infection Prevention and Control Priorities	
Purpose	Assurance	
Previously considered	EMC 13 th July 21, Quality Committee 21 July 21	

Executive Summary

Introduction

At the request of the Board, this is the bi-monthly Infection Prevention and Control (IPC) report which provides the Trust's position on mandatory surveillance, key learning and activities of the IPC multidisciplinary service. Estates also provide an assurance report on environmental cleanliness within the Trust

Summary

- The Trust had one healthcare associated MRSA bacteraemia in May against a trajectory of zero
- There were 6 cases of hospital onset healthcare associated C. difficile infections in May and June, and zero cases of Community onset healthcare associated C. difficile infection for May and June
- 5 line associated bloodstream infections
- The Infection Prevention and Control Team delivered PPE Champion training across Stoke Mandeville, Wycombe, Amersham and Buckingham Hospital sites

Decision

The Board / Committee is requested to discuss and approve

Relevant Strategic Priority

Quality

People

Money

Implications / Impact

Patient Safety

HCAI's contribute significantly to patient safety and experience. They can impact on prolonged hospital stay, increase resistance of microorganisms to antimicrobials & disrupt patients and their families lives

Risk: link to Board Assurance Framework (BAF)/Risk Register

Infection Prevention and Control

Financial

Impact LOS and increased use of resources

Compliance Select an item. Select CQC standard from list.

Safety and CQC standards

Partnership: consultation / communication

CCG

Equality	Patients who pose a known or potential infection risk are equally entitled to treatment. IPC measures to support their safe management should be in place to support this. COVID-19 has been found to disproportionately impact individuals from BAME communities, men and people over 50
Quality Impact Assessment [QIA] completion required?	No

IPC at BHT: Key points from the IPC Report

- The Trust had one healthcare associated MRSA bacteraemia in May against a trajectory of zero
- There were 6 cases of hospital onset healthcare associated C. difficile infections in May and June, and zero cases of Community onset healthcare associated C. difficile infection for May and June
- For May and June, there were zero cases of probable and definite COVID-19 infections
- 5 line associated bloodstream infections
- The Infection Prevention and Control Team delivered PPE Champion training across Stoke Mandeville, Wycombe, Amersham and Buckingham Hospital sites



IPC visit to Bucks Neuro Rehab at Amersham



IPC visit to Buckingham Hospital for PPE Training

The Trust is committed to reducing healthcare associated infection. There is a zero tolerance for MRSA bacteraemia, there has been one case in May 2021. Public Health England (PHE) has not set a limit for C. difficile infection cases for the Trust, last year this was 65.

		Totals	Integrated Medicine	Integrated Elderly & Community Care	Surgery & Critical Care	Women, Children & Sexual Health	Specialist Services
<i>Clostridioides difficile</i> - HOHA (<i>Hospital onset healthcare associated</i>)	May- June	6	3	0	1	0	2
	Total 2021/22	8	4	0	2	0	2
<i>Clostridioides difficile</i> – COHA (<i>Community onset healthcare associated</i>)	May- June	0	0	0	0	0	0
	Total 2021/22	4	2	1	0	1	0
<i>Cumulative Clostridioides difficile</i> – Cases deemed avoidable / unavoidable following MDT meeting	Total 2021/2 Avoidable	0	0	0	0	0	0
	Total 2021/22 Unavoidable	2	7	1	3	1	2
	Yet to be determined	0					
MRSA Bacteraemia (BHT associated post 48 hours) Post Infection Review will be carried out for all cases identified.	May -June	1	1	0	0	0	0
	Total 2021/22	1	1	0	0	0	0
MSSA Bacteraemia (BHT associated post 48 hours) Those that are BHT associated with devices will have a Root Cause Analysis (RCA) carried out.	May-June	3	2	0	0	0	1
	Total 2021/22	6	3	0	0	0	0
Gram Negative Blood Stream Infections (GNBSI) (BHT associated post 48 hours)	May-June	6	3	1	1	0	1
	Total 2021/22	12	6	1	2	0	3

COVID-19 Cumulative figures

Month	Total No. of Specimens taken from any source	Total No. of Negatives from Specimens taken from any source	Total No. of Specimens not tested	Total No. of Positives from Specimens taken from any source
May	3724	3450	55	219
Jun	5317	5171	56	90
Jul	5110	5054	11	45
Aug	5622	5571	31	20
Sep	7096	6998	59	39
Oct	7354	7194	68	92
Nov	9151	8789	87	275
Dec	9158	7892	291	975
Jan 21	8469	7116	338	1015
Feb	7826	7239	232	355
Mar	7673	7318	244	111
Apr	7725	7499	28	198
May	8167	7962	193	9
Jun	9000	8572	401	27

Month	No. of Specimens from Inpatients (including A&E, CSRU, PDU)	No. of Positives from Inpatients (excluding A&E, CSRU, PDU)	No. of positives from Specimens as PHE definitions: Community = <= 2 days after admission Indeterminate = 3-7 days after admission Probable = 8-14 days after admission Definite = 15 or more days after admission	No. of Inpatient Deaths from patients with positive swabs after 8 days of admission	Total No. of Deaths of inpatients with positive swab taken at anytime (includes previous column no.)
May	2618	48	43, 6, 9, 8	1	20
Jun	2762	17	21, 2, 3, 4	0	5
Jul	3017	12	11, 1, 3, 1	3	6
Aug	3118	10	1, 0, 0, 0	0	3
Sep	3178	3	9, 0, 0, 1	0	1
Oct	3327	6	43, 0, 1, 0	0	1
Nov	4217	54	86, 12, 8, 15	4	19
Dec	4806	270	213, 31, 22, 42	12	64
Jan 21	3941	314	402, 52, 48, 51	19	115
Feb	3482	228	140, 30, 42, 18	11	45
Mar	3630	69	25, 9, 1, 18	1	4
Apr	3812	18	12, 3, 0, 0	0	0
May	4137	2	4, 1, 0, 0	tbc	tbc
Jun	4646	5	9, 0, 0, 0	tbc	tbc

COVID-19

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

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

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

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

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

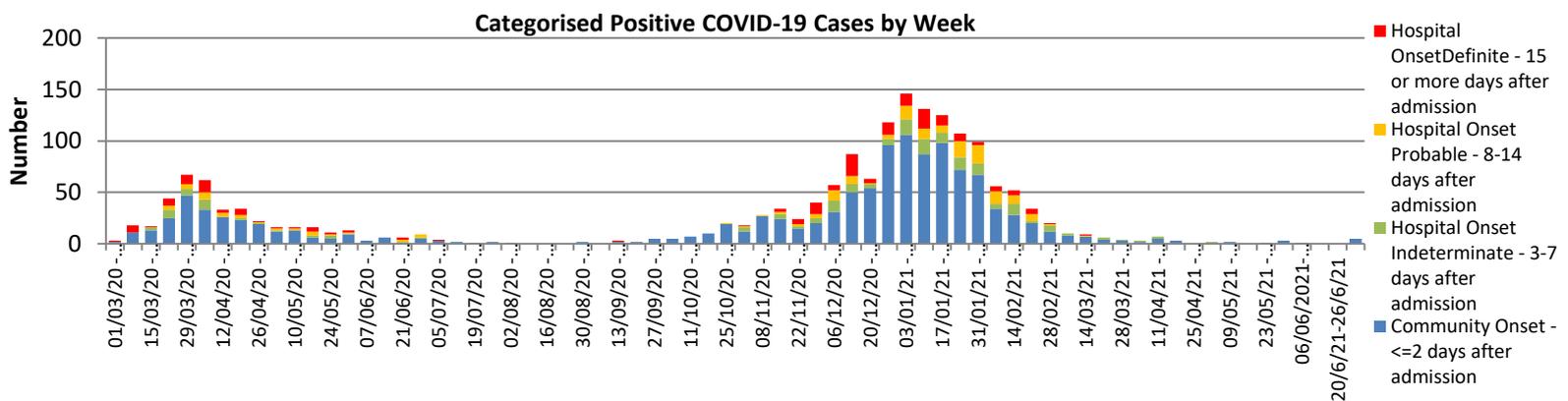
Nosocomial Infections - No. of positives from Specimens as PHE definitions (above)				
Month	Community	Indeterminate	Probable	Definite
May	43	6	9	8
Jun	21	2	3	4
Jul	11	1	3	1
Aug	1	0	0	0
Sep	9	0	0	1
Oct	43	0	1	0
Nov	86	12	8	15
Dec	213	31	22	42
Jan 21	402	52	48	51
Feb	140	30	42	18
Mar	25	9	1	2
Apr	12	3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

The chart below shows the number of COVID-19 positive cases from patients by week as per the definitions above. The Trust is beginning to see an increase in admissions of patients with community onset COVID in line with Wave 3 modelling.

The IPC Team are reviewing all COVID-19 Root Cause Analysis from March 2020 by division with the patient’s multidisciplinary teams scheduled throughout May and June to ensure that the learning is reviewed for each case.

Within the Trust the IPC service supports:

1. The Trust with specialist advice on the placement of patients according to infection risk and low, medium or high risk pathway
2. Implementation of standardised COVID triage tool for all patient admissions and transfers
3. And monitors infection prevention practices such as hand hygiene, PPE compliance and cleaning
4. Share learning from ‘near misses’ and contact tracing exercises with clinical areas and at Site and Silver meetings



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

Learning from MRSA bacteraemia Post Infection Review (PIR)

The PIR was not able to identify a possible source of acquisition of the MRSA bacteremia at BHT. Despite request BHT IPCT have been unable to gain access to the patient medical notes at Peterborough.

Learning was identified. Action plan as been developed.

The patient required insertion of peripheral vascular catheter (PVC) and radial arterial cardiac catheterisation. It was noted that there was learning on the ongoing care of the PVC.

Previous positive status was not documented.

Further audits were required to ensure that IPC is embedded in all practice.

Key learning identified as:

- Education required to ensure all staff, including agency staff, are familiar with both infection prevention and control practices and the ongoing management of PVC at the Trust.
- To review alert tag on Medway for all admissions and take the necessary action as required
- Ensure removal of PVC inserted in AFC after 48hrs.
- Visual Infection Phlebitis (VIP) Score recorded every 12 hrs
- Compliance with PPE guidance was found not to be optimal
- Accurate documentation of IPCT advice in both IPCT and patient notes to be improved
- Review current MRSA guidance to ensure up to date with national guidance for the prevention of Surgical Site.

Learning from C. difficile Root Cause Analysis (RCA)

Key learning identified in the May and June C. difficile Root Cause Analysis multidisciplinary meetings:

- No medical representation for some of the areas at the multidisciplinary meetings, this has been escalated by the Infection Control Doctor
- Delay in isolation due to capacity
- Ensure appropriate stool specimens are processed – patients with loose stool require C difficile testing and microscopy, culture and sensitivity
- Stool chart documentation
- Communication between teams regarding infection status, stool sampling and patient's pattern
- Noted poor compliance with mandatory IPC training
- Need for vigilant use of laxatives and protein pump inhibitors

Action:

IPC Team to review C. difficile section in the IPC Manual, a Trust wide policy is required. Infection Prevention and Control Nurses to work with divisions to include in education sessions.

Learning from COVID Root Cause Analysis (RCA)

- Prompt isolation is required of symptomatic patients until COVID is ruled out – this includes full clinical review of patients and not just negative PCR result –
- Staff to ensure that if infection is suspected to consider positive until ruled out. This applies to all transmissible infections e.g. flu, C Diff, TB
- Adhering to low, medium and high risk pathways
- Follow up of processing of swabs staff to follow up with the laboratory and to speak to IPCT or microbiology
- Delay of laboratory processing samples in one of the RCAs
- Poor compliance with cleaning of equipment
- Poor PPE compliance, noted eye protection and hand hygiene before putting PPE on and after removing PPE
- Increased number of bed moves for patients

Good Practice

- Successful use of Safety Huddle and PPE Champions to share messages and good practices

Actions

- Mandatory and PPE training compliance
- Remind staff all equipment must be cleaned before / after patient use and a I am clean sticker used- spot checks to be undertaken

Bacteraemia Line Infections

Aims & Ambitions

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

		Year Totals	Current Month (May)
Central Line	Avoidable	0	0
	Unavoidable	1	3
	Yet to be discussed	N/A	2
Peripheral Line Infections		0	1
Totals		0	6
	Deemed not line infection		3

Definitions to determine Avoidable / Unavoidable

Avoidable

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

Unavoidable

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

Line Infections Meeting on 8th June 21

7 discussed , 2 scheduled in July

Summary of outcome monitoring notes from meeting:

Blood cultures not paired when infection suspected – To be fed back to clinical teams.
 VIP charts not being completed or monitored in majority of cases.
 Removal of devices if site VIP 2 and oozing.
 Changing needle free devices as recommended – CVAD charts have been updated to clarify this in more detail.
 Appropriate dressings need to be used for TPN patients (CHG) from ITU.
 Possible contamination of blood cultures . Review of all staff accessing devices that have not been trained / supervised. **NW following up with medical educators.**
 Ordering Limbo covers for surgical patients to cover devices.
 ANTT teaching / competency to be reviewed.
 Audits to be conducted on all ward areas to re assess practice.
 Education sessions to be performed to highlight VIP and cannulation importance.

Yearly Comparison Table

		17-18	18-19	19-20	20-21
Central Line	Avoidable	5	3	2	4
	Unavoidable	24	24	7	31
Peripheral Line		3	4	1	4
Totals		32	31	10	39

Bacteraemia Line Infections

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- In some cases, some learning can be identified and followed through, but this does not reasonably correlate to the patient obtaining the episode of line infection under review.

Line Infections Meeting on 8th July 21

4 discussed , 2 from May included

Summary of outcome monitoring notes from meeting:

VIP monitoring/ recording in all cases at home & in hospital & consistency of scoring grade
 Blood cultures not taken in A&E when infection suspected – To be fed back to clinical teams.
 Documentation of each visit for oncology patients required on Evolve Not just electronic VIP chart.
 Line locks and proactive planning within paediatrics.
 Communication of CVC needs of step down ITU patients on TPN.
 Actioning CVC removal quicker when issues identified.
 Hand hygiene to enhanced with all patients.

Actions:

ITU have reviewed glove wearing in DSUITU with IPC.
 Increase hand hygiene awareness .
 Paediatrics have updated all community staff in CVAD care & VIP recording. Line lock protocols to be developed for non onc/haem children.

		Year Totals (excluding current month)	Current Month (June)
Central Line	Avoidable	0	0
	Unavoidable	4	3 (2 from May)
	Yet to be discussed	0	0
Peripheral Line Infections		1	0
Totals		5	3
	Deemed not line infection		4

Yearly Comparison Table

		17-18	18-19	19-20	20-21
Central Line	Avoidable	5	3	2	4
	Unavoidable	24	24	7	31
Peripheral Line		3	4	1	4
Totals		32	31	10	39

In May and June we continued to roll out the newly combined hand hygiene and PPE audits to inpatient areas on Perfect Ward. Outpatient areas are being set up on a manual tool as they do not have access to Perfect Ward.

Compliance with the audit on Perfect Ward is 47% areas (53/112), this is being followed up with the clinical areas

Of the areas who participated, some areas complete the audit multiple times in the month to measure practice

In the audits, improvement is demonstrated; May average score 92%, June average score 98%

594 sequences of care using the World Health Organisation 5 Moments of Hand Hygiene observed during May and June

Rank	Question	Score this month	Score last 12
1	Is hand sanitiser available at the point of care you are observing?	100% (73)	100% (99)
2	Is the right PPE available at the point of care you are observing (i.e. by the bay, by the clinic)?	100% (73)	98% (99)
3	Is the staff member bare below the elbows?	99% (73)	99% (99)
4	Was hand hygiene carried out and correctly during and after doffing (removal) of PPE?	97% (73)	94% (99)
5	Was correct Hand Hygiene carried out before putting on Personal Protective Equipment?	96% (73)	94% (99)
6	Is the PPE correct for the care activity and patient pathway?	96% (73)	94% (99)

Numbers in brackets show number of inspections score is calculated from.

Property Services Cleaning Compliance Report

Property Services encourages wards and departments to support on the following aspects, which has been a challenge or impossible for the domestic team to carry out the touch point cleanings as to the expected standard throughout the Trust.

1. Rusty bin or bins without lids in the clinical areas – Recommendation to replace
2. Signs on the walls and doors – minimised or removed
3. Cardboard boxes stored on the floor – arranged for off floor storing
4. Windows fabric curtains – recommendation replace by window blinds
5. Fabric felt notice boards – Recommend remove and replace wipeable notice boards
6. Toilets and showers with open consumables and patients used linen – Increase removal.

Stoke Mandeville Hospital

Low Compliance

Due to the change (different version) in clinical liner bags supply to the wards, the bins often seen overflowing particularly out of hours. This had mainly impact the cleaning standard ITU, A & E and AMU.

Action- The correct size liner bags have been re-supplied, the standard has been restored.

The severely stained IPS panels identified in Endoscopy.

Action- Sodexo maintenance is currently identified a new technique to repair or replace the IPS panels to re-store in clean condition.

High Compliance

Generally weekly floor machine cleaning and touch points cleaning have seen increased through out the Trust.

The wheelchairs are cleaned after each use and 'I am clean Sticker' is applied. Daily wheelchairs are thoroughly cleaned top to bottom with Tristal, this is seen improvement.

High Wycombe & Amersham Hospitals

Low Compliance

Renal Unit, IPS panel seen low levels of cleaning standard, the cleaning and maintenance contractors are looking into how to improve the standard.

Mortuary and CSSD cleaning standard compromised due to poor building condition.

Works have been arranged to improve the building condition.

High Compliance

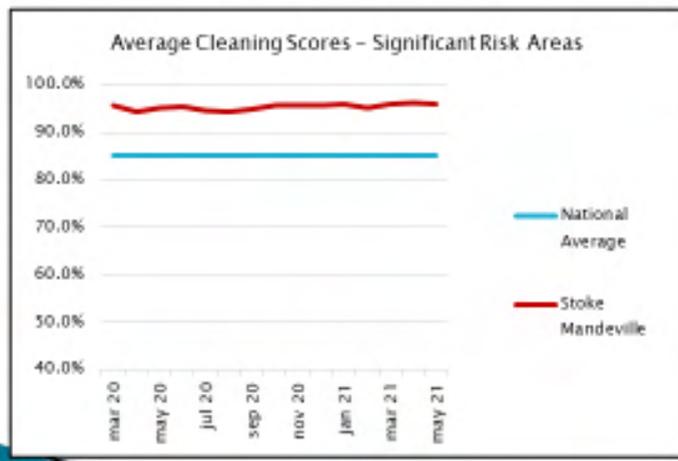
Despite the fabric condition of the building, in many wards in the tower block, the cleaning standard has been maintained to the highest level.

High standard of cleanliness is maintained in Waterside and BNRU.

Infection Prevention & Control Report – May - June 2021

Property Services Cleaning Scores Summary May 2021 (June not available yet)

CLEANING AUDIT SCORE SUMMARY-MAY 2021



Reassurance from Property Services Department
 “The domestic service managers confirmed standards have been restored. The Property Services Monitoring Officer undertake audits of the areas to verify the cleaning standards.”

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IPC Training Figures

Statutory training		Corporate			Integrated Medicine			Surgery & Critical Care			Specialist Services			Integrated Elderly Care			Women, Children & Sexual Health Service			Total		
Training Method		Number of staff required to attend	No. of staff who have attended	Attendance %	Number of staff required to attend	No. of staff who have attended	Attendance %	Number of staff required to attend	No. of staff who have attended	Attendance %	Number of staff required to attend	No. of staff who have attended	Attendance %	Number of staff required to attend	No. of staff who have attended	Attendance %	Number of staff required to attend	No. of staff who have attended	Attendance %	Number of staff required to attend	No. of staff who have attended	Attendance %
IPC (No direct patient contact)	E-learning	572	489	85%	154	106	69%	232	203	88%	172	153	89%	109	97	89%	110	97	88%	1349	1145	85%
IPC (Direct patient contact)	E-learning	141	118	84%	829	660	80%	1041	846	81%	736	605	82%	848	728	86%	716	634	89%	4311	3591	83%
Hand Hygiene (Direct patient contact)	E-learning	152	131	86%	839	714	85%	1045	915	88%	765	714	93%	854	773	91%	718	680	95%	4373	3927	90%

Annual Track of Overall Totals

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
No. of staff required to attend	10029		10033									
No. of staff who have attended	8462		8663									
Attendance %	84%		83%									

Note: Green = improved compliance Red = deteriorated compliance
Comments: There continues to be an increase in compliance however training is below 90%. This is raised at divisional meetings.

Meeting: Trust Board Meeting in Public

28 July 2021

Report from Chair of Quality and Clinical Governance Committee

Date of Committee: 23 June 2021

Key agenda items considered:

Item	Committee assured	Further work	Referral elsewhere for further work	Recommendation to Board
IPR	Yes	Yes Actions for follow-up with reports to this Committee in next 6 months.		Assurance and Continued oversight
Patient Harm, Safety Surveillance and, Safeguarding/vulnerable patients (Monthly), SI Report and Action Tracker	Yes			Assurance and Continued oversight
Cancer Report	Yes	Yes. Patient harm and safety data to be included in future report		Assurance and Continued oversight
Integrated Medicine Division Deep Dive	Yes	Yes Emergency Department issues		Assurance and Continued oversight of Emergency Department Challenges
Quarterly Integrated Safeguarding Report	Yes			Assurance and Continued oversight

DoLs process Audit Report	Yes	Yes Address possible underlying reason for number of DoLs reports not copied to the Safeguarding team which may not be addressed by training and awareness alone		Assurance and Continued oversight
Serious Incident Report including Maternity	Yes			Assurance and Continued oversight
External Reviews		Yes Increase awareness of the External Reviews and actions required across the Trust		Approval and Continued oversight
CQC Quarterly Insight Report Summary	Yes			Assurance and Continued oversight
Maternity Incentive Scheme (CNST)	Yes			Approval
SEDIT Quality Report	No	Yes	Physical space, Teamwork and staffing	Further discussion at Board level as to actions planned to address

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

Meeting: Trust Board Meeting in Public

28 July 2021

Agenda item	Learning from Deaths – Medical Examiner report 2020/21
Board Lead	Chief Medical Officer
Type name of author	Dr Helen Pegrum & Binila Thomas
Attachments	Learning from deaths paper & Presentation on End of Life
Purpose	Information
Previously considered	EMC 6 th July 2021, Q&CG 21 st July 21

Executive Summary

1. Update on Medical Examiner and Learning from Deaths Programme in BHT
2. Quality indicators for BHT
3. Regional and National involvement of service
4. Impact of Covid 19
5. End of Life care in line with national guidance and CQC report of May 2021

Decision	For information
Relevant strategic priority	
Quality <input checked="" type="checkbox"/>	People <input checked="" type="checkbox"/> Money <input checked="" type="checkbox"/>
Implications / Impact	
Patient Safety	Medical examiner service supports learning from deaths and dissemination of learning across the Trust
Risk: link to Board Assurance Framework (BAF)/Risk Register	This program supports mortality reduction
Financial	External income from National Medical Examiners Office provides funding for the local service
Compliance Select an item. Select CQC standard from list.	National requirement
Partnership: consultation / communication	Partnership with Medical Examiner offices across BOB-ICS.
Equality	The ME office collects mortality data for the Trust. This has not currently been analysed but is submitted and will be brought forward in future reports. The ME office supports the expediting of reporting for religious groups when requested.
Quality Impact Assessment [QIA] completion required?	Not required

Learning from Deaths report 2020-2021

Improving safety through quality improvement and Cultural change

Background

The Medical Examiner (ME) Service was adopted in Buckinghamshire Healthcare Trust (BHT) during 2017. The MEs are employed by the NHS with a separate line of professional accountability. Their independence is overseen by the National Medical Examiner, Dr Alan Fletcher and Regional Medical Examiners. Dr. Zoe Hemsley leads the South East of England. This team provides leadership, support and guidance for the development of the system.

In BHT, the MEs are screening all deaths within the Trust including the Community Hospitals. In March 2021, we have started the community roll out of ME service, by screening all deaths from the Florence Nightingale Hospice. We are currently in discussions with the GP representatives and Bucks CCG to further the ME role out into non acute settings.

The BHT Medical Examiner service integrates with the Trust's learning from death programme to improve patient safety through quality improvement. The BHT Lead ME, Dr Helen Pegrum, is the clinical lead for regional AHSN mortality group. The trust is working closely with other trusts and the regional mortality review groups.

Training and Support

The Royal College of Pathologists (RCP) have implemented the mandatory e-learning in addition to all Medical Examiners attending face to face training. All BHT MEs and MEO have completed this face to face training.

The RCP have implemented training for the Medical Examiner Officer (MEO) nationally. Our MEO is facilitating these training sessions approximately 3-4 sessions a year.

The national database system has not progressed significantly, and we are waiting for more information. The Datix platform used for Structured Judgmental Review was phased out since January 2021. Currently the SJR reviewers are using an Excel template to record the review. We are in the process of acquiring a new database for the MEs service.

Funding for the ME service is provided by the NHS England and NHS Improvement on behalf of Health and Social Care. ME office provide quarterly activity reports to NHSE&I as part of the funding process.

Role of Medical Examiner

Medical Examiner's role is to provide safeguard to the public by scrutinising the deaths within the Trust. They ensure accuracy in death certification and refer the right cases to the coroner as applicable. Medical Examiner also contact the next of kin during the screening process to discuss the cause of death and provide the bereaving family an opportunity for raising any concerns in care they observed during their visits. This also provides them an opportunity to report excellence in care.

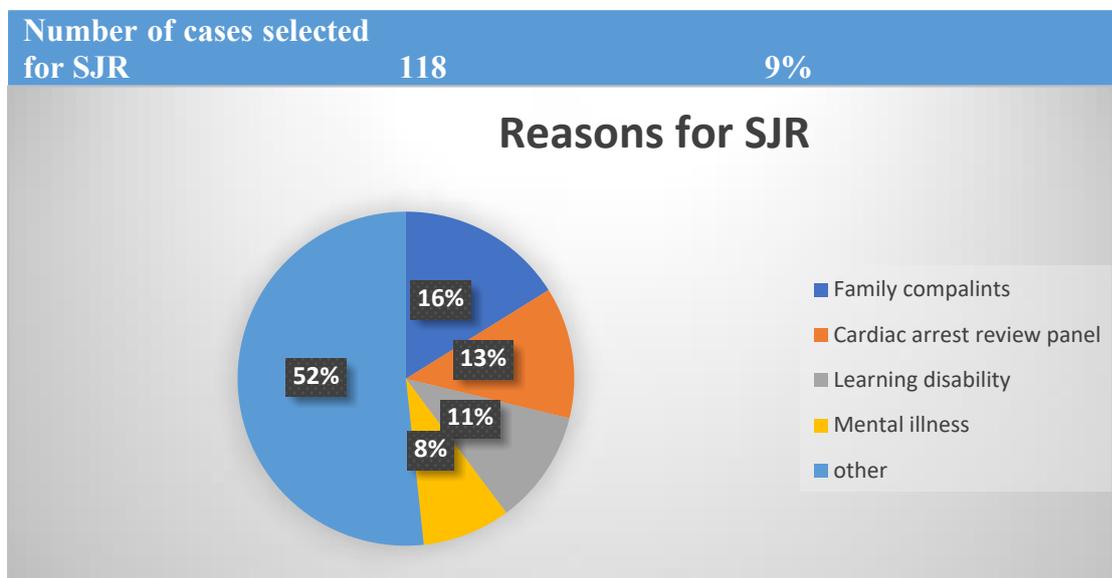
Results

- 1312 deaths in BHT between April 2020 and March 2021
- 100% compliance with all Medical examiner screening for Adult Deaths in BHT
- 118 cases selected for further review as an SJR
- 6 SIs declared following the SJR review.
- 71 % SJR completed with care rating given.

Mortality Data April 2020-March 2021

Excellence reporting	108	8.23%
Family Compliments	448	34%
No care problems identified	1221	93%
SI investigations	6	0.45%
No of families ME spoken	1045	71.6%

SJR Data April 2020 to March 2021



Other Themes leading to SJR

- Problems in communication
- Unsafe discharge/ readmission within 72 hours

- Concerns in care provided
- Delay in treatment
- Treatment omissions
- End of life care timelines
- Concerns raised by staff

SJR Review outcomes

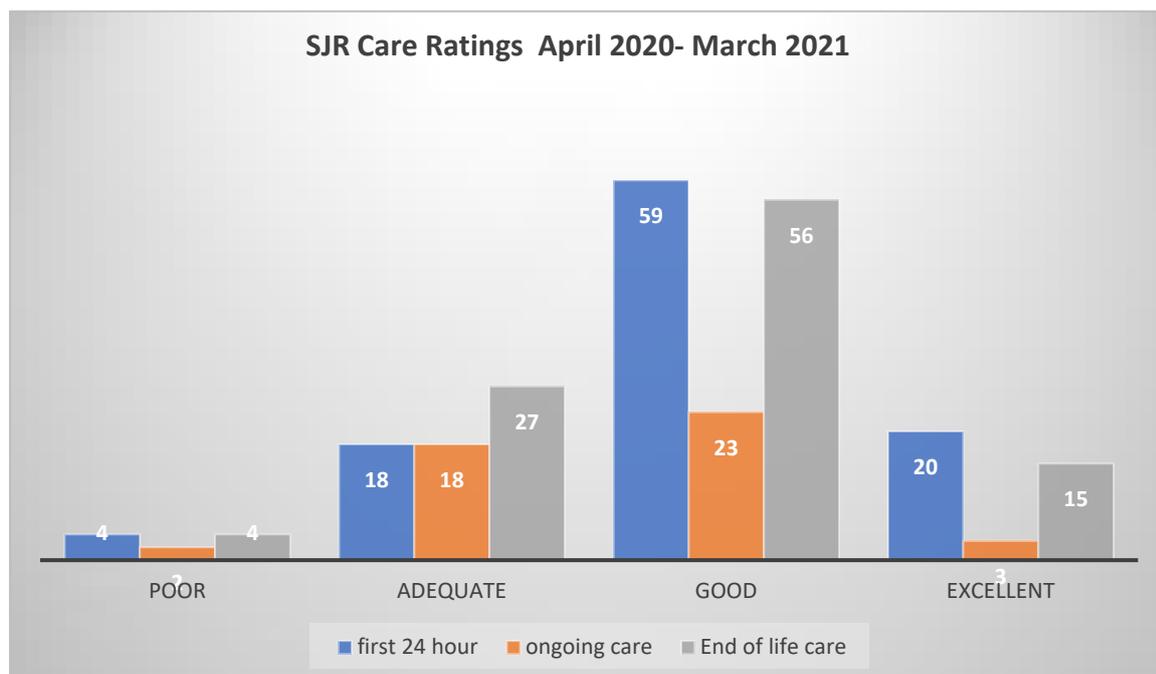
Recurrent Themes identified

- Multiple ward moves
- Delayed initiation of end of life care
- Poor discharge assessments
- Poor documentation

Care rating from SJRs April 2020-March 2021

Good or excellent care	34	29%
No problems in care	24	20%
Problems in care very unlikely to have contributed to death	19	16%
Problems in care unlikely to have contributed to death	3	3%
Problems in care more likely than not to have contributed to death	4	3.4%
Outstanding SJRs	34	29%

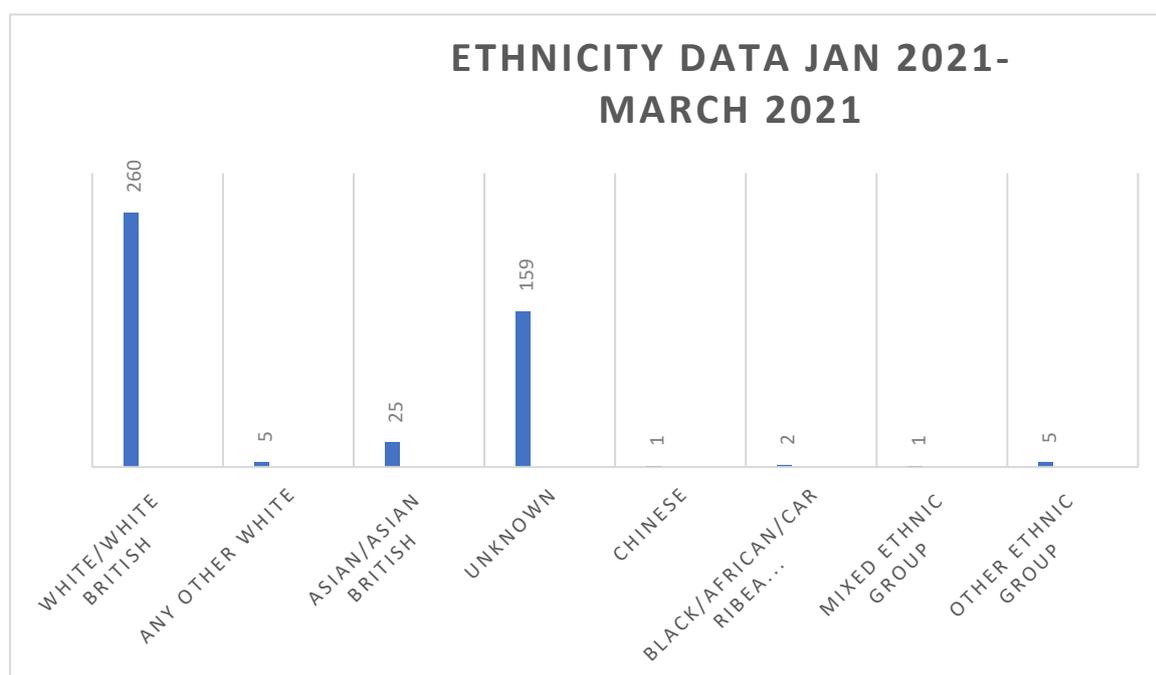
Care Rating



Equality and Diversity

We have a diverse work group within the ME service. Equality and Diversity Policy is embedded within the ME service and look after all persons without regard to age, ethnic or national origin, gender or sexual orientation, religion, or disability. We review patients care provided in the trust to ensure there are no inequalities in provision of care. BHT ME service supports timely arrangements for the bereaved families including faith communities to expediate burial within 24 hours. Medical Examiner service in BHT provides service Monday to Friday. However, a new pathway to expediate the registration of Out of Hour faith deaths is in place to ensure the family wishes are met wherever possible.

Ethnicity Data



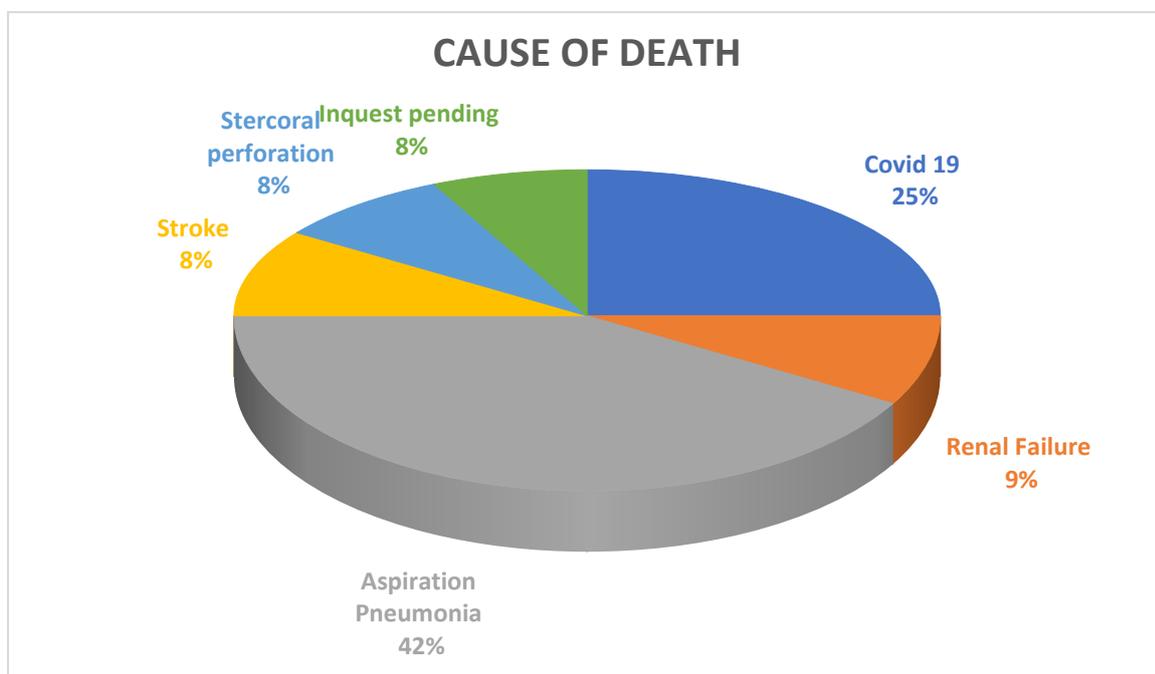
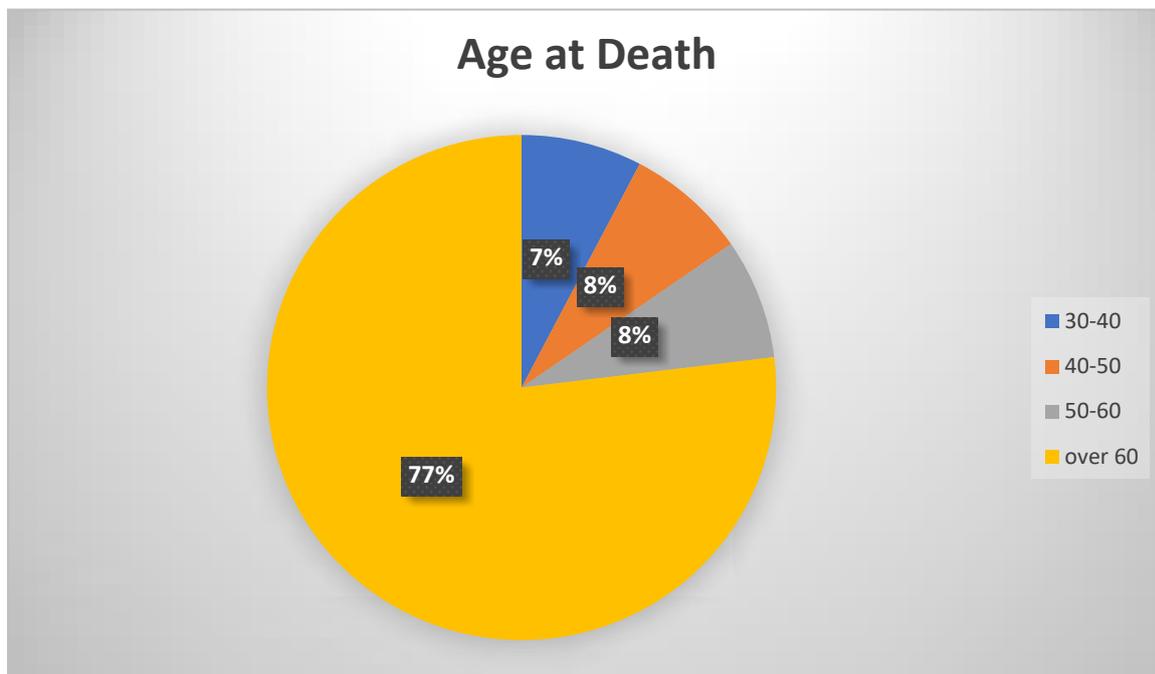
LeDeR Report

All learning disability deaths within the trust undergo ME screening process and a mandatory SJR by the department patient was cared in. A review by learning disability nurses will follow the SJR and action plan is developed if any problems in care is identified. Our Trust works closely with the BUCKS CCG LeDeR programme lead for shared learning and service improvements. The new LeDeR policy for ICS was published in March 2021 and will encompass patients with Autism, a mandatory focussed review of death of people from BAME community and of people diagnosed with Autism. To improve the discharge planning and to avoid distress to the families, LD nurses liaise with the wards and provide support. An LD patient passport is being trialled to assist the transfer of information to and from the hospital.

LeDeR Demographics

- Total LD deaths in the trust between April 2020-March 2021 is 13.
- Most patients (77%) died over the national average age for LD deaths of 59.

- 46% of patients died of Aspiration Pneumonia.

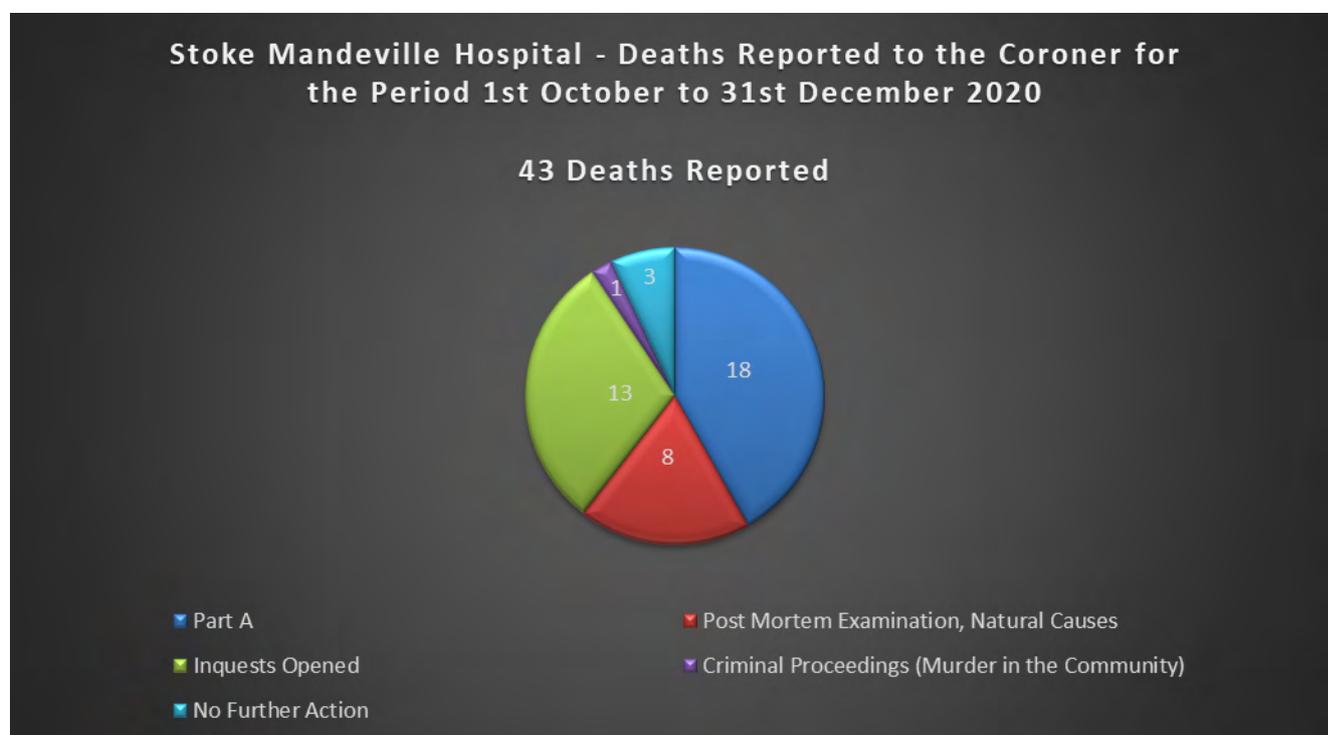


Florence Nightingale Hospice March 2021 data

No. of deaths	18
SJR selected	0
No problems in care	5
Good or excellent care	13
Family compliments	13
Excellence report	1
SI	0

Coroner and the ME service

ME service and the coroners have established a very good working relationship. We have regular meetings to discuss issues relating to the referrals, government updates and annual updates. We met up in May 2021 and the next meeting will be in October 2021. The coroners have noted an increase in the accuracy of the referrals due to the involvement of the MEs in completing the MCCD.



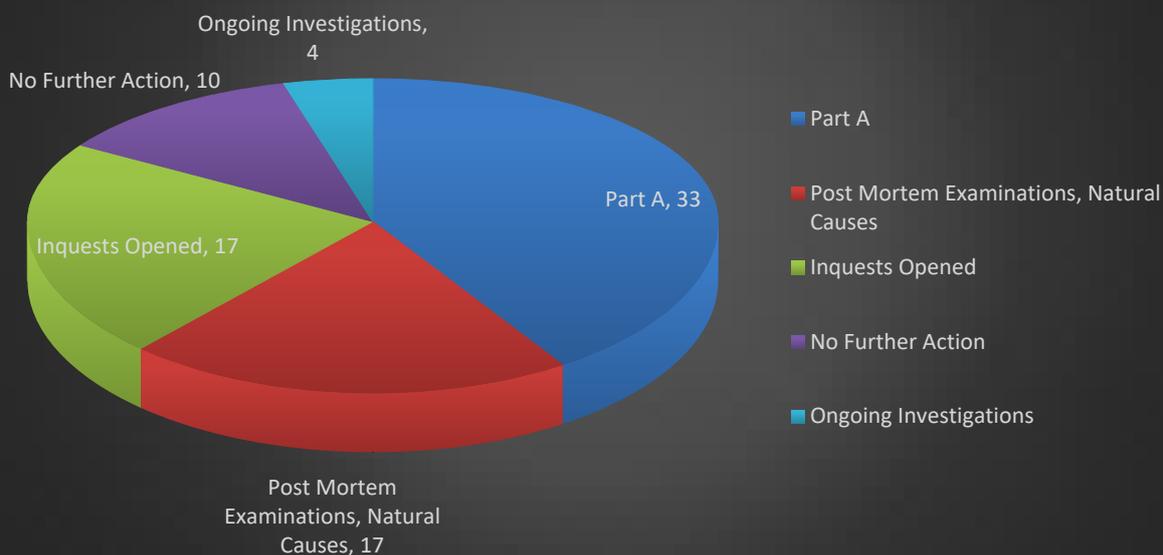
Wycombe Hospital - Deaths Reported to the Coroner for the Period 1st October to 31st December 2020

17 Deaths Reported



- Part A
- Post Mortem Examinations, Natural Causes
- Inquests Opened
- Ongoing Investigations
- No Further Action

Deaths Reported to the Coroner for Period 1st January to 31st March 2021, Stoke Mandeville Hospital
82 Deaths Reported



Deaths Reported to the Coroner for the Period 1st January to 31st March 2021 from Wycombe Hospital 17 Deaths Reported



Dissemination of learning

- Quarterly meetings continue to take place on Teams with Coroner, Registrar and local authority.
- Regular meeting between MEs and Coroner, last one in May 2021 on Teams.
- Case studies of learning from death is presented in Mortality reduction Group meetings, Divisional meetings and lessons learnt sessions on academic half day.
- All SJRs are discussed in the SDU meetings and an action plan is developed. The learning from SJRs are disseminated within the SDU and divisionally as applicable.
- Regular meetings are conducted with the learning disability nurses, LeDeR programme Regional Lead and Lead Nurse for Mortality Review. Ideas, suggestions and learnings are shared in these meetings.
- We liaise with the Mental Health Liaison Nurse for a second review on the SJR conducted divisionally for further learning.
- Quarterly meetings are being held by regional Academic Health Science Network for shared learning and support.

Service updates

- **COVID 19**
 - Changes have been implemented across ME service and bereavement services.
 - ME phone calls with the relatives are lengthier as lots more explanations are needed for the
 - Coronavirus Act 2020 was implemented in response to the Pandemic.
 - Death registration process is online now.
 - MEs are no longer needed to view the body or complete the cremation form

- Increased number of deaths in January (45%) and February (79%) 2021 compared to same time in 2020 due to the pandemic.
- One ME has resigned from the post due to clinical commitments. These sessions will be covered by one of our existing MEs.
- All relatives are offered call from the Bereavement support service.
- New Mortality review lead nurse in post since January 2021.
- SJR compliance was poor in the last year due to the clinicians being busy during the pandemic.
- Clinical Governance Leads are notified of all outstanding SJRs and have made a real progress in the last two months.

Future challenges

- The national guidance is to roll out the ME service to the community by April 2022.
- In anticipation to the community roll out, we have received guidance on recruiting and funding from the NHSE & I.
- In 2021/2022 the Trust is expected to expand the non-cute Trust deaths scrutiny up to 90%.
- Our ME office will require the capacity to provide scrutiny for approximately 3658 deaths.
- We will be recruiting the MEs and the MEOs in response to the national guidance and the Trust plans to work in line with the national model of the ME system in the community roll out.
- We will be meeting up with the CCG and GP colleagues to discuss the roll out process.
- We will need a new digital system/ Database for our ME service to collect, collate and analyse the data in a more efficient way.

DNACPR — review for CQC

Overview

1. DNACPR Policy Framework
2. CQC Review 2020
3. Advanced Care Planning – Use of Treatment Escalation Plans
4. Training
5. Mental capacity approach
6. Shaping the future for End of Life Care

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DNA CPR Policy

- Developed at BHT in 2010 following approach lead by South Central Network
- Patient centred approach
- Aim to prevent undignified and inappropriate resuscitation for patients and families
- Decision once discussed follows patient across healthcare settings
- Decision may be indefinite or reviewed if clinical condition changes
- Patients and families should be involved but in Bucks a medical decision is required

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DNACPR – CQC Review 2020

- Concerns regarding blanket application of DNACPR decisions
- Role of person-centred care in decision making
- Questions as to whether inappropriate DNACPRs may remain in place
- Decisions should be based on
 - Clinical judgement
 - Free from discrimination
 - In line with Equality Act 2010
 - Objective
 - Legal duty to inform a patient with mental capacity that DNACPR in place

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Advanced Care Planning

- Treatment Escalation Plans
 - Broader approach to advance care planning
 - Pre-empt deterioration and ensure wide discussions
 - Frailty scores (Rockwood) guide but do not rule decisions
- TEP guidance in place in BHT since..... Aligned to concepts in the ReSPECT process
- TEP linked to Community - Aligned to Summary Care Records and Patient Wishes – particularly important to Nursing and Residential Homes and those at home with known Long Term Conditions
- Discharge to Assess process

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Covid – System Approach

- Collaborative working group GPs, CCG, Palliative Care, Medicine for Older People, Safeguarding, ICU Medicine
- “Care of frail individuals Guidance Notes”
- Considered points of contact with patients and best approach to system wide care
- Linked with SCAS and Summary Care Record
- Often ensuring advanced care decisions already made were documented fully and visible to all agencies

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Covid System Approach

- Primary Care
 - Consider frailty patients
 - Review individuals and assess frailty score
 - Ensure TEPs in place where appropriate
 - LD – specific guidance not to use CFS or “blanket” apply DNACPR in this group
- Care Homes
 - Letter sent by CCG to advise re project
 - Medicines Optimisation Team involved
 - Use of RESTORE 2 to manage the deteriorating NH/RH resident
 - Exercise to capture pre-existing TEPs / DNACPR
- Support telephone line provided by MfOP
- Palliative Care support put in place

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Training in End of Life Care

- Medical
 - Induction training in EoL for all doctors run by palliative care team
 - Covers DNA CPR process and policy
 - Dementia training covers decision specific skills
 - MDT Simulation Suite – training on managing uncertainty and EOL care
- Nursing
 - Dementia and frailty training discusses Power of Attorney and role of family
 - Mandatory EOL module for nursing staff from Dec 2020 (78% compliance Mar 20)
- Ward based
 - Board Rounds discuss EOL needs
 - Palliative care teaching on wards
- System
 - Paramedic education delivered by palliative care team
 - FedBucks GPs and ANPs annual education + new staff training

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Mental Capacity Issues

- Stage 1 – Is there a temporary or disturbance of the brain that stops the person making this decision
- Stage 2 - if yes to above and decision needs making can the person understand, retain, weigh up and communicate decision?
- All decisions based on does it have to be made today.
- If acting in Best Interests then find out as much as possible about previous decisions and wishes and rationales.
- Check and balance against training decisions
- Use of Ethics Committee for specific cases

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DNACPR Audit

- Annual audit of compliance with policy
- Results - from February 2020
 - Audit of all DNACPR forms and clinical notes on a single day in BHT
 - 190 forms
 - 35% completed PRIOR to index admission – followed patient
 - 85% had a Treatment Escalation Plan (TEP) in place
 - 50% of patients subsequently discharged – indicating timely use of DNACPR
- Points for Improvement
 - Need to improve conversations with patients and families
 - Complaints: 5 in 2019, 8 in 2020
 - Review dates – only there in 20%
- Repeat audit 9/3/2021

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Any questions?

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Meeting: Trust Board Meeting in Public

28 July 2021

Agenda item	2021/22 Month 3 Finance Report
Board Lead	Barry Jenkins, Chief Financial Officer
Type name of Author	Aneel Pattni, Deputy Chief Financial Officer
Attachments	Month 3 Finance Committee Report
Purpose	Assurance
Previously considered	EMC, F&BPC

Executive Summary

- 2021/22 I&E month 3 year to date (YTD) headline position of break even** in line with the provisional annual budget agreed by Board in April 2021. This is supported by £16.1m of non-recurrent Block top-up, Covid-19 income and Elective Recovery funding, this income has been accrued based on the latest guidance from NHSE/I.
- Reported position year to date includes £1.5m of Covid-19 related incremental expenditure and £6.3m Covid-19 income.** Covid-19 expenditure has fallen to £0.3m in month 3, down from £0.4m in month 2.
- Full year forecast of £22.3m deficit in line with plan.** The plan and forecast includes H1 income and expenditure related to the delivery of additional activity that would qualify for Elective Recovery Funding (ERF). The H1 ERF income forecast of £11m has not been updated to reflect guidance issued by NHSE/I on 9th July, which indicates that the activity threshold will be increased from 85% to 95% with effect from 1st July 2021. This is expected to reduce ERF income in H1. NHSE/I is planning to release financial guidance for H2 in September 2021. This is a draft full year plan and it remains subject to final review and approval by the Board.
- Capital, Balance Sheet and Cash Flow** analysis are not included in the report due to the team focussing on completing the year end audit.

Decision The Board is requested to NOTE the paper.

Relevant Strategic Priority

Quality <input type="checkbox"/>	People <input type="checkbox"/>	Money <input checked="" type="checkbox"/>
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Implications / Impact

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

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

Safe & compassionate care,

every time

Finance Report Month 3 - 30th June, 2021

Contents

Page 3	Financial performance
Page 4	Key Highlights: Income
Page 5	Key Highlights: Expenditure (Pay & Workforce)
Page 6	Key Highlights: Expenditure (Non Pay)
Page 7	Divisional Position
Page 8	Glossary and Definitions

Financial performance

Table 1 - Income and expenditure summary

(£m)	In Mth Plan	In Mth Actuals	In Mth Variance	YTD Mth Plan	YTD Actuals	YTD Variance	Annual Plan	Forecast
Contract Income	46.2	42.8	(3.4)	127.6	126.4	(1.2)	477.3	477.3
Other income	2.3	1.9	(0.5)	7.0	6.3	(0.7)	27.9	27.9
Total income	48.5	44.6	(3.9)	134.6	132.7	(1.9)	505.2	505.2
Pay	(25.8)	(26.5)	(0.7)	(75.2)	(80.1)	(4.9)	(298.7)	(298.7)
Non-pay	(19.3)	(15.3)	3.9	(49.1)	(44.2)	4.9	(187.6)	(187.6)
Total operating expenditure	(45.1)	(41.8)	3.3	(124.3)	(124.3)	0.0	(486.3)	(486.3)
EBITDA	3.4	2.8	(0.6)	10.3	8.4	(1.9)	19.0	19.0
Non Operating Expenditure	(3.4)	(2.8)	0.6	(10.3)	(8.4)	1.9	(41.3)	(41.3)
Retained Surplus / (Deficit)	(0.0)	(0.0)	(0.0)	0.0	0.0	0.0	(22.3)	(22.3)
Non Recurrent I&E	(5.4)	(5.4)	0.0	(16.1)	(16.1)	0.0	(48.3)	(48.3)
Normalised I&E Surplus / (Deficit)	(5.4)	(5.4)	(0.0)	(16.1)	(16.1)	0.0	(70.6)	(70.6)

Executive Summary

- The Trust reports a break-even position year to date (YTD) in line with plan.

- The plan used in this report is based on NHSE/I planning guidance issued at the end of March 2021 which covers guidance for the first six months of the year (referred to as H1). NHSE/I has issued providers with pre-populated plans for H1 based on a continuation of the emergency financial regime. In calculating the Trust's income and expenditure, NHSE/I has applied a simple high level methodology of Q3 (2020/21) multiplied by 2. The ICS has confirmed the H1 settlement includes Covid-19 funding of £12.4m. NHSE/I's expectation is that this funding settlement will allow the ICS, commissioners and providers to deliver break even for this period. The plan for the second half of the year currently (referred to as H2) indicates a £22.3m deficit. The H2 plan is subject to final approval by the Trust Board and agreement with BOB ICS and NHSE/I.

- The plan has been adjusted this month to reflect income and expenditure relating to Elective Recovery Fund (ERF) activity totalling £11m. The YTD position assumes £5.8m income relating to ERF monies.

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

- Covid-19 expenditure totals £0.3m in month 3, £1.5m YTD and is reported within the overall expenditure position for this financial year at divisional level. Income to cover Covid-19 expenditure is assumed to be within the block values received and is reported within contract income in the table opposite.

- YTD pay costs total £80.1m, £4.9m adverse to plan. Key drivers of this adverse position include medical staffing spend and shortfalls in CIP delivery due to the plan being phased equally across the year. Further details are provided on page 5.

- YTD non-pay costs total £44.2m, £4.9m favourable to plan. Key drivers of this underspend include drugs and clinical supply expenditure being lower than plan. Further details are provided on page 6.

- The non-recurrent I&E adjustment removes the benefit of H1 Block income top-up, Covid-19, ERF funding receivable from NHSE/I and Bucks CCG and other non-recurrent items. This would result in an underlying normalised deficit of £70.6m for the full year.

Key Highlights: Income

NHS Income and Activity

• YTD Contract Income at month 3 totalling £126.4m is £1.3m adverse to plan (Table 2).

• The contract income position includes the NHSE/I top-up funding settlement which provides £32.3m of top-up income for H1, including £12.4m of Covid-19 funding. This non recurrent top-up income totals £5.4m per month and is given with the expectation that the Trust will breakeven in H1.

• The contract income plan has been amended this month to include Elective recovery plan (ERF) income totalling £11m in H1 (with a corresponding entry in expenditure). This is in line with the revised operating plan submitted to NHSE/I in June 2021. Based on activity information, the YTD position includes £5.8m of this income. The key points of the guidance relating to ERF monies are summarised below:

- Elective Recovery Fund will be made at system level. Systems will be paid through the ERF for activity delivered above nationally set thresholds as compared to 2019/20 activity levels which will be an aggregate of inpatient and outpatient activity delivered by both NHS and IS providers and will include both CCG and Specialised Activity. The threshold level is set against a baseline value of applicable elective activity delivered in 2019/20, allowing for available funding, workforce recovery and negative productivity impacts of the pandemic through 2021/22. For April, 2021 it is set at 70%, rising by 5 percentage points in subsequent months to 85% from July. At the time of writing, informal briefings from NHSE/I have indicated an increase this threshold to 95% from July. This would have the effect of reducing potential ERF income in Q2. The Trust forecast for H1 and full year does not currently reflect this potential reduction.

- In addition, systems will also need to demonstrate they have met five elective recover 'gateways'. The five gateways are:

1. Clinical validation, waiting list and long waits
2. Addressing health inequalities
3. Transforming outpatients
4. System-led recovery
5. People recovery

- Assessment of the gateways will be monthly and ERF payment transaction will be monthly rather than cumulatively to provide a continued incentive for systems that do not achieve the baseline in the early part of the year.

- Once gateway assessment has taken place, the review of nationally set activity thresholds will take place after final activity information is available after the availability of SUS flex and freeze data. Payments will then be made to the lead CCG in the CS. These timeframes therefore indicate that payment to the lead CCG will not be until 3 months after the month that the ERF payment is requested. At the time of writing, NHSE/I has not provided confirmation of the Trust's month 1 ERF income, this has been delayed pending the potential threshold changes in Q2.

• The Statistical Process Control Chart (Graph 1) for Contract Income shows income is above the mean average throughout the 2020-21 financial year and month 1 for the new financial year. The reduction in contract income from October through to December 2019 relates to the agreed return of ICS Risk Allocation funding to Bucks CCG (£1.5m per month) and in January 2020 relates to the provision for bad debts including Spinal delayed discharges. The increase in December 2020 income relates to the one off benefit to the position following the settlement of the 2019/20 contracts position. The February 2021 position includes £2.6m additional monies received from NHSE/I relating to funding support for lost income during the Covid-19 pandemic and the March 2021 position includes further income received to cover income lost during the Covid-19 pandemic totalling £2.8m. The May 2021 position includes ERF income totalling £3.4m and for June £2.4m bringing the total ERF income reported in the YTD position to £5.8m as noted above.

Table 2 - Breakdown of Contract Income

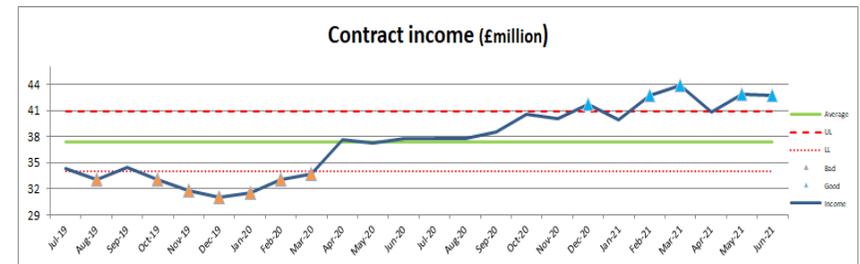
Commissioner	Budget M1-6	Budget M7-12	Annual Budget Total 2021-22	YTD Budget	YTD Actuals	YTD Variance
Bucks CCG	142.6	142.6	285.2	71.3	71.4	0.1
Other NHS	18.0	18.0	36.0	9.0	9.0	0.0
Specialist Commissioners	37.1	37.1	74.2	18.5	18.4	-0.1
Other Income	3.4	3.3	6.7	1.7	0.5	-1.2
Bucks Council	6.9	6.9	13.8	3.5	3.5	0.0
Top up	19.7	10.0	29.7	9.9	9.9	0.0
Covid funding	12.4	0.0	12.4	6.2	6.2	0.0
Growth & SDF	4.1	4.1	8.2	2.1	1.7	-0.4
ERF	11.0	0.0	11.0	5.5	5.8	0.3
Total	255.3	222.0	477.3	127.7	126.4	-1.3

Other Income

Table 3 - Breakdown of other income

Category (£m)	Annual Budget	YTD Budget	YTD Actuals	YTD Variance
Research	1.2	0.3	0.3	0.0
Education And Training	9.4	2.3	2.6	0.2
Non-NHS PPS & Overseas Visitors	2.7	0.7	0.7	(0.0)
Injury cost recovery scheme	1.2	0.3	0.1	(0.2)
Donated Asset Income	1.0	0.2	0.0	(0.2)
Other Income	12.4	3.1	2.7	(0.4)
Total	27.9	7.0	6.3	(0.7)

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



• Other Income (Table 3) is £0.7m adverse to plan YTD.

• Private Patient and Overseas work is in line with plan YTD totalling £0.7m.

• Donated Asset Income reports a £0.2m adverse variance. This variance however is removed when calculating the bottom line financial position as the full impact of donated asset income and depreciation is removed when calculating the final position.

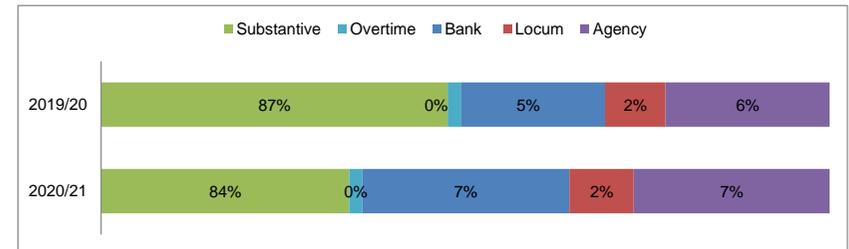
• Education and Training income is £0.2m favourable to plan however additional expenditure has been incurred to match this.

Key Highlights: Expenditure (Pay & Workforce)

Table 4 - YTD pay position

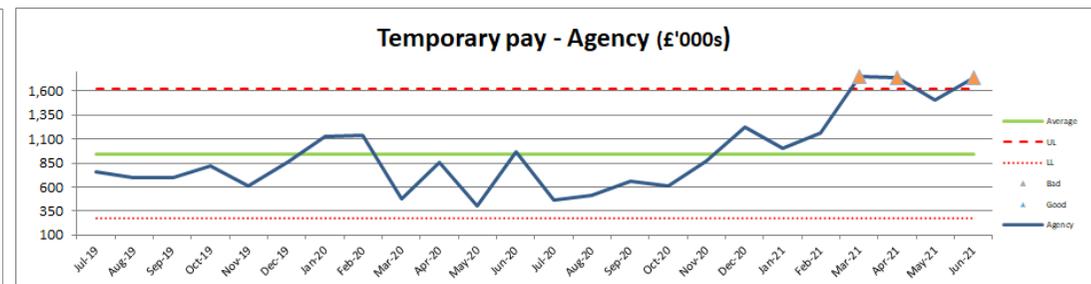
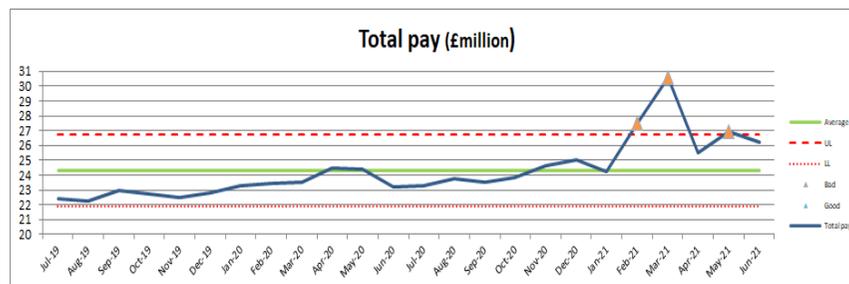
Pay category (£m)	YTD Spend *	% of Total Pay Bill	Last Year YTD Spend	Last Year % of Total Pay Bill
Substantive	66.9	84%	66.4	87%
Overtime	0.4	0%	0.4	0%
Bank	5.7	7%	3.8	5%
Locum	1.8	2%	1.6	2%
Agency	5.4	7%	4.3	6%
Total	80.1	100%	76.4	100%

Graph 2 - YTD pay position



- Pay expenditure totals £80.1m year to date (YTD), £4.9m adverse to plan. The pay position includes £1.5m expenditure associated with managing Covid-19.
- Temporary staffing expenditure (Bank, Agency & locum) totals £12.9m YTD, a large proportion of which is offset by underspends against substantive budgets totalling £9.5m. Agency expenditure totals £5.4m YTD, £1.7m in month with key usage areas including Emergency Medicine, IT, Radiology, Medicine for Older People, Acute Medical wards and managing Covid-19. The vacancy control panel (VCP) will undertake analysis and support divisions with deep dives to review areas of agency spend.
- The pay efficiency target totals £2.2m YTD. This target will be applied to individual budget lines once final plans are identified and processed.
- 2020-21 year end provisions for the Flowers Legal Case, working time directive payments, annual leave not taken in 2020-21 and BHT Thrive associated expenditure continue to be held in the balance sheet position at month 3 and will be released to match spend as and when this comes through. Provisions for sickness cover and estimated new year A4C pay awards are also held within the 2021-22 YTD position totalling £2.0m.
- The Pay Statistical Process Control Charts are detailed below (Graph 4). Key highlights include:
 - The increase in total pay in September 2019 relates to the Medical Staff Pay Award.
 - The increase in total pay spend in April 2020 relates to the 2020-21 Agenda for change pay award (£0.7m) and CEA award payments to medical staff (£0.5m).
 - The increase in total pay costs in February 2021, relate to provisions for the Flowers Legal case, unsocial hours claims and payment of consultant CEA awards.
 - The increase in total pay costs in March 2021 includes payment of the bank winter incentive payments and pay related provisions as noted above.
 - The increase in total pay costs in May 2021 relates to the provisions for sickness cover and A4C estimated pay aware increases.
 - The reduction in agency costs in March 2020 relate to the capitalisation of IT agency costs relating to the HSLI Capital IT project.
 - The reduction in agency costs in July 2020 relate to a number of backdated agency shifts being identified as relating to the Covid-19 pandemic.
 - The increase in agency costs from November to December 2020 relates to sickness cover and Christmas holiday cover.
 - The increase in agency costs from January 2021 onwards relates to management of the latest wave of the covid -19 pandemic in addition to high usage in the areas noted above.

Graph 3 - Pay Statistical Process Control (SPC) Charts



Key Highlights: Expenditure (Non Pay)

Table 5 - YTD non-pay position

Non-Pay category (£m)	Annual Budget	YTD Budget	YTD Actuals	YTD Variance
Drugs	48.3	12.1	11.1	1.0
Clinical supplies	36.7	9.2	7.9	1.3
Other non-pay	102.7	27.8	25.2	2.6
Total Expenditure	187.6	49.1	44.2	4.9

- Non-pay expenditure totals £44.2m year to date (YTD), £4.9m favourable to plan.

- Although continuing to increase, activity levels being below normal following the covid-19 pandemic is the key driver in this underspend with expenditure on clinical supplies reporting a £1.3m favourable variance against plan and drugs a £1.0m favourable variance against plan.

- The non pay efficiency target totals £1.3m YTD. This target will be applied to individual budget lines once final plans are identified and processed.

Table 6 - YTD drugs position

Drug Categories (£m)	Annual Budget	YTD Budget	YTD Actuals	YTD Variance
PBR Drugs	9.7	2.4	2.6	(0.2)
PBR excluded Drugs	36.8	9.2	8.1	1.1
Other Drug Items	1.8	0.4	0.4	0.1
Total expenditure	48.3	12.1	11.1	1.0

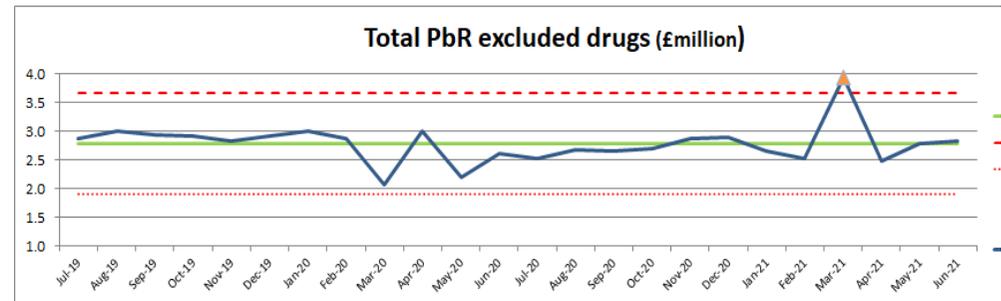
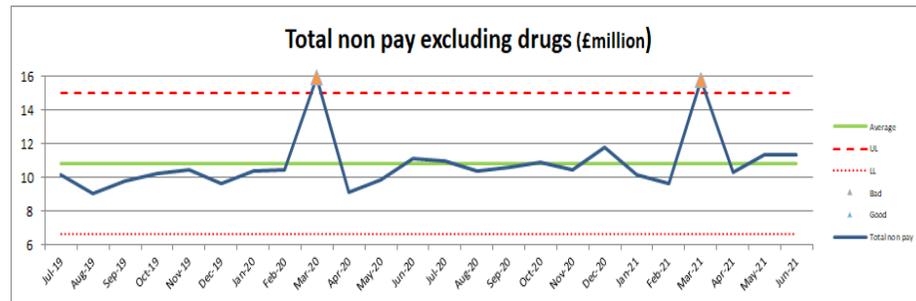
- Drugs expenditure totals £11.1m YTD, a £1.0m favourable variance to plan. PBR drugs report a £0.2m overspend YTD and PBR excluded drugs, a £1.1m favourable position to plan.

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

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

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

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



Divisional Position

Breakdown of financial position by division

Table 7 - Divisional income and expenditure

Division / (£m)	YTD Variance against Plan	Outturn Plan	Finance YTD Sector Rating	Current Month Run Rate		
				M01	M02	M03
Integrated Medicine	(0.6)	(85.5)	3	(7.2)	(7.5)	(7.4)
Integrated Elderly Care	(0.5)	(41.5)	3	(3.5)	(3.6)	(3.5)
Surgery And Critical Care	(0.5)	(100.7)	3	(8.1)	(9.2)	(8.8)
Women and Children	(0.2)	(44.7)	3	(3.7)	(3.8)	(3.8)
Specialist Services	0.5	(78.3)	3	(6.2)	(6.6)	(6.3)
Total Clinical Divisions	(1.4)	(350.7)		(28.7)	(30.8)	(29.9)
Chief Executive	0.2	(3.8)	3	(0.2)	(0.2)	(0.2)
Chief Operating Off-Management	(0.5)	(4.0)	3	(0.4)	(0.4)	(0.6)
Corporate Services	(4.4)	1.2	N/A	(0.1)	(2.0)	(2.0)
Commercial Director Mgmt	(0.3)	1.0	3	(0.0)	(0.0)	0.0
Finance Dept.	0.2	(6.8)	3	(0.7)	(0.7)	(0.2)
Information Technology	(1.2)	(10.1)	3	(1.1)	(1.1)	(1.4)
Performance and Delivery	(0.0)	(4.1)	3	(0.3)	(0.4)	(0.4)
Property Services	0.0	(55.6)	3	(4.8)	(4.6)	(4.5)
Human Resources	(0.9)	4.0	3	0.5	(0.4)	(0.0)
Medical Director	0.1	(0.5)	3	(0.0)	0.0	(0.0)
Nursing Director	(0.1)	(16.4)	3	(1.4)	(1.4)	(1.4)
PDC And Depreciation	3.0	(35.6)	N/A	(2.7)	(1.8)	(2.3)
Covid-19 Division	0.0	0.0	N/A	(0.8)	0.8	0.0
Strategy And Business Dev.	0.0	(0.2)	3	(0.0)	(0.0)	(0.0)
Total Corporate	(3.9)	(130.9)		(12.2)	(12.2)	(13.0)
Contract Income	(1.2)	477.3		40.8	42.9	42.7
Provisions	6.1	(18.0)		0.0	0.0	0.0
Donated Asset Reporting Adj	0.4	0.0		0.2	0.1	0.1
Retained Surplus / (Deficit)	0.0	(22.3)		0.0	0.0	(0.0)

Key reasons for YTD divisional variances are as follows:

Integrated Medicine (£0.6m overspend YTD).

• Underspends on the new modular build are being offset with temporary staffing pay pressures in Emergency Medicine, Respiratory, Rheumatology and the Site Team. In addition, the division has incurred expenditure associated with managing the covid-19 pandemic totalling £0.5m YTD.

Integrated Elderly Care (£0.5m overspend YTD).

• Pay overspends are the key drivers behind the YTD overspend with medical staffing costs reporting a £0.2m overspend due to high cost agency usage and professional & technical staff also reporting a £0.2m overspend relating to temporary staffing usage. In addition, the division reports a £0.3m unallocated efficiency target. Divisional Income reports a £0.2m over delivery YTD relating to aging well monies (offsetting expenditure) and mortality review income.

Surgery and Critical Care (£0.5m overspend YTD).

• The key drivers behind this overspend includes costs incurred to manage covid-19, £0.8m and Anaesthetics and Critical Care pay pressures, £0.1m overspent YTD. Non pay continues to underspend by £0.8m YTD primarily relating to Theatre clinical supplies being lower than plan (£0.4m) which is linked to lower than normal activity levels following the Covid-19 pandemic. The division reports a £0.6m unallocated efficiency target YTD. Month 3 has also seen the division report expenditure totalling £0.1m relating to restore and recovery work. This has been matched with budget relating to Elective Recover fund (ERF) income.

Specialist Services (£0.5m underspend YTD).

• Reductions in managed service contract expenditure, Stem Cell income being above plan and drugs expenditure being favourable to plan are the key drivers in the £0.5m YTD reported underspend. The division reports a £0.3m YTD unallocated CIP target.

Information Technology (£1.2m overspend YTD).

• This overspend relates to temporary staffing costs and consultancy expenditure. The division reports a £0.2m YTD unallocated CIP target.

Human Resources (£0.9m overspend YTD).

• This overspend is driven by the Trustwide workforce efficiency target. This target will be applied to individual budget lines once final plans are identified and processed.

Corporate Services (£4.4m overspend YTD).

Corporate services are where central provisions are held for items including the impact of the estimated Agenda for change pay awards, sickness cover, bad debt and balance sheet adjustments. This overspend is offset with the underspend against provisions, £6.1m underspent YTD.

Covid-19 Expenditure

• All 2021-22 covid-19 expenditure is now fully reported within the divisional positions. YTD covid-19 expenditure totals £1.5m YTD with the full divisional split as follows:

Glossary and Definitions

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

Meeting: Trust Board Meeting in Public

28 July 2021

Report from Chair of Finance and Business Performance Committee

Date of Committee: 20 July 2021

Key agenda items considered:

Item	Committee assured	Further work	Referral elsewhere for further work	Recommendation to Board
Monthly Integrated Performance Report and Recovery	Yes	Consideration of the challenges and pressures within ED and Elective Care/ RTT. Noted that future IPR reports will have some benchmarking data for further analysis/ information Diagnostic Care also has pressures and BHT showing challenged results. Significant challenge in managing the waiting list/ P5/6 pressures and needing to perform additional urgent work to assess shape of whole waiting curve, are we managing patients in the best way; what are our next steps. To understand impact on ERF; to further inform committee/ board re comms plan on the challenges and how they are being addressed – staff, patients, other community stakeholders. To consider benchmarking data report that is underway and take actions therefrom also .	n/a	Ongoing and urgent focus

Monthly Finance Report M3	Yes	Breakeven position shown for M3 and expected to be result for H1. H1 outturn has provision for £7m ERF income included within it (of which £5.5m already expected for the first three months. Impact of changing rules from 85% to 95% should not have significant impact on the h1 plan although limits the potential income the trust could have won. Pay costs continue to be a concern - see emerging risks below.	n/a	
Transformation and Efficiency Update	Yes	CIP programme at risk of not delivering for H1, although overall BHT expect to reach breakeven this may require mitigating actions including discussion with BOB regarding ERF shares. Concern raised re the handling of pay underspends in respect of the CIP programme and further discussion needed together with the handling of longstanding vacancies	n/a	
UEC Transformation Deep Dive	Yes	3 year system programme noted – needing to be a system wide programme in order to be successful in meeting overall national standards for UEC delivery. Highest impact areas will be Front door transformation and the impact of 111. Due to Regulator focus BHT needing rapid improvement in improving the breach levels of the non-admitted ED pathway (ie 4 hour target). Receiving support from Royal Berks to advise and assist with improvement journey. Have got additional GP support in place to see additional patients at SMH to deal with backlog	n/a	
Wycombe SOC	Yes	Overall agreement to approve SOC with recognition that next stage is PBC. Additional information needed for further discussion to include – ICS resource/ impact; understanding of financial benefits	n/a	Approval recommended to Board

every time		(as well as the costs); understanding of benefits to patients and the opportunity to attract high calibre candidates to new sites.		Buckinghamshire Healthcare NHS Trust
Wycombe energy Infrastructure Project Carbon Energy Fund - CIC	Yes	Recommend approval – however consider that for this case, and others Cttee needs assurance that Finance have considered both the Revenue and Capital aspects of the BC. This review should be noted in the front sheet to offer further assurance to the Cttee. Specifically - for this BC - need to have assurance that the 22/23 capital requirement will get priority as needed.	n/a	Approval recommended to Board
Contract award for Orthotic Products and Services	Yes	No additional comments. For future contracts, recommended that additional work is performed on a BHT wide basis to ensure contract end, and therefore renewal dates are better highlighted and there is a more timetabled approach to bringing Contracts for approval to Cttee.	n/a	Approval recommended to Board
Amersham Community Diagnostic Hub	Yes	After discussion, agreed with the approval of this business case and recognised the hard, fast work that had been put in by the teams to get the papers submitted to ICS in short time scale. Recognise alot of additional work, and business case preparation is needed between now and September when funding for Y2 will need to be sought. Noted that these CDH services are in addition to existing services and will create significant additional capacity for Bucks	n/a	Approval recommended to Board
Thames Valley Radiology Imaging Network MOU	Yes	No additional comments.	n/a	Approval recommended to Board

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

- Significant pressures and risks surrounding RTT/ Waiting list pressures and also challenges within the ED. Regulator has particular focus on these areas and focus needed to ensure no restrictions on BHT operations put in place.
- Significant risk around the delivery of CIP plan for H1, and possibly H2. Mitigations being developed and efforts ongoing to work with Divisions to prioritise the delivery of CIP plans
- Ongoing pay cost pressures within the H1 finance position. Needing to review the operating model of staffing / and the pressures of absence through staff isolation that is causing pressure on the safe staffing model and therefore increase temp staffing costs.

Meeting: Trust Board Meeting in Public

28 July 2021

Report from Chair of Charitable Funds Committee

Date of Committee: 27th May 2021

Key agenda items considered:

Item	Committee assured	Further work	Referral elsewhere for further work	Recommendation to Board
Fundraising Strategy	Yes	Additional meeting to happen between BJ/ NG-N and Hayley Dan (Fundraising consultant) – to summarise next steps, with a proposed action plan and costing of resources. CFC to then meet again between scheduled meetings to consider plan and the Fundraising Strategy Report in more detail.		Expectation that summary proposals from the detailed review of the Fundraising Strategy paper to be presented to Board (as Corporate Trustee) in September
Legacies	Noted	NG-N to prepare next steps for progressing legacies programme across the Trust for consideration by Committee.	n/a	To note
Portfolio Investments	Yes	Cazenove presented update of investments - £8.6m at 30 April 021. To present summary of Total return for the year under review in future reports.	n/a	To note
Charitable Funds	Yes	Audit scheduled for October 2021	n/a	To note

Statements as at 31 3 2021 (unaudited)				
Robotic Theatres Bid (£499,000)	Approved the case in principle, subject to Corporate Trustee	Scannappeal have offered to raise £1m towards the overall cost of £1,499,000 exc VAT. The overall business case needs to also progress through FBP.	FBP	Approved the case in principle and recommended to Board for approval as Corporate Trustee
Lindengate Nature Connection Programmes (£60,480)	Approved	Approved by CFC; significant impact across staff groups (expect that 2 nd year of Programme will be match funded by NHS Charities Grant also). Work to improve and protect the psychological wellbeing and build resilience of staff, reduce staff sickness and therefore to provide ongoing quality service to all patient groups.	n/a	To note
Staff Network Activities (£9,500)	Approved	Approved by CFC; benefit across staff network groups (in particular Kalinga, Embrace and BHT Ability) – will enhance sense of belonging, open to allies; promote belonging and inclusion of all staff and therefore better patient care. Propose that future bids for specific groups are reviewed with a finance limit (TBA) and to ensure consideration always given to the colleague impact as well as patient benefit.	n/a	To note
Lighting up the Towers (£10,000)	Approved	Approved by CFC; benefit across LGBTQ+ staff network group, but also flag and lighting will be used to promote other causes/ celebrations as required – eg NHS birthday. Will enhance sense of belonging - of staff, patients and the local	n/a	To note

		communities and recognise that the Trust promotes an inclusive environment for all.		
Charitable Funds Business Cycle and workplan	Approved		n/a	To note
Self-Assessment 2020/21	Approved	Will need to be reviewed once Fundraising Strategy begins to be rolled out.	n/a	To note
Terms of Reference	Approved	Minor amendments	n/a	The Board are requested to approve the Terms of Reference which are appended.
Investment Policy	Noted		n/a	To note
Unrestricted Reserve policy	Approved	Noted the calculation for the forthcoming year, in line with the policy 9unchanged from prior year).	n/a	To note
Risk Assessment	Yes		n/a	To note
Appointment of new Committee Members as NED	Yes	Yet to appoint a NED to the CFC in accordance with the TOR.	n/a	To note
Appointment of two new Honorary Committee Members.	Yes	The Committee agreed the need to have an Honorary Independent Member for the interest of the staff. (Non-voting member) and requested the recruitment. This position was advertised internally by the Communication Department. Nicola Gilham	n/a	To endorse

		<p>and Barry Jenkins reviewed the applications and interviewed two candidates.</p> <p>The Candidates were Maria Earley (Staff Engagement Manager) and Dr Nana Theodorou (Head of Research and Innovation).</p> <p>After the interview process was completed, it was agreed that both candidates have the right skills, ability and working experience to support the Committee in managing the activities of the Charitable Fund.</p> <p>It was agreed that Maria Earley due to her working experience, familiarity supporting staff engagement and development and her current working duties within the Trust, would be an asset supporting the Committee as <u>Honorary Independent Member for the interest of the staff.</u></p> <p>Additionally, it was agreed that Dr Nana Theodorou apart from having a substantial experience in charitable activities by being member of the Board in other charities, her clinical, medical and research skills and working background will be ideal to support the Committee as <u>Honorary Independent Member for the interest of the medical/clinical activities.</u></p>		
--	--	--	--	--

		The Committee recommend the appointment of Nana Theodorou as Clinical Honorary representative and Maria Earley as Staff Honorary representative to join the Committee for a year's tenure, and review thereafter. Both positions are Non-voting member.		
Charitable Funds Policy	Yes	Continue to use existing policy, with a review to occur following the approval and implementation of the Fundraising strategy.	n/a	To note

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

None.

Buckinghamshire Healthcare NHS Trust

Charitable Funds Committee Terms of Reference (ToR)

INDEX

Index	Page
1. Background	3
2. Purpose	3
3. Constitution	3
4. Membership	4
5. Quorum	4
6. Meetings	5
7. Authority	5
8. Duties	5
9. Reporting	7
10. Review	7
11. Support	7
12. Monitoring Compliance and Effectiveness	7
13. Document Control	8

Charitable Funds Committee

Terms of Reference

1. Background

- 1.1 The Charitable Funds Committee (CFC) has been established to exercise the Trust's functions as sole corporate trustee of Buckinghamshire Healthcare NHS Trust Charitable Fund (registered charity number 1053113).
- 1.2 The Trust Board is regarded as having responsibility for exercising the functions of the Trustee. The Trust Board delegates these functions to the CFC, within any limits set out in these Terms of Reference and the charitable funds section of Standing Financial Instructions.

2. Purpose

- 2.1 The overall purpose of the Committee is to assist the Board as the Corporate Trustee in the performance of their duties through providing assurance that the Trust's charitable activities are within the law and regulations set by the Charity Commissioners for England and Wales, the Charities Act 2011 *as amended by* Charity Act 2016, the Statement of Recommended Practice on Accounting and Reporting for Charities (SORP), the Charity's Trust Deed and applicable United Kingdom guidance and regulations for NHS charities.
- 2.2 The Committee will approve charitable funds expenditure in accordance with the standing orders and standing financial instructions as well as approve investment policy and monitor investments on a regular basis.
- 2.3 These terms of reference establish formal and transparent arrangements for the oversight of the appropriate use of charitable funds within the Trust and provide a vehicle to ensure the independence of the decision-making process for the Charity from that of the Trust as a whole.

3. Constitution

- 3.1 The Board resolves to establish a standing Committee of the Board to be known as Charitable Funds Committee (the Committee). The Committee is a Non-Executive committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference.
- 3.2 The Trust was appointed as corporate trustee of the charitable funds by virtue of Statutory Instrument 2002 (2271) and the Charitable Funds Committee serves as its agent in the administration of the charitable funds held by the Trust. The Committee has been formally constituted by the Board in accordance with its Standing Orders, with delegated responsibility to make and monitor arrangements for the control and management of the charitable funds and will report through the Board.

4. Membership

4.1 The Committee shall be appointed by the Board from amongst the non-executive or executive directors of the Trust and shall include up to three directors who have the personal and professional characteristics necessary to be effective.

4.2 The CFC comprises:

- (Two) non-executive Directors, where one of them preferably should be financially literate.
- (One) executive Director, normally the Director of Finance.
- (Four) Honorary Independent Members.

4.3 The CFC's structure is:

- Chair: a Non-Executive Director.
- Director of Finance.
- Non-Executive Director.
- Honorary Independent Member for the interest of the donors. (Non-voting member)
- Honorary Independent Member for the interest of the patients. (Non-voting member)
- Honorary Independent Member for the interest of the staff. (Non-voting member)
- Honorary Independent Member for the interest of the medical/clinical activities (Non-voting member)
- Operational Leads: Trust's Director of Finance, Head of Charities Finance and Fundraising Manager.
- CFC Administrator: Head of Charities Finance.

4.4 When a member is unable to attend a meeting, they may appoint a deputy to attend on their behalf. The nominated deputy of a Board member will have the same voting rights as the member; any other deputies will have no vote.

4.5 Other Charity and/or Trust officers may be asked to attend when the CFC is discussing areas that are the responsibility of that individual. The CFC may also invite external advisors to attend for appropriate items, especially if items require detailed knowledge in areas such as investments.

5. Quorum

5.1 The quorum necessary for the transaction of business shall be two (One NED and one Executive Director). A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee. In the absence of the Committee Chairman and/or an appointed Deputy, the remaining non-executive member present shall elect one of themselves to chair the meeting.

5.2 Where a Committee meeting is not quorate under paragraph 5.1 within one half hour from the time appointed for the meeting; or becomes inquorate during the course of the meeting, the Committee members present may determine to adjourn the meeting to such time, place and date as may be determined by the members present.

6. Meetings

6.1 The Committee shall meet at least two times per year and at such other times as the Chair of the Committee shall require. Meetings of the Committee shall be summoned by the CFC Administrator of the Committee at the request of the Chair of the Committee.

6.2 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, shall be forwarded to each member of the Committee no later than ten days before the date of the meeting. Supporting papers shall be sent to Committee members and to other attendees, as appropriate seven days ahead of the date of the meeting.

6.3 The Committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities.

7. Authority

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

7.2 The Charitable Funds Committee is an advisory body with no executive powers; it is not the duty of the Committee to carry out any function that properly belongs to the Board of Directors or the Executive Management Committee.

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

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

7.5 The Charitable Funds Committee has the authority to require any member of staff to attend its meetings.

8. Duties

The Charitable Funds Committee shall be responsible for the following duties:

8.1 Governance and Policies

8.1.1 Ensure the Charity complies with current legislation.

8.1.2 Produce an annual trustees report for the Charity in accordance with section 45 of the Charities Act 1993 and Charities Act 2011 as amended by Charity Act 2016.

- 8.1.3 Review and ensure external audit and internal audit recommendations are actioned.
- 8.1.4 Ensure funding decisions are appropriate and consistent with objectives, and to ensure said funding provides added value and benefit to patients and staff above those afforded by income for commissioned services.
- 8.1.5 Receive regular reports on the Charitable Trust's fundraising activities.
- 8.1.6 Provide regular Internal and External Audit reports to the Audit Committee to enable it to provide assurance to the Board that the Charity is properly governed and well managed across the full range of activities.

8.2 Finance and Controls

- 8.2.1 Approve annual accounts for the Charity and ensure relevant information is disclosed.
- 8.2.2 Set and review an expenditure policy, including the use of investment gains.
- 8.2.3 Monitor the Trust's scheme of delegation for expenditure for the levels:

Up to, and including £5,000	Fund Holders
£5,001 up to, and including £20,000	Finance Director
£20,001 up to, and including £50,000	Chief Executive
£50,001 up to, and including £100,000	Charitable Funds Committee
Over £100,001	Trust Board
- 8.2.4 Approving expenditure over £5,001. This responsibility may be discharged by the Chair of the Committee and Director of Finance acting together. All approved expenditure of over £5,001 will be reported to the next meeting of the Committee.
- 8.2.5 Review individual fund balances within the overall Charity on a regular basis.
- 8.2.6 Review a regular report of all expenditure from charitable funds.
- 8.2.7 Agree expenditure plans from individual fund holders in accordance with funds objectives.
- 8.2.8 Implement appropriate policies and procedures to ensure that accounting systems are robust, donations received are acknowledged and that all expenditure is reasonable and in accordance with donors wishes.
- 8.2.9 Agree guidance and procedures for fundraising and expenditure.
- 8.2.10 Ensure that all fundraising and expenditure is clinically and ethically appropriate.

8.3 Investment

8.3.1 Determine the charitable fund's investment policy, including the selection of appropriate investment advisers and banking service provider.

8.3.2 Review the performance of the Charity's investments.

8.4 **Other**

8.4.1 Encourage where appropriate a culture of fundraising and raise the profile of the Charity within the Trust and local population.

8.4.2 Develop and approve promotional material of the Charity on behalf of the Trustees to ensure that material used will promote the charitable funds purposes and not place the Charity's reputation at risk.

9. **Reporting**

9.1 The minutes of all meetings shall be formally recorded and a summary report regarding the Committee's activities should be submitted, together with recommendations where appropriate, to the Board of Directors.

9.2 The Charity's Annual Report shall include a section describing the work of the Committee in discharging its responsibilities.

10. **Review**

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

11. **Support**

11.1 The Committee shall be supported administratively. This support shall ensure:

- The agreement of the agenda with Chair and attendees and collation of papers. Papers will be distributed seven days before the meeting electronically. Advice to the Committee on pertinent areas is provided.
- That Minutes are taken and a record of matters arising and issues to be carried forward is made.

12. **Monitoring Compliance and Effectiveness**

In order to support the continual improvement of governance standards, the CFC will report annually to the Trust Board:

- a self-assessment of the effectiveness of the CFC
- an annual work plan, where appropriate
- an up to date Risk Register
- a written report to the Trust Board of work performed through the year.

13. Document Control

Version	Date	Author	Comments
1.0	1 st December 2013	E. Hollman	Draft for Committee Chair
2.0	30 th January 2014	Nelson Garcia-Narvaez E. Holman	Approved by CFC and the Board
3.0	29 th May 2016	Nelson Garcia-Narvaez	Approved at EMC 22/07/16
4.0	12 th January 2017	Nelson Garcia-Narvaez	Approved at CFC 12 th January 2017 Approved at Trust Board 31 st May 2017
5.0	28 th February 2018	Nelson Garcia-Narvaez	Approved at CFC 28 February 2018 Approved at Trust Board 28 March 2018
8.0	23 rd November 2018	Nelson Garcia-Narvaez	Approved at CFC 28 November 2018 Approved at Trust Board 31 July 2019
9.0	28 th May 2020	Nelson Garcia-Narvaez	Approved at CFC 28 May 2020 Approved at Trust Board
10.0	27 th May 2021	Nelson Garcia-Narvaez	Approved at CFC 27 May 2021 Approved at Trust Board TBC

Public Trust Board Meeting

28 July 2021

Report from Chair of Strategic Workforce Committee

Date of Committee: 12th July 2021

Key agenda items considered:

Item	Committee assured	Further work	Referral elsewhere for further work	Recommendation to Board
Chief People Officers report	Yes	Only second time used, general consensus it is a very useful report and should be continued	N/A	N/A
FTSUG annual report	Yes	Author to consider elaborating on point 1.6 and make minor amendments to appendixes as discussed before forwarding report further	No, author to complete	Yes
Annual Workforce Equalities Report	Yes	All to consider why declarations of disability are dropping at Band 8 Share strategic priorities and top-level actions next Strategic Workforce Committee	N/A	Yes
Learning lessons to improve our people practice	Yes	Consider how this excellent work and major culture change is communicated to all our people	N/A	Yes, committee recognises importance of roll out and embedding of new policies and ensuring managers are trained.
Guardian of safe working hours annual report	Yes	Further work is required to ensure junior doctors receive their workplans in advance. Not an easy challenge but we only get one chance to make a great first impression	Yes, to all parties involved in the process	Yes, committee assured but recognise the challenge in ensuring communications to new doctors.
Health & Safety	Partial	Author to amend paper to show COSH digital training will be completed by no later than the end of Nov 21.	No	No

every time				
		Further work is required to understand the levels of staff abuse and assault before developing a plan to dramatically reduce it. In hand and already reported to SWC at last meeting.		
Fire Safety annual report	Yes	Consider that If toasters are the main cause of alarms should they be banned or are the alarms a good training exercise?	No	No
COVID-19 Vaccination programme summary	Partial	Committee concerned at reported low take up of second dose for BAME staff. Agreed to keep working on this and report back to next committee meeting. Following the excellent work in this area what can we learn to introduce into our Flu vaccination programme	No	No
Education update report	Yes	Consider adding the enormous financial benefits of 'growing our own' Re 'pre reg student' placements – can this be extended to non-clinical roles at GCSE, A level and degree level?	No	No
Medical Appraisals	Yes			Yes
Agile Working	Yes	How can we identify and offer early alternatives to our people that have been forced to work working from home and are very uncomfortable doing so? would prefer to return to the office.	No	No

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

The Committee was clear about the underlying risk throughout this meeting of getting communications and culture right at the middle management level of the Trust. A further briefing to come to the committee on this issue.

Meeting: Trust Board Meeting in Public

28 July 2021

Agenda item	Annual Workforce Equalities Report 2020-2021
Board Lead	Bridget O'Kelly
Type name of Author	Carley Brown, Christine Hughes
Attachments	Annual Workforce Equalities Report 2020-2021 and Appendix 1
Purpose	Assurance
Previously considered	EMC - approved

Executive Summary

- This report provides assurance that we are meeting our annual Public Sector Equality Duty obligations for our workforce, alongside an overview of our ED&I work this year and WRES/WDES figures.
- Our workforce profile data is in keeping with the population of Buckinghamshire or other NHS organisations.
- WRES - Significant improvements have been made in relation to equal outcomes from disciplinary processes, and improvements have been achieved in our recruitment indicator for the fourth consecutive year. Our workforce ethnicity profile data demonstrates that more work is required to achieve equal progression pathways into senior leadership positions.
- WDES - The recruitment ratio for disabled vs non-disabled applicants deteriorated slightly this year. A comprehensive action plan specifically looking at this issue will be put in place to address this in 2021/22.
- EMC have approved this paper and noted that divisional data would be available for Q1, recognising that this is a crucial part of the process of embedding this work.

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

Relevant Strategic Priority

Quality <input type="checkbox"/>	People <input checked="" type="checkbox"/>	Money <input type="checkbox"/>
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Implications / Impact

Patient Safety	Improving workforce ED&I is directly linked to better, more inclusive patient care
Risk: link to Board Assurance Framework (BAF)/Risk Register	4.3 Variations in organisational culture and behaviours 4.8 The organisation is not always inclusive and does not always treat people equally
Financial	Staffing costs comprise c70% of Trust expenditure
Compliance Select an item. Select CQC standard from list.	CQC Well Led Framework, Regulation 18
Partnership: consultation / communication	ED&I Steering Group
Equality	Workforce ED&I is a key part of the Trust's responsibilities under equalities legislation and best practice. This report aims to understand disparities across our workforce in comparison to national and industry averages. It is recognised that our Workforce Equality Standards demonstrate that some colleagues

	with protected characteristics experience disadvantages within BHT. This report highlights progress achieved to date in reducing such disadvantages.
Quality Impact Assessment [QIA] completion required?	N/A

Annual Workforce Equalities Report 2020-2021

Buckinghamshire Healthcare NHS Trust



BHT Ability Network



BHT Proud Network



BHT VIBES Network



BHT Kalinga -
Filipino
Colleagues
Network

BHT EMBRACE
Network

1 in 4 Network



BHT Carers'
Network

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A Message from our Chief People Officer

Buckinghamshire Healthcare NHS Trust is committed to promoting Equality, Diversity, and Inclusion (ED&I), creating a diverse, accessible and inclusive organisation where everyone feels like they belong. We aim to ensure that respect for diversity and inclusion are embedded in all areas of the community we serve.

My team is focused on building a workforce that better represents our patients and our communities, while ensuring that every colleague feels like they truly belong at BHT.

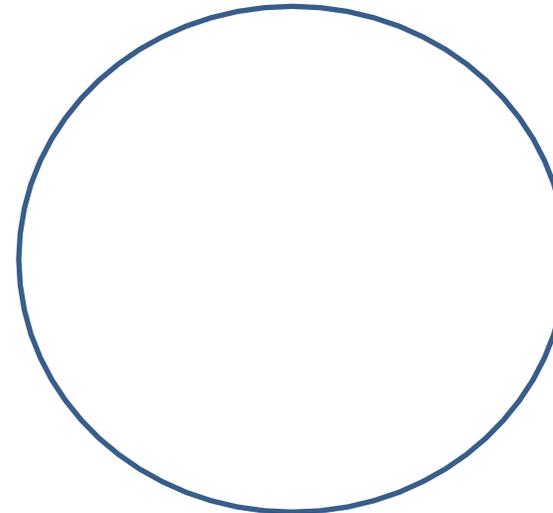
As you'll see in this report, BHT has made progress in several areas of our equality metrics this year, signifying progress towards our inclusion aims – but we know there is much more to do. We've undertaken innovative trials to make our people processes and practices fairer and more inclusive, including our work on unbiased recruitment which has been shortlisted for a HSJ Award. More broadly, we have taken several steps to lay the foundations of inclusion at BHT this year, including strengthening our development offering for people managers within the Trust to ensure that the custodians of our culture know how to be effective allies and champion inclusion within their areas of responsibility.

We also continued our work to understand the identities, intersectionality, and experiences of colleagues across BHT through engagement initiatives. We continue to grow our excellent staff networks who have provided invaluable input to our decisions and support for colleagues this year, including supporting the COVID-19 risk assessment and vaccination programmes, and providing lived experience of navigating our workforce spaces with a disability to our Work Spaces Committee.

Looking forward, we will continue to use data-informed efforts to support diversity and inclusion as we progress, working to reach our goals of creating an organisation where everyone feels they belong.

Thank you for joining us and following our journey.

Bridget O'Kelly
Chief People Officer



“My team is focused on building a workforce that better represents our patients and our communities, while ensuring that every employee feels like they truly belong at BHT”

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Executive Summary - How we met the PSED this year

As a publicly funded organisation, Buckinghamshire Healthcare NHS Trust (BHT) is required to publish information annually on how it has met the Public Sector Equality Duties (PSED) and taken steps to eliminate unlawful discrimination, advance equality of opportunity for people with protected characteristics and foster good relations between those who share protected characteristics and those who do not. This report provides assurance to the Trust Board and to the Public that BHT is meeting its PSED obligations and continuing to promote an inclusive culture across the organisation. The report summarises our workforce equality, diversity and inclusion activity in 2020/21 alongside our PSED requirements and Equality Standard data.

Our workforce data demonstrates that in many characteristics, the profile of BHT staff is in keeping with the population of Buckinghamshire or other NHS organisations. Equality objectives for the Trust were published in 2019, and will be renewed in 2022.

The Trust has undertaken significant work this year to progress its equality commitments made in 2020 by our Executive Team. This has included Executive sponsorship of our staff networks and action plans and celebrating numerous ED&I engagement events such as Black History Month, Disability Month, International Women's Day and PRIDE Month. Furthermore, significant work has begun to review our people processes and policies to ensure parity of outcomes for colleagues who share protected characteristics and those who do not. The Trust trialled an innovative inclusive recruitment process this year to minimise opportunities for biased decisions which has been identified nationally as an example of best practice in inclusive recruitment, and shortlisted for a HSJ Award. New development packages have also been implemented to support managers to create a more inclusive working environment within their areas.

Our Workforce Race Equality Standard (WRES) 2021 data demonstrates that significant improvements have been made this year in relation to equal outcomes from disciplinary processes, and improvements have been achieved in our recruitment indicator for the fourth consecutive year. Our workforce ethnicity profile data demonstrates that more work is required to achieve equal progression pathways into senior leadership positions.

The recruitment ratio for disabled vs non-disabled applicants deteriorated this year, suggesting that disabled applicants were less likely to be appointed at interview compared to non-disabled applicants. A comprehensive action plan is in place to further reduce inequalities and promote an inclusive environment across the Trust. We are confident that the plan will help us to achieve significant improvements in the near future.

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Contents	Page
Report Introduction	4
What is the Public Sector Equality Duty?	5
Protected Characteristics	6
Our ED&I Objectives	7
Section 1: ED&I Progress & Achievements	8
Managing Inclusively	9
Inclusive Recruitment	10
Staff Networks	11
Engagement	13
Section 2: Workforce Information	14
Data Quality	15
Gender	16
Age	17
Ethnicity	18

Contents	Page
Disability	20
Sexual Orientation	21
Religion & Belief	22
Section 3: Equality Standards 2021	23
Overview	24
Workforce Race Equality Standard (WRES) Overview	25
WRES Indicator 1	26
WRES Indicators 2-9	27
Workforce Disability Equality Standard (WDES) Overview	28
WDES Indicators 1	29
WDES Indicators 2-4b	30
WDES Indicators 5-10	31
Gender Pay Gap Reporting	32

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Report Introduction

The Trust's Equality, Diversity and Inclusion journey began in earnest in 2010, with the introduction of the Equality Act and then the launch of the Public Sector Equality Duty (PSED). Through the PSED and the Equality Delivery System (EDS2) the Trust has strived to improve the experience at work for Trust colleagues.

In 2015 the Workforce Race Equality Standard was introduced, with specific measures and goals to enable improvements in the working lives of our Ethnic Minority colleagues. Then in 2017, the Trust began to report on the Gender Pay Gap, as a way of ensuring that we are both remunerating women fairly and enabling their progression to more senior roles in BHT. In 2019, our newest Equality Standard was introduced. The Workforce Disability Equality Standard aims to improve the workplace experience of colleagues who have a Long Term condition or a Disability, and again contains very specific measures and goals to enable this.

The Trust previously reported on its compliance with the Public Sector Equality Duty in August 2019, when it published eleven reports on different aspects of its work in relation to both patients and colleagues. In March 2020 it was announced that in England planned compliance activity with the PSED was suspended due to COVID-19. This report focusses on Our Colleagues and covers the 2020-21 Financial Year

This report encompasses the information required to meet our Equality Duties in relation to our workforce for 2020/21. The data contained within the report is taken from our electronic staff record system as of 31st March 2021, unless otherwise specified. A separate report will be published in relation to our PSED requirements for our patients.

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What is the Public Sector Equality Duty?

The [Public Sector Equality Duty](#) (PSED) came into force across the UK in 2011, and is related to the Equality Act 2010. It means that public organisations have to consider all individuals when carrying out their day-to-day work – in shaping policy, in delivering services and in relation to their own employees. It requires that public bodies have due regard to the need to:

To ensure transparency, and to assist in the performance of this duty, PSED Special Duties also require public organisations to publish:

Special Duties

Information to demonstrate their compliance with the Equality Duty, at least annually

Equality objectives, at least every four years

Information relating to employees who share Protected Characteristics

Information relating to service users who share protected characteristics

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Protected Characteristics

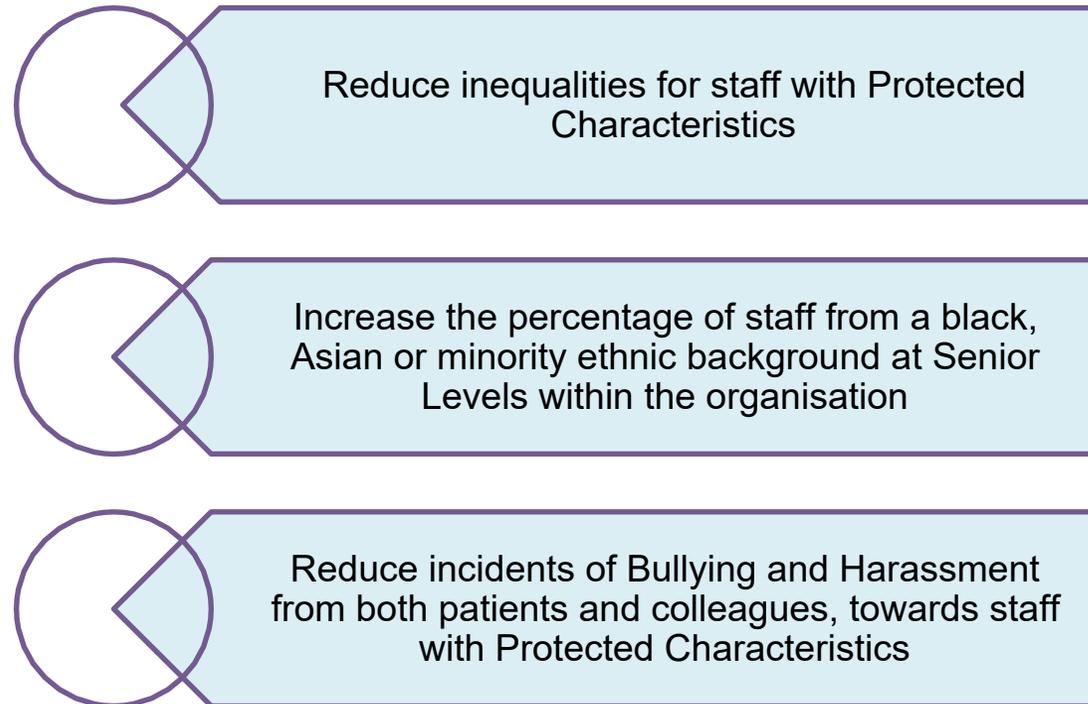
There are 9 Protected Characteristics which are covered by the Equality Act 2010 and the PSED. Our report will provide an overview of our data and activities in relation to some of these characteristics.

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Our Equality, Diversity & Inclusion Objectives

In 2019 the following equality objectives were set by our Trust Board for 2019-2023, in line with our PSED requirements.

- 
- Reduce inequalities for staff with Protected Characteristics
 - Increase the percentage of staff from a black, Asian or minority ethnic background at Senior Levels within the organisation
 - Reduce incidents of Bullying and Harassment from both patients and colleagues, towards staff with Protected Characteristics

The Trust has also set itself some ambitious objectives in relation to our Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES), which are included in Section 3 of this report.

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Section 1: ED&I Progress 2020/21

This section contains a snapshot of some of our activities undertaken this year in support of equality, diversity and inclusion.

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ED&I Progress & Achievements

Managing Inclusively – Developing and Assessing our Leaders

A core part of our work to reduce inequalities and drive forward inclusion is education and learning. We understand that advancing inclusion requires that all people managers, decision makers and budget holders have a clear understanding of what equality and inclusion means for them and their area of responsibility and why it is important.

This year, we've redesigned our staff induction process with a greater focus on inclusion, and designed a new management development package in collaboration with industry experts Pearn Kandola. All people managers at BHT are now required as part of their roles to undertake a learning programme on inclusive management, culture, decision-making and relationships. They will also be offered the opportunity to further build their self-awareness through undertaking an Inclusive Management 360 feedback report.

As part of our performance management processes, all managers are also now required to reflect on (and evidence) the work they have personally undertaken to advance inclusion within their area of responsibility in their annual appraisal.

Later this year, in line with national guidance all candidates for senior leadership roles (Band 8a+) will be assessed at interview on their personal contributions to furthering inclusion.

Pearn Kandola's Inclusive Leadership Model

ED&I Progress & Achievements

Inclusive Recruitment at BHT

Last year we made a commitment to review all of our people processes and practices to ensure they were truly fair and inclusive, with equal outcomes for colleagues who share protected characteristics compared to those who do not. We've undertaken significant work this year to start that journey, beginning with our recruitment process.

We launched new recruitment training which is now mandatory for all hiring managers, and undertook several innovative trials of new recruitment processes which were designed to eliminate key opportunities for bias to affect the decision making process, as oppose to only attempting to de-bias a person's decisions (using Unconscious Bias training or similar methods).

During the trials, we reviewed the methods used to select and assess candidates and replaced these with methods which are evidenced to be most predictive of job performance and least biased. This meant eliminating CVs and covering letters, and replacing them with scenario and skill based application forms. We also used blind shortlisting (removing all personally identifiable information and randomising the order of applications for each short-lister to counter ordering effects) and used structured interviews with full marking criteria and independent scoring by all panellists.

We learnt a lot during these trials and are using them to design a sustainable, unbiased process for all roles which will launch later this year. We're now using this inclusive recruitment method for all Board-level appointments, including our new Chief Medical Officer post. This process has been identified as best practice nationally in an NHSE/I resource on inclusive recruitment and been shortlisted for a HSJ Award.

What's next?

We're now redesigning our other people processes including appraisal and talent management processes, to ensure they are unbiased and inclusive. A review of all people policies is also underway to support a Just Culture.

Staff Networks

Staff networks have continued to meet virtually throughout the pandemic and play a key role in advancing inclusion within the Trust. They have provided input to trust-wide decisions and supported initiatives including COVID-19 vaccinations and risk assessments, reverse mentoring, and inputting to the Trust's Space committee review of working areas. Key updates from each network this year are as follows:

EMBRACE Network – The network has provided additional support to the wellbeing of network members, input into the decision making on the Covid-19 Staff Risk Assessment process and distributing communications regarding the Covid-19 vaccination programme.

BHT One in Four - (Mental Health Network) – Established on 21 October 2020. The Network shared the lived experiences of colleagues mental health during National Mental Health Week. The current focus is on growing the Network.

BHT VIBES - (Belief & values Network) - VIBES provided support to colleagues of different religions during the first Wave of COVID-19. This included comprehensive advice for Muslim staff during Ramadan, which was offered in collaboration with our Trust Imam.

Staff Networks Continued

BHT Ability - (Disabled staff network) – The network celebrated Disability Awareness Month in November and supports colleagues with Access to Work applications. They also attend the BHT Space Committee to provide input on navigating our working areas with disabilities. They're also supporting work to improve the process for accessing Reasonable Adjustments.

BHT Proud - (LGBTQ+ network) - The Network organised a development session for the Trust Board to undertake their Rainbow Badge Training and become allies of the LGBTQ+ community. They also arranged for the Pride flag to be projected onto two of our acute buildings as part of a number of activities during Pride Month.

Kalinga Network – a Staff Network for Filipino staff was established as part of our response to Covid-19. Work is underway to establish the needs of the network and its 230 members.

BHT Carers – Established in June 2020 as part of Carers' Week – despite holding further meetings, attendance has been low so future work will be focussed on growing the Network to support our Carer community.

Engagement

The Trust celebrated a number of national Inclusion events this year, including:

•Inclusion week

•National Inclusion Week 2020 was celebrated in the Trust during September. Each of the Staff Networks hosted a day where communications were focussed on that Network or relevant protected characteristic. A Virtual Fair with information for all of the Networks ran online during the week.

•Black History Month

• Throughout October we celebrated Black History Month 2020 with a series of communications and daily virtual events. BHT held 12 events including discussion groups, cooking classes and coaching events, and these were complimented with national NHS workshops, public events and events hosted by partner organisations.

Disability History Awareness Month

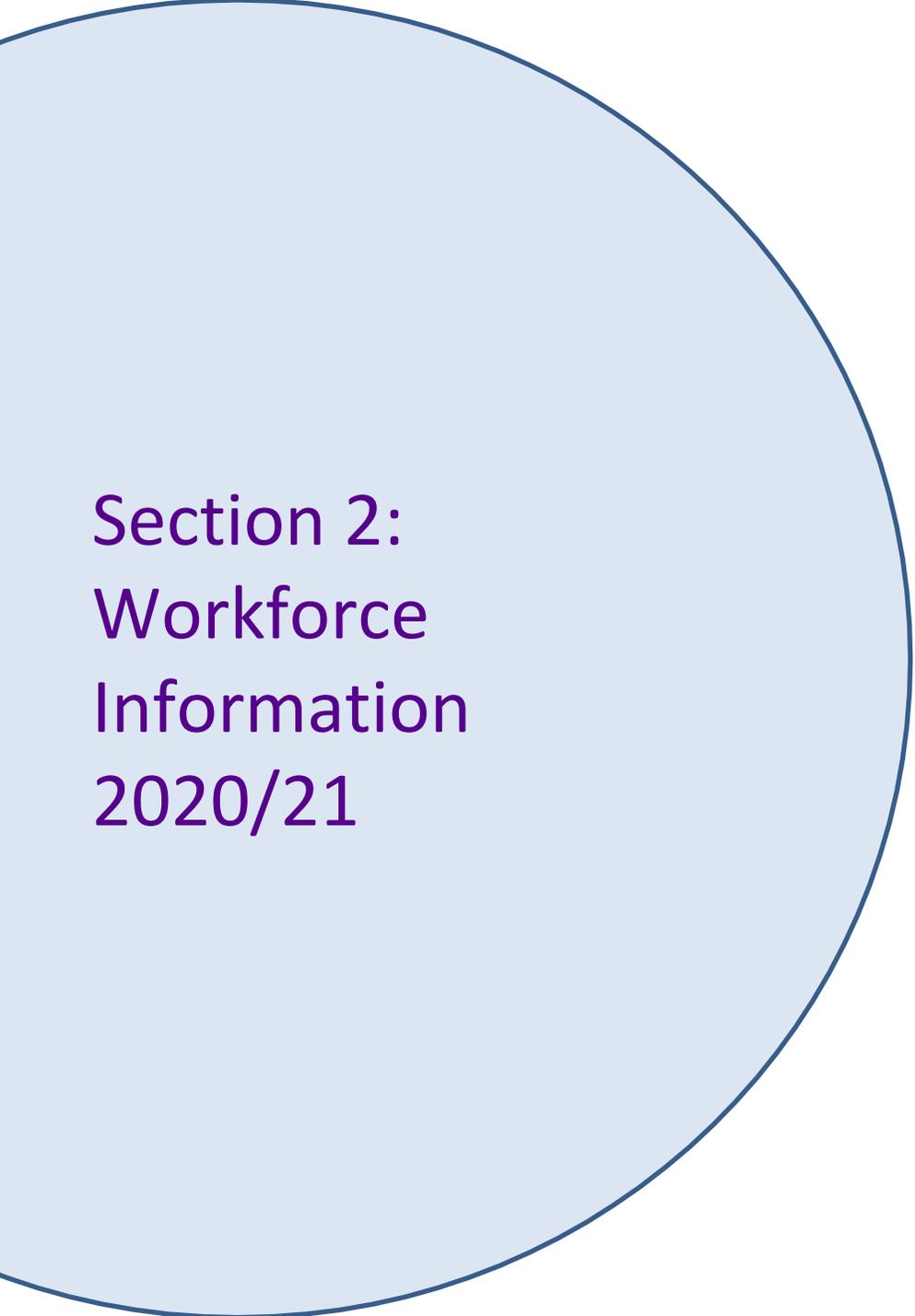
This National Event which ran from 18 November to 20 December 2020, has been celebrated in BHT for the first time. Activities were co-designed with the BHT Ability Network and included a virtual online fair, a virtual discussion regarding Disability Access, and a Guest Speaker event on The Social Model of Disability with Andrew Clark from local charity BuDS.

International Women's Day

We celebrated IWD 20 on 8th March 2020 with local and national events focussed on the impact of COVID-19 on women, under the theme of #EverydayCourage. BHT colleagues also joined a national networking programme designed to connect aspiring female leaders

PRIDE Month

PRIDE Month was celebrated throughout June at BHT. Amongst internal celebratory activities, a ceremonial PRIDE flag was raised for the first time by our Trust Chair Hattie Llewelyn-Davies, and the PRIDE flag was also projected onto two of our acute hospital buildings as a symbol of our allyship to the LGBTQ+ community.



Section 2: Workforce Information 2020/21

This section contains an overview of our workforce data in relation to some of the protected characteristics.

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Non Disclosure Rates for Protected Characteristics

The table below sets out the numbers of staff who have chosen 'prefer not to say' or have not defined their status for the following Protected Characteristics using our Electronic Staff Record (ESR) System as of 31st March 2021.

- **Ethnicity** – 5% of colleagues have not specified their Ethnicity
- **Disability** - 10.2% of colleagues have not specified if they have a Disability
- **Sexual Orientation** – 30.3% of colleagues have not specified their Sexual Orientation
- **Religion or Belief** – 33.5% of colleagues have not specified their Religion or Belief
- For the four protected characteristics listed above, this is partly due to our International recruitment activities and Recruitment Open Days where the online recruitment process is not used, and therefore the data is not captured as fully as possible

For the remaining five protected characteristics:-

- **Maternity Leave**– this process is linked to Payroll and we capture all Maternity Leavers
- **Marriage and Civil Partnership** – This is a compulsory field on our online recruitment systems and therefore we are aware of this for all of our colleagues
- **Age** – This is a compulsory field on our online recruitment systems and therefore we are aware of this for all of our colleagues
- **Gender** - This is a compulsory field on our online recruitment systems and therefore we are aware of this for all of our colleagues
- **Gender Reassignment** –Work is in progress nationally to enable us to capture this on ESR

Improving Data Quality – We have been working to improve our data quality this year through harnessing data available to us through other systems and processes used in relation to our Trust Colleagues. This has reduced the non-disclosure of ethnicity from 12% to 5%.

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Gender

What does this tell us?

The workforce profile remains predominantly Female (80.7%, n5020) and 19.3% (n1203) Male.

The gender profile of England is 51% Female and 49% Male, and Buckinghamshire reflects this*. However, the gender profile for national NHS workforce is 77% Female and 23% male, therefore our workforce profile is in keeping with the health and social care sector average.

*The Census Data for Buckinghamshire was collected in 2011, therefore population figures may have changed. The new Census is being completed in 2021.

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Age

What does this tell us?

- The biggest age group in the Trust overall is 51-55
- The biggest age group for Bands 1-7 is 46-50, followed by 51-55
- For our Medical Staff the biggest age group is 31-35 and this reflects both England's working population and that of the NHS
- In the NHS the biggest age group is 45-54, with 28% of its workforce falling into that age group. A total of 26% of BHT staff fall into that group

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Ethnicity

What does this tell us?

The chart on the left demonstrates that 69 % of our staff overall are from a White ethnic background, with 13% from an Asian ethnic background.

26% overall are from an ethnic minority background and 5% have not stated their ethnicity.

In the NHS as a whole, data published in January 2020 shows that 19.7% of all NHS Staff are of an ethnic minority background, and 77.9% are of a White background.

This means that BHT has a higher percentage of ethnic minority colleagues than the average across the NHS. Buckinghamshire Census data (2021) will support the Trust to further understand it's workforce population ethnic profile in relation to the Buckinghamshire population.

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Ethnicity By Pay Band/Staff Group

What does this tell us?

The graph on the left shows that as of the 31 March 2021 our workforce ethnicity profile within our pay grade structure was as follows:

- In Bands 1-7, 75.4% of our colleagues are from a White ethnic background, and 24.5% are from a Black, Asian, Mixed or Other ethnic minority background
- In Band 8 and above, 80.8% of our colleagues are from a White ethnic background and 19.2% are from an ethnic minority background
- Amongst Medical Staff 49.1% were from a White ethnic background and 50.8% from an ethnic minority background. Medical Staff have the most frequently stated proportion of colleagues with a Black, Asian, Mixed or Other ethnic minority background, in keeping with the national workforce profile for medical colleagues
- The Non Agenda for Change staffing group are the Very Senior Managers within the Trust. Within this group, 92.3% of this group were from a White ethnic background and 7.7% are from a Black ethnic background

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Disability

What does this tell us?

- Our disability/long term condition (LTC) declaration rate remained approximately the same between 2020 and 2021
- Disability declaration is highest between Bands 1-7
- Declaration is low in Band 8
- Disability declaration includes different types of disability, including hidden disability
- Our colleagues with disabilities are supported by our BHT Ability Staff Network

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Sexual Orientation

What does this tell us?

- 1.2% of colleagues have declared that they are from an LGBTQ+ background and this data has not changed since 2020
- 22.6% of colleagues have not stated their sexuality
- There is no data for sexual orientation for the population of Buckinghamshire
- No census data on sexual orientation is currently available, however the Census 2021 will collect information on this protected characteristic. This will give us a better understanding of the sexuality profile of our workforce in comparison to our local population.

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Religion and Belief

What does this tell us?

- Our most frequently stated religious group is Christianity (43.1% of our colleagues)
- 25.8% of colleagues have not disclosed their religious/belief group
- The smallest groups are Judaism (0.1%), then Sikhism (0.6%), Buddhism (0.8%), Hinduism (2.4%) and Islam (4.6%)
- There has been minimal change across these groups since 2020.

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Section 3: Equality Standards 2020/21

This section contains an overview of our latest data in relation to our Equality Standards.

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The Equality Standards

As part of our PSED obligations, the Trust is required to report annually on the following Equality Standards and to use the outputs to inform an Action Plan for each of these Standards.

The Equality Standards are:

- **Workforce Race Equality Standard (WRES)** – This was introduced in 2015 and is designed to measure and enable improvement of the working lives of colleagues from an ethnic minority background.
- **Workforce Race Disability Standard (WRDES)** – This was introduced in 2019 and is designed to measure and enable improvement of the working lives of colleagues with disabilities and long term conditions.
- **Gender Pay Gap Reporting (GPG)** – This is an annual exercise designed to measure the gap in pay between men and women and is designed to enable organisations to close this gap through appropriate actions.

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Workforce Race Equality Standard (WRES) Progress

Implementation of the Workforce Race Equality Standard (WRES) is a requirement for all NHS Provider organisations. BHT is expected to show progress against 9 indicators which measure whether or not employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace. This work requires the commitment, agreement and financial support of the Board and in 2020, executive directors at BHT became sponsors of key actions within our WRES action plan.

In 2020, the Trust created two specific objectives to progress racial equality:

1. The ethnic make-up of our Board and senior leaders will be 24% BAME, reflecting that of our workforce by 2022
2. Our recruitment processes will be fair, with equal outcomes for BAME and white applicants by the end of 2021

Summary of WRES Progress in 2021

Significant improvements have been made this year in relation to equal outcomes from our recruitment and disciplinary processes. Our recruitment indicator has decreased for the fourth consecutive year, reducing from 2.44 in 2018 to 1.28 in 2021. The national parity benchmark for indicators 2-4 is any figure between 0.8-1.2. Our 2021 data demonstrates that we have achieved parity of outcomes for disciplinaries and access to training.

Our workforce ethnicity profile data (indicator 1) highlights a 5% difference in the number of ethnic minority colleagues in Band 1-7 roles compared to senior leadership roles (Band 8A+). This suggests that more work is required to achieve equal progression pathways into senior leadership positions.

There were no statistically significant differences to our staff survey indicators this year (indicators 5-8). This was anticipated as our enhanced WRES action plan was put in place in October 2020; the same time period in which the survey data was collected. We are confident that our WRES action plan will support significant improvements in these areas in the future.

WRES Progress

- 1) **Workforce representation.** Percentage of white and BME staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce

WRES Indicator 1 - 31 March 2020 Bands 1-7				WRES Indicator 1 - 31 March 2021 Bands 1-7		
	White	BME	Not Stated	White	BME	Not Stated
Bands 1-7	3758 74%	1199 24%	120 2%	3679 72%	1198 23%	255 5%
Bands 8A+	279 80%	62 18%	9 2%	293 77%	69 18%	17 4%

What does this tell us?

The above tables highlight the differing ethnicity profile of our workforce across the various pay bands. There is a 5% difference between the number of colleagues from a Black, Asian, Mixed or Other ethnic minority background in Bands 1-7 compared to senior leadership bands 8A and above. This suggests that more work is required to achieve equal progression pathways into senior leadership roles.

WRES Progress

Key
 = Improvement
 = No significant change
 = Deterioration

The below data covers the period from the 1st of April 2020 to 31st March 2021.

Metric	2019/20 Score	2020/21 Score	Progress 2021	Parity between groups
2) Recruitment. Relative likelihood of white candidates being appointed from shortlisting across all posts compared to BME candidates	1.98	1.28	Improved	No
3) Disciplinarys. Relative likelihood of BME staff entering the formal disciplinary process compared to White staff, as measured by entry into a formal disciplinary investigation	1.95	1.23	Improved	Yes
4) Training & Development. Relative likelihood of staff accessing non-mandatory training and CPD	0.96	1.07	No change	Yes
5) Patient Bullying & Harassment. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	White = 28% BME = 24.7%	White = 24.2% BME = 26.2%	* No change	There is no national benchmark for parity between groups for these indicators
6) Staff Bullying & Harassment. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White = 22.2% BME = 24.5%	White = 21.6% BME = 28.9%	* No change	
7) Career progression perceptions. Percentage believing that trust provides equal opportunities for career progression or promotion	White = 87.9% BME = 76.7%	White = 89.7% BME = 74.2%	* No change	
8) Discrimination. Percentage of staff who have experienced discrimination at work from their manager/team leader or other colleague	White = 5.9% BME = 11.5%	White = 6.2% BME = 18.6%	* No change	
9) Board representation. Percentage difference between the organisations' Board voting membership and its overall workforce	Board Voting = 27.3% BME Overall Workforce =24.3% BME	Board Voting = 36.4% BME Overall Workforce =24.7% BME	* No change	

* = Despite visual changes in the data compared to previous years, advanced statistical analysis was undertaken on these results which demonstrated that the observed changes are not statistically significant, and instead are considered normal data variation. As such the results have been labelled as 'No significant change'.

Workforce Disability Equality Standard (WDES) Progress

The Workforce Disability Equality Standard (WDES) is a set of ten specific metrics which requires all NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff. The WDES enables BHT to better understand the experiences of our disabled staff and supports positive change for all existing employees by creating a more inclusive environment for disabled people working and seeking employment in the NHS. Year on year comparisons enables us to measure progress against the indicators of disability equality.

In 2020 BHT created two specific objectives in relation to disability equality within the Trust:

1. Our recruitment processes will be fair, with equal outcomes for disabled and non-disabled applicants by the end of 2021
2. All disabled staff will be provided with reasonable adjustments where needed by end of 2022

Summary of WDES Progress in 2021

The recruitment ratio for disabled vs non-disabled applicants deteriorated this year, suggesting that disabled applicants were less likely to be appointed at interview compared to non-disabled applicants.

There have been no significant changes to any other WDES indicators this year. This was anticipated as our enhanced WDES action plan was put in place in October 2020; the same time period in which the survey data was collected. We are confident that our WDES action plan will support significant improvements in these areas in the future.

WDES Progress

Indicator 1 - Workforce representation. Percentage of disabled vs non-disabled staff in AfC pay-bands, medical subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce.

WDES Indicator 1 - 31 March 2020 Disability declared				WDES Indicator 1 - 31 March 2021 Disability declared		
	No	Yes	Total	No	Yes	Total
Band 1-7	4927 98%	151 3%	5078	4981 97%	152 3%	5133
Band 8A+ Total	343 98%	6 2%	349	369 98%	8 2%	377

What does this tell us?

The above tables highlight that the number of staff declaring a disability has stayed approximately the same over the last two years. Buckinghamshire Census data 2021 will support us to better understand the profile of our staff in relation to the population of the county.

WDES Progress

Key
 = Improvement
 = No significant change
 = Deterioration

The below data covers the period from the 1st of April 2020 to 31st March 2021.

Metric	2019/20 Score	2020/21 Score	Progress 2021	Parity between groups 0.8-1.2
2) Recruitment. Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts.	1.06	1.27	Deteriorated	No
3) Performance management. Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.	0	0	No change	Comparisons not possible.
4a) Bullying & Harassment. Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from: i. Patients/Service users, their relatives or other members of the public	Disabled =29% Non-disabled =26.8%	Disabled = 31.9% Non-disabled = 23.3%	*No change	There is no national benchmark for parity between groups for these indicators
ii. Managers	Disabled =17.7% Non-disabled =10.7%	Disabled =18.4% Non-disabled =10.3%	*No change	
iii. Other colleagues	Disabled =24.8% Non-disabled =15.9%	Disabled =21.9% Non-disabled =16.3%	*No change	
4b) Reporting harassment. Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.	Disabled =42.3% Non-disabled =46.7%	Disabled =46.3% Non-disabled =45.4%	*No change	

* = Despite visual changes in the data compared to previous years, advanced statistical analysis was undertaken on these results which demonstrated that the observed changes are not statistically significant, and instead are considered normal data variation. As such the results have been labelled as 'no significant change'.

WDES Progress

Key
 = Improvement
 = No significant change
 = Deterioration

The below data covers the period from the 1st of April 2020 to 31st March 2021.

Metric	2019/20 Score	2020/21 Score	Progress
5) Career progression perceptions. Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.	Disabled =80.4% Non-disabled =86.1%	Disabled =83.9% Non-disabled =87.3%	*No change
6) Pressure to work. Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	Disabled =26.3% Non-disabled =18.1%	Disabled =26.4% Non-disabled =20.8%	*No change
7) Feeling valued. Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.	Disabled =37.2% Non-disabled =48.3%	Disabled =40.3% Non-disabled =48.8%	*No change
8) Reasonable adjustments. Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.	75.2%	77%	*No change
9a) Engagement. The staff engagement score for Disabled staff, compared to non-disabled staff.	Disabled =6.7 Non-disabled =7.2	Disabled =6.8 Non-disabled =7.2	*No change
9b) Engagement. Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? (Yes) or (No)	Yes	Yes	No change but benchmark achieved
10) Board representation. Percentage difference between the organisation’s Board voting membership and its organisation’s overall workforce, disaggregated: • By voting membership of the Board. • By Executive membership of the Board.	% Voting Disabled = 9% % Executive Disabled = 0% % Workforce Disabled = 2%	% Voting Disabled = 9% % Executive Disabled = 0% % Workforce Disabled = 3%	

* = Despite visual changes in the data compared to previous years, advanced statistical analysis was undertaken on these results which demonstrated that the observed changes are not statistically significant, and instead are considered normal data variation. As such the results have been labelled as ‘no significant change’.

Gender Pay Gap Reporting

- The images opposite illustrate the gender distribution across Buckinghamshire Healthcare NHS Trust in four equally sized quartiles. In order to create the quartile information all staff are sorted by their hourly rate of pay, this list is then split into 4 equal parts (where possible).
- This demonstrates that in quartile 1, 2 and 3 the split between male and female employees is broadly consistent, however in the highest quartile there are more male employees than the other quartiles.
- The variance in the highest quartile is mainly due to significantly different gender splits within the medical staffing group. In contrast, the Allied Health Professional and Nursing staff groups have a higher proportion of female staff in the highest quartile compared to male staff.
- We are confident that men and women are paid equally doing equivalent jobs across the organisation.

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Agenda item	Freedom to Speak Up – Annual Report April 2020– March 2021
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Meeting: Trust Board Meeting in Public

28 July 2021

Board Lead	Bridget O’Kelly
Type name of Author	Tracey Underhill
Attachments	Nil
Purpose	Approval
Previously considered	Executive Management Committee 29.06.21. The Committee asked if themes identified relating to management in the concerns raised had fed into the development of the Peak 1 management programme which they have and the EMC also reflected on the importance of the demographics. Strategic Workforce Committee 12.07.2021 asked regarding timescales for our next steps which is by year end 31 st March 2022.

Executive Summary

This report provides the Trust Board with a reflection of the work and progress achieved over the past year to support the freedom of our staff to feel safe to speak up without the fear of detriment or blame at BHT. Despite the COVID 19 pandemic, progress has been made across this agenda and the following executive summary on page 1 provides you with a summary of the key headlines.

Decision	The Trust Board Meeting in Public is requested to note the contents of this Annual Report.
Relevant Strategic Priority	
Quality ☒	People ☒ Money ☒
Implications / Impact	
Patient Safety	A positive speaking up culture is key to patient safety
Risk: link to Board Assurance Framework (BAF)/Risk Register	1.1 Inadequate staff resource to deliver outstanding quality care (insufficient levels of qualified, experienced staff and training opportunities) 4.1 Pandemic-related negative impact on morale, wellbeing and retention 4.3 Variations in organisational culture and behaviours 4.8 The organisation is not always inclusive and does not always treat people equally
Financial	Costs are incurred if people do not speak up to prevent errors, incidents, poor practice or declare fraudulent behaviours. There are both human and financial associated costs. This is part of core business
Compliance <small>Select an item. Select CQC standard from list.</small>	NHS Contract, CQC Well led, NHS Constitution and National Guardian Office Board Guidance, Annual Trust and Quality Report
Partnership: consultation / communication	N/A
Equality	Concerns raised can highlight equality related issues. Regarding the FTSUG service, work will be progressed this year to further scrutinise and strengthen our ability to quantify equitable access by the wider protected characteristic groups.
Quality Impact Assessment [QIA] completion required?	N/A

1 Executive Summary

Despite the COVID 19 pandemic and the unprecedented challenges this has presented us with throughout 2020/2021 this Annual Report reflects on what has been a very busy and productive year.

- The Freedom to Speak Up (FTSUG) has maintained an uninterrupted service to support colleagues throughout the COVID 19 pandemic and across BHT ensuring full staff access as normal. The usual level of support has been given to all wishing to raise concerns.
- Activity has again shown another year on year increase with 105 cases being managed, the highest number of cases to date. Bearing testament to the above. (See *section 3.0 for more information*).
- Like many other colleagues the FTSUG has also undertaken additional duties during waves one and two. These included undertaking training and fit mask testing colleagues and leading a small group of relevant colleagues to review and improve the death in service protocol. In the second wave, weekend voluntary duties on the wards were undertaken in an effort to support clinical staff, freeing up clinical time and supporting relatives and carers with their enquiries. Collaborative and cross specialty working saw BHT working at it's best, with it's wholesale "one team one goal approach".
- Key plans to expand the BHT Freedom to Speak Up Service (FTSU) from 1 whole time equivalent (w.t.e); highlighted in last year's Annual report 2019 /2020 have been realised. New "Outreach" Freedom to Speak Up Guardians (OFTSUGs) were appointed in March and have been undergoing training to gain registration. See *section 4.3 for more information*.
- The FTSUG participated in a partnership project opportunity with the NGO for BHT, enabling our contribution to a national piece of research, commissioned by the NGO and being undertaken by Roger Kline and "brap" a charitable organisation focused on equality. The aim of the research is to see if the ethnicity and background of a FTSUG has an impact on people speaking up. We await results.
- The national staff survey results for this past year show improvement in the confidence in the organisation to address concerns raised by staff and we are showing to be 2% above comparator Trusts for the welcomed new question which asks staff about their confidence in feeling safe to speak up about any concern in the organisation, as opposed to just unsafe clinical practice. The latter of which we have shown a decrease of 1.6%. This is the first decrease since 2017. (See *section 3.4 for more information and further explanation*).
- The National Freedom to Speak Up Index 2021 results show us to be in the middle rankings and just very slightly above both the national average and the Trust type average with a score of 79.7% this year. It is 0.3% below our 80% achievement last year and so is a little disappointing. The top ranked organisation score was 87.6%. (See *section 3.5 for more information*).
- A successful October "Speaking Up" month saw the introduction of a "Speak Up Alphabet"
- Key Trust wide events developed in response to concerns raised were:
 - a) A FTSUG Speaking Up BAME Event held on the 8th July 2020 with guest speaker Yvonne Coghill and an internal expert panel in response to local and national concerns raised about COVID 19. More than 80 staff participated in the virtual MS teams event.
 - b) A virtual webinar with an expert paediatric panel was developed for staff to attend in response to previously unknown concerns being raised to the FTSUG about the significant impact COVID 19 has had on the children of staff working in a clinical setting. Health and Wellbeing developed the webinar.

2 Key National Update

Just over five years has passed since the publication of the Francis Freedom to Speak Up Review. The Speaking Up Culture of the health sector across England has changed but there is more to do. Currently the National Guardian Office (NGO) are reporting over 700 Freedom to Speak Up Guardians have been established in more than 400 NHS primary and secondary care, independent sector organisations and national bodies.

2.1 To date, the numbers of concerns raised through these FTSUGs and reported centrally to the NGO total more than 50,000. That is 50,000 concerns that people have spoken up about who might not otherwise have done so; to keep their patients and colleagues safe.

- During the pandemic, the NGO launched Pulse surveys asking FTSUGs across the Country to complete them to gauge the impact of the pandemic on “Speaking up”.
- With the CQC and Chief Inspector for Hospitals, the National Guardian wrote out to all CEOs and Chairs to remind them of how important it was to maintain safe “Speaking Up” channels for their workers.
- There was a significant increase nationally which has been largely reflected locally across the three months in concerns raised about bullying and harassment with a rise from 46% in April to 57% in May and climbing up to nearly 70% in June 2020. This category has seemingly remained high throughout the pandemic and remains the category that sees the highest level of concerns reported ie more than patient quality and safety which follows pre pandemic reporting trends.

2.1.2 The NGO has developed a 5-year strategy and as part of that have launched two of the three packages of defined training recommended to Trusts to be treated as for mandatory training.

Package 1 – “**Speak Up**” for all staff. Package 2 – “**Listen up**” for all managers and senior staff and Package 3 – “**Follow Up**” is still to be released which is aimed at all Board members.

Dr Henrietta Hughes OBE – National Guardian said at the launch of this training:

“Speaking up begins with a conversation, usually with your line manager. How your manager reacts has a tremendous impact on the perception of whether speaking up is welcomed. Managers play a vital role in fostering a speak up culture and the psychological safety of workers. That is why it is essential that they have the tools so they can effectively listen and respond.”

(See section 3.5 for more information on how we intend to support this at BHT).

2.1.3 Dr Henrietta Hughes has recently announced the sad news that she has decided to step down as of September this year as the National Guardian, following five years in the role.

Dr Hughes was appointed to the role in July 2016 which was established to help lead a cultural change within the NHS following the Freedom to Speak Up Review. Previously a Medical Director at NHS England, she continued her clinical role as a GP in central London alongside her National Guardian duties, including supporting the COVID vaccination roll-out.

3 Local Update

3.1 Activity - Over the past year the FTSUG has received and managed 105 cases amounting to more than 130 individuals raising concerns to the FTSUG. *(See following table)*

3.2 We have continued to see good representation from a diverse range of staff groups, individuals and bandings. This is important for assessing equitable access to the service. Importantly, this should be further strengthened by establishing our local presence across the

geographic areas via our new Outreach FTSUGs. To help evidence this, new work is to be progressed this year to develop an electronic secure platform. This will help the service to demonstrate more detailed anonymised information on the wider range of protected characteristics of those accessing the service. In addition, we are also going to request a more detailed protected characteristics report to scrutinise our staff survey results. These are the results specific to the relevant “Speaking Up “questions. *(See appendices for specific questions and more information)* This breakdown will help provide us with some valuable information to further check that we are offering a personal, fair and diverse service.

Five members of staff have been retained over the past year as a result of contacting the FTUG and having concerns addressed. These staff have been mostly clinical, *(one of which had handed in their resignation letter)*. This means skills, knowledge, organisational and service knowledge have been retained demonstrating human and cost savings. This is one example of how the FTSU service can help to add additional value.

Quarter	2017/2018	2018 / 2019	2019/2020	2020/2021
	Inaugural Year Cases	Cases	Cases	Current year Cases
Q1 Cases	3 <i>(Start-up quarter)</i>	20	26	32
Q2 Cases	10	16	19	23
Q3 Cases	20	22	35	35
Q4 Cases	13	16	17	15
Year Totals	46	74	97	105

3.3 Resulting key themes from concerns

- Bullying and poor behaviours including poor general behavioural related matters.
- Poor management / staff / team relations
- People have also felt that increased work has not always been locally acknowledged
- Some approaches to managing work creating work.
- Shortages of some staff groups, staff vacancies, sickness, adding to pressures and the need to have enough senior or qualified staff where needed to help people feel more supported and safe.
- Staff feeling concerned about the effects on their children of them working in a COVID positive environment leaving lasting impacts.
- The increase in workload sometimes resulting in more risk management which has not always felt to have been acknowledged or appreciated at a local level and people are left feeling personally responsible which adds additional personal stress when they are already tired post COVID.
- Patient safety concerns, including some relating to poor clinical practice
- Concerns being previously raised locally but not being dealt with or not fully addressed resulting in a return of the problem or an increase in severity or risk of the same problem.
- Staff to staff inappropriate behaviours
- Lack of engagement or timely effective communications regarding changes, last minute changes to plans put in place.

- Change management and a lack of engagement and communication.
- Poor team culture and dynamics and some staff feeling unfairly treated
- COVID specific concerns
- A small number of poor learning “in practice” experiences due to demands and additional pressures and COVID restrictions eliminating opportunities for most face to face training.

3.4 External Validation – See Appendices Graphs A, B and C)

The Trust's results from the NHS National Staff Survey remained stable with some improvement and were above average for similar Trusts.

The improvement for 17c was welcomed as this has been an area given a little more focus this year. Whilst the responsibility for addressing the concerns lies with those to whom concerns are raised to; previous results have shown this question has shown a slower line of improvement. So it is good to see more focused follow up work has shown some benefit.

However, 17 b has seen a slight decrease. In viewing the results below it is important to see Appendix A,B and C as the graphs show that whilst our result for 2020 for Q 17b (re speaking up about unsafe clinical practice) has slightly decreased by 1.6% the organisations nationally labelled as “best” also show a decrease of 2%, whilst the average has gone up by 1%. This is the first decrease BHT has seen since 2017 on this question.

How the pandemic has impacted on this specifically is hard to determine without more evidence. It is possible, that in light of the increased numbers of concerns about bullying behaviours raised locally, and nationally, this may well be the reason why staff did not feel as safe as usual to speak up about unsafe clinical practice. The increase in bullying type behaviours may also have been a direct result of the extreme pressures, tiredness and relentless problem solving that clinicians and decision makers were facing during these periods in the pandemic.

Question 18f was a welcomed new question introduced into the 2020 survey and our result was significantly better than the average for comparator Trusts. This question is not specific to clinical concerns as is 17b and speaks more to the wider speaking up culture which shows us to be 2% above the comparator Trusts.

Table 1: Results National Staff Survey to specific FTSU related questions.

	Question	2019	2020	Comparator
17b	I would feel safe to raise concerns about unsafe clinical practice	74%	72%	71%
17c	I am confident that the organisation will address my concern	59%	60%	59%
18f	I feel safe to speak up about anything that concerns me in this organisation	Not asked	67%	65%

3.5 National Freedom to Speak Up Index, BHT Results 2021

The national FTSU Index 2021 was published by the National Guardian Office (NGO) on the 27th May this year. The index is developed and based on results from the National Staff Survey and so this year's index is based on the recent staff survey results for 2020. The index helps to build a picture of what the speaking up culture feels like for workers. It is a metric for NHS Trusts, drawn from four questions in the NHS Annual Staff Survey, asking whether staff feel knowledgeable, encouraged and supported to raise concerns and if they agree they would be treated fairly if involved in an error, near miss or incident.

Since the introduction of Freedom to Speak Up Guardians in 2015, the FTSU Index has improved and risen 3.7 percentage points nationally from 75.5% in 2015 to 79.2%.

Whilst nationally we see an upward trajectory, there is a continued disparity between the highest performing organisations and the lowest, with a 21 percentage point difference between them. More concerning is that this disparity has increased this year.

The 2021 index report based on 2020 national staff survey results shows BHT as having achieved a score of 79.7 % for this year. In comparison *we achieved 80% up 2% in 2020 and 78% in 2019.*

The 2021 national average index score is 79.2%.

The 2021 national average index score for Acute and Acute and integrated Trusts is 79%.

So we are positioned just above the national and trust type average in this year's Index and placed along with many other organisations in the mid ranking scores.

We are 8% below the top ranked organisation which was 87.6% and achieved by Cambridgeshire Community Services NHS Trust

The national average for the Freedom to Speak Up (FTSU) Index score has improved by 0.5 percentage points over the past year. The improvement has slowed over recent years from a 1.4 percentage point increase between 2017 and 2018 to a 0.5 percentage point increase between 2019 and 2020.

2016	2017	2018	2019	2020
76.7%	76.8%	78.1%	78.7%	79.2%

The figures below are the steadily increasing averages for our Trust type. **Acute and Acute & Community Trusts** over the past 5 years, showing general wider improvement across our sector which is encouraging.

2016	2017	2018	2019	2020
76.4%	76.5%	78.1%	78.5%	79.0%

4.0 Key FTSU related Trust wide achievements this year

4.1 A FTSUG Speaking Up BAME Event held on the 8th July 2020 with guest speaker Yvonne Coghill and an internal expert panel in response to information released nationally at the time showing an increased level of risk / impact in the early stages of the COVID 19 pandemic on BAME colleagues. It was a successful event with more than 80 staff attending the virtual MS teams event.

4.2 A virtual webinar with an expert panel was developed for staff to attend in response to previously unknown concerns being raised about the significant impact COVID 19 has had on the children of staff. E.G mental and physical wellbeing of staff children has been impacted as a result of fear about their parents working in a clinical environment which has led to an array of symptomatic problems staff were grateful of some help and support to deal with. The webinar was put together by Health and Wellbeing and was recorded and accessible for staff who couldn't attend via our intranet as well as a list of useful signposting advice and information.

4.3 The new outreach model has been developed and recruited to for the fixed term one year appointments of four part time Outreach FTSUGs who have been progressing through training to gain registration. This equates to one additional whole time equivalent. This model is new and innovative providing Speaking Up outreach into the local areas and allocating specific resource to the Community services to strengthen a local presence into this area as well as the acute. This model will help to provide improved sustainability, diversity, accessibility and visibility. It has offered candidates flexible working, secondment, promotion and development opportunities showing BHT to be an employer of choice.

4.4 We have recruited to our designated NED vacancy and warmly welcome Mo Girach to his new role

5.0 Summary

This has been an eventful and busy year which this annual reflection attempts to summarise. There is much work still to do to further embed and continue our journey to strengthen a positive Speaking Up culture at BHT across the organisation. This report demonstrates the progress being made and with additional resource in place moving from one whole time equivalent to a team, we can make further improvements and hear even more concerns, utilising more learning, and improving patient and staff safety and experiences.

We will need to be more cognisant of the real risk of allowing the organisation to seeing Freedom to Speak Up as someone else's role, or to do, this agenda is everybody's business and needs to be embedded within core workstreams across the Trust as we move forward. It needs to become business as usual and to achieve this, will need senior and local leadership as well as strong communications support to create true ownership and visibility.

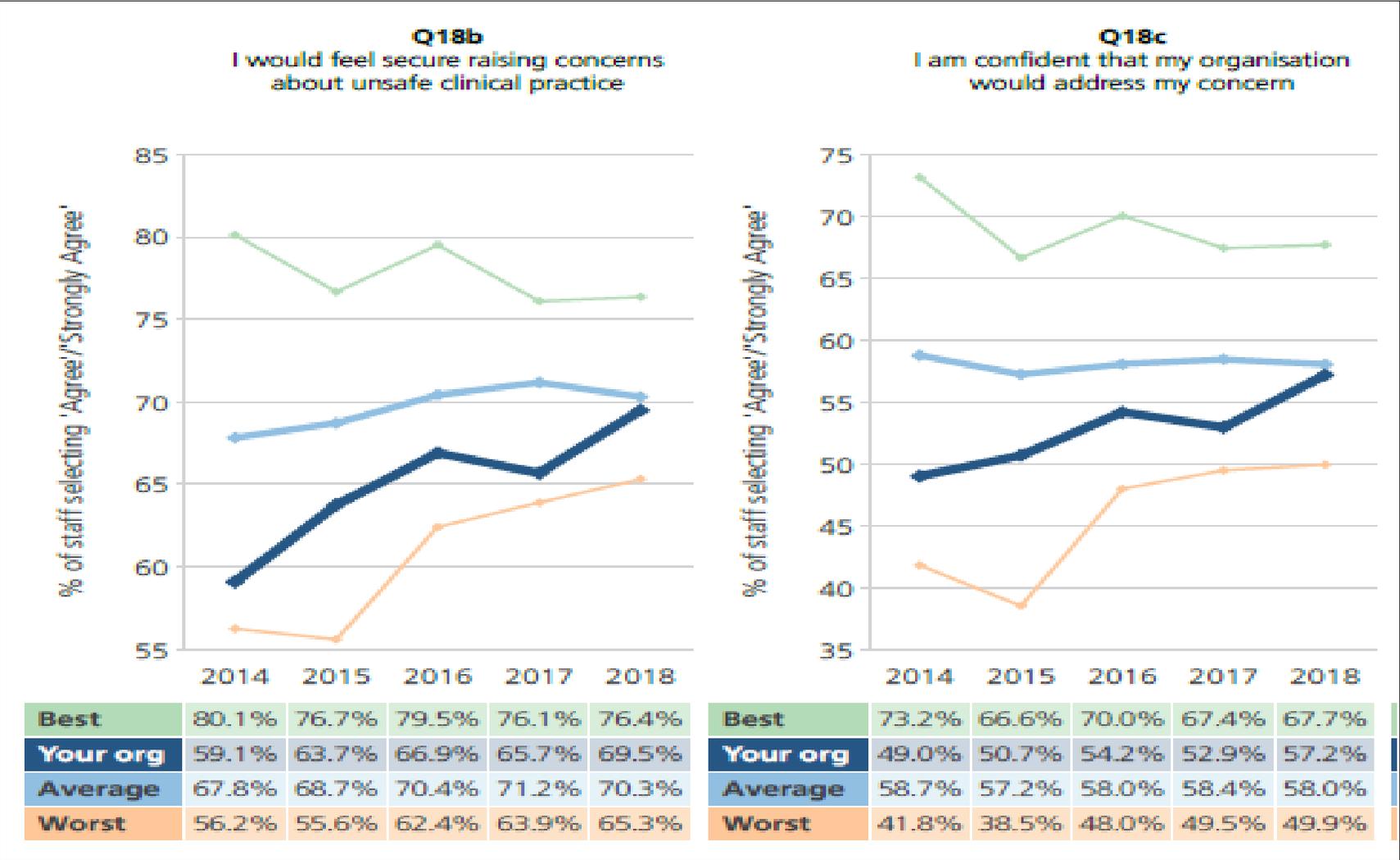
We must genuinely and widely embrace this as part of our cultural change to be assured of achieving and sustaining a positive speaking up culture. Achieving this will not only benefit "Speaking Up" which is critical to underpinning patient and staff safety, but it is integral to the development of a learning, just and fair culture which in turn will help us achieve a personal, fair and diverse organisation providing high quality of care to our patients.

6.0 Next Steps

- To establish and develop the new Outreach FTSUG team and model
- To implement and undertake the key work to meet our objectives for the forthcoming year, which includes the development of a network of Trustwide “Speak Up” champions who will have a clear defined role, who will be supported and who will receive FTSU Champion training locally.
- To achieve the best level of awareness and outreach to date for our October Speaking Up month campaign this year.
- To launch the national Speak Up and Listen Up training campaign for staff across the organisation.
- To develop a set of metrics that will evidence the added value the new Outreach FTSUG team members have brought to enable us to build sustainability and look to extend their employment beyond the one year.

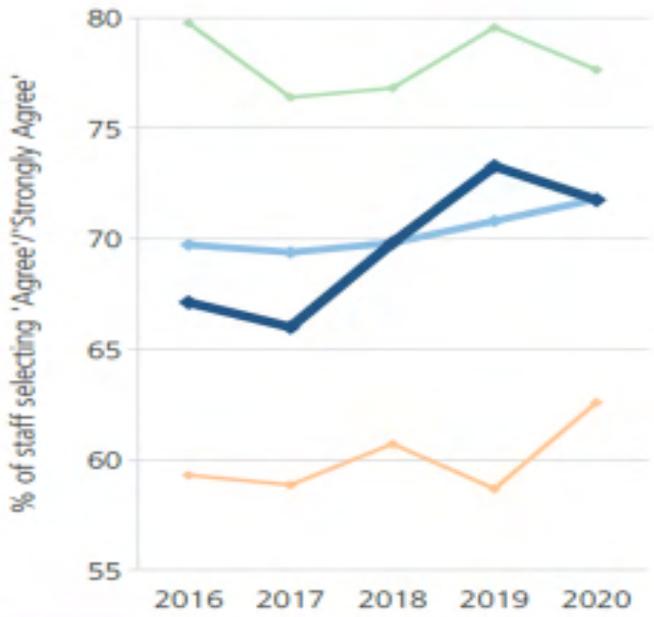
2014 to 2018 National Staff Survey Results for comparison.

BHT –
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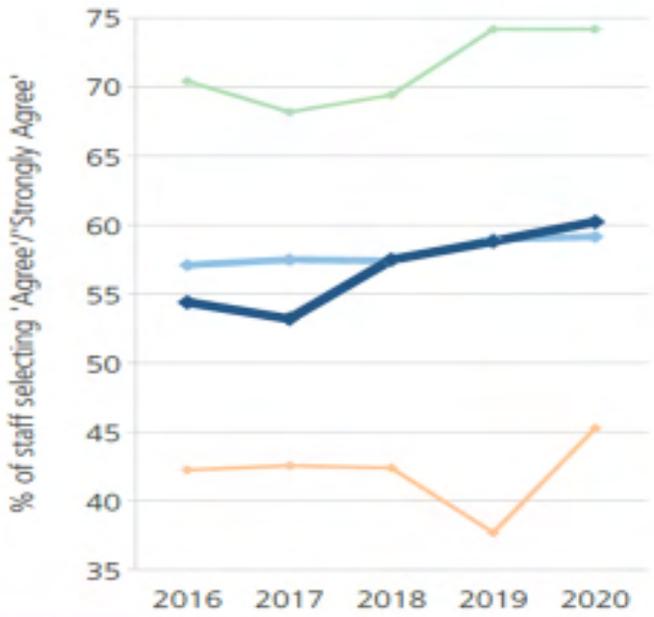
National Staff Survey Results 2020

Q17b
I would feel secure raising concerns about unsafe clinical practice



Best	79.7%	76.4%	76.8%	79.6%	77.6%
Your org	67.1%	66.0%	69.8%	73.3%	71.7%
Average	69.7%	69.4%	69.8%	70.8%	71.8%
Worst	59.3%	58.8%	60.7%	58.7%	62.6%

Q17c
I am confident that my organisation would address my concern

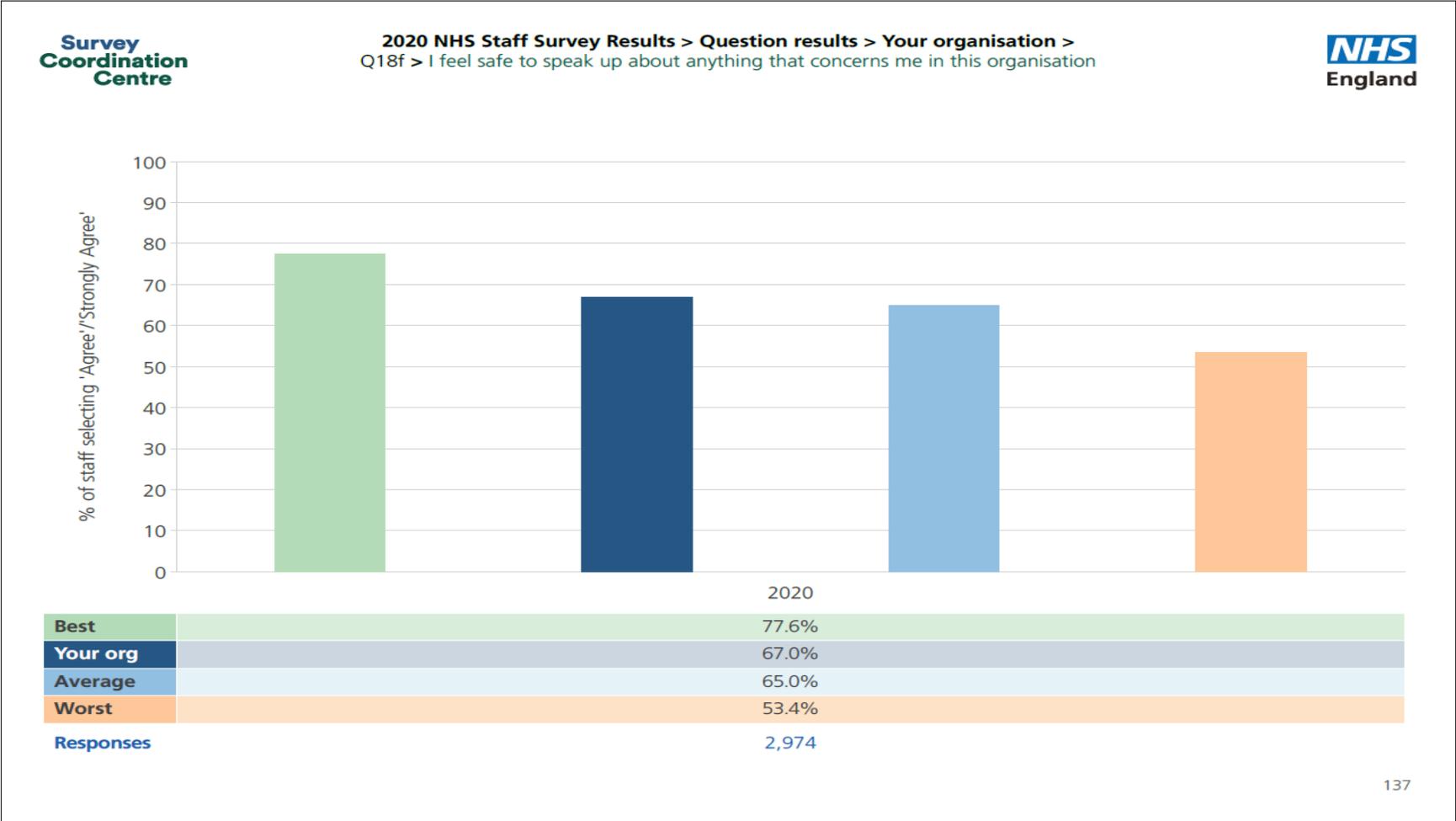


Best	70.4%	68.2%	69.4%	74.2%	74.2%
Your org	54.4%	53.2%	57.5%	58.8%	60.2%
Average	57.1%	57.5%	57.4%	58.9%	59.1%
Worst	42.2%	42.5%	42.4%	37.7%	45.2%

BHT
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New “Speaking Up” Question – National Staff Survey for 2020

BHT
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This question provides a better measure of the organisational “Speaking Up” culture i.e for any concern

Meeting: Trust Board Meeting in Public

28 July 2021

Agenda item	Medical Appraisal & Revalidation Annual Board Report 2020/2021	
Board Lead	Mr Andrew McLaren	
Type name of author	Medical Appraisal & Revalidation Team	
Attachments	Annex-d-annual-board-report-and-statement-of-compliance	
Purpose	Assurance	
Previously considered	EMC: 06 July 21 Approved Strategic Workforce - 12 July 21 Approved	

Executive Summary

The report is to provide assurance to the Trust Board that internal processes for Medical Appraisal and Revalidation are robust, and to report on the 20/21 activity.

Decision	The Board is requested to approve the report and asked to delegate approval for the CEO to sign the Annex-d-annual-board-report-and-statement-of-compliance confirming that the organisation, as a designated body, is in compliance with the regulations.
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Relevant strategic priority

Quality <input checked="" type="checkbox"/>	People <input checked="" type="checkbox"/>	Money <input type="checkbox"/>
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Implications / Impact

Patient Safety	The report has no direct impact on patients
Risk: link to Board Assurance Framework (BAF)/Risk Register	The report does not link to Board Assurance Framework Risk register
Financial	There is no financial implication in the report
Compliance Select an item. Select CQC standard from list.	The Trust will continue to meet its compliance and legislative requirements
Partnership: consultation / communication	The report is not required to consult with any partnership
Equality	The report does not affect equality
Quality Impact Assessment [QIA] completion required?	The report does not require a QIA

Annual Board Report

Medical Appraisal and Revalidation Summary of 2020-2021 Appraisal Year

Author	Sarah Klamut, Medical Quality & Development Manager
Lead executive	Mr Andrew McLaren, Interim Chief Medical Officer and Responsible Officer

Contents

1. Changes to medical appraisal & revalidation activities	3
2. Executive summary	4
3. Purpose of the paper	4
4. Governance arrangements	5
5. Medical appraisal	5
6. Quality assurance	6
7. Access, Security & confidentiality	6
8. Revalidation recommendations	7
9. Recruitment & engagement, background checks	7
10. Monitoring performance	7
11. Responding to concerns & remediation	7
12. Future developments	7
13. Recommendations	8
Appendix 1 - Letter from Professor Stephen Powis	9
Appendix 2 – Annex D Statement of compliance (Attached)	

Changes to medical appraisal & revalidation activities in light of the Covid Pandemic.

In a letter dated 19 March 2020 from Professor Stephen Powis, National Medical Director, NHS England and NHS Improvement to Responsible Officers (RO) it was strongly recommended that medical appraisals should be suspended until further notice and affected appraisals regarded as cancelled, not postponed.

In March 2020, the General Medical Council (GMC) postponed revalidation dates for doctors who were due to revalidate between 17 March and the end of September 2020. Since then and in response to the feedback received from responsible officers nationally, the GMC decided to move revalidation dates back by one year for revalidations between 1 October 2020 and 31 July 2021.

The changes to professional standards activities was to immediately increase capacity in the medical workforce by allowing doctors to undertake clinical practice.

In consultation with divisional chairs and Executive Management Committee (EMC) approval 5 May 2020, a decision was taken by the responsible officer to cancel all appraisals for the 20/21 appraisal year (1/04/20 – 31/03/21). These appraisals will be considered approved missed appraisals.

The following factors were considered:

- Uncertainty with COVID-19 situation.
- Undue burden on appraisers to undertake appraisals in a shorter period of time.
- Could create inequity if some doctors are expected to undertake an appraisal and others are not.
- Limited opportunity for doctors to complete the missing elements required for an annual appraisal e.g. continuous professional development (CPD), personal development plan (PDP), multi-source feedback (MSF) and quality improvement activities not directly relevant to the current outbreak.
- Revalidation recommendations will be assessed on fulfilment of the revalidation requirements rather than the number of appraisals undertaken.

Doctors were advised that they could have an appraisal if they wish to and that they would be processed and recorded. Doctors with approved missed appraisals will be required to reflect on the whole scope of their practice from the last recorded appraisal.

Medical Appraisal activity resumed from 1st April 2021 for all doctors.

1.0 Executive Summary

- 1.1 This report covers the 2020/2021 medical appraisal activity from 1 April 2020 – 31 March 2021.
- 1.2 By the 31 March 2021 **449** Doctors had a GMC prescribed connection to the Trust for medical appraisal and revalidation. This includes Consultants, SAS doctors, locally employed doctors and locum bank doctors with a Trust contract.
- 1.3 Arrangements are in place to ensure doctors are appraised and revalidated to a standard that meets the requirements of the RO regulations and are working effectively.
- 1.4 In the 2020-2021 appraisal year, the responsible officer cancelled all appraisals. These appraisals will be considered missed approved. However, doctors could have an appraisal if they wished to. 59 out of 449 (13.15%) GMC prescribed doctors managed to undertake a medical appraisal in 20/21.
- 1.5 Medical appraisal will resume from 1st April 2021 for all doctors. Doctors who did not undertake an appraisal in 20/21 will be required to reflect/discuss their whole scope of practice for the previous 2 years or since the date of their last appraisal. There are 8 doctors who have not had an appraisal for more than 2 years and are expected to undertake one in 21/22.
- 1.6 The GMC recognised during 2020 that some doctors were ready to revalidate and restarted revalidations giving designated bodies flexibility to revalidate doctors where appropriate.
- 1.7 NHSE's national annual organisation audit (AOA) exercise was cancelled for the 2020/2021 appraisal year due to the COVID-19 outbreak. NHSE's have also announced that the audit has been stood down again this year. NHSE's confirmed that they will no longer be requesting Quarterly Reports.

2.0 Purpose of the Paper

- 2.1 The Trust has a statutory duty to support its RO in discharging their duties under the Responsible Officer Regulations and it is expected that the Board will oversee compliance by:
 - Monitoring the frequency and quality of medical appraisals in the organisation.
 - Checking there are effective systems in place for monitoring the conduct and performance of their doctors.
 - Confirming the feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors.
 - Ensuring that appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that medical

practitioners have qualifications and experience appropriate to the work performed.

2.2 It is a requirement that the Trust Board receives an annual report on medical appraisal and revalidation.

2.3 The purpose of this report is to update the Trust Board as part of the RO regulations on arrangements within the Trust and performance in achieving compliance with the process.

2.4 The Board is asked to **Note** the report

3.0 Governance Arrangements

3.1 Medical appraisal and revalidation are supported by the medical appraisal and revalidation team. The team has access to GMC Connect to ensure that the list of doctors for whom the designated body (Buckinghamshire Healthcare NHS Trust) is responsible for is up to date.

3.2 All complaints involving medical staff are notified to the RO.

3.3 The Trust's patient safety team and complaints department provide data on complaints and Datix reports to medical staff to support their appraisals.

3.4 A Medical Appraisal & Revalidation Policy is in place and was formally agreed September 2018 through the Trust's policy approval processes. The Policy is due to be reviewed in 2021.

3.5 Regular meetings are held with a GMC Employer Liaison Adviser to discuss local concerns/investigations concerning doctors, GMC cases, deferrals and non-engagement recommendations. These have continued throughout the Pandemic.

4.0 Medical Appraisal

4.1 The medical appraisal & revalidation database is audited on a monthly basis against GMC Connect and ESR to record new starters and leavers and to ensure there is an accurate record of doctors requiring an annual appraisal.

4.2 All doctors with a prescribed GMC connection are allocated an appraisal month in which to have an appraisal. This is usually within 12 months of the last appraisal and in line with revalidation dates.

4.3 Medical appraisal can be postponed or deferred if a doctor is off sick, on maternity leave or has agreed in advance with the appraisal lead. Medical appraisal was cancelled during the 20/21 year due to the pandemic and are recorded as missed approved.

- 4.4 Annual medical appraisal compliance is now monitored by an online medical appraisal management system with L2P. Any compliancy concerns will be escalated to the appraisal lead, SDU leads and divisional chairs if necessary.
- 4.5 From 1st June 2020 all doctors connected to the RO have access to the online medical appraisal management system with L2P (excluding bank locum doctors who still use a paper version). The system allows a doctor to assign an appraiser, book an appraisal meeting, complete the appraisal paperwork and add supporting information all via the system.
- 4.6 Doctors undertake a patient and colleague feedback exercise (required once in 5 years for revalidation) This is completed on the L2P system and includes an online patient feedback function. L2P collate the data and provide the doctor with a report for discussion/reflection at their appraisal.
- 4.7 The quality and consistency of medical appraisal relies heavily on the skills and the professionalism of medical appraisers. There are 58 Trust approved medical appraisers. Annual appraiser network meetings are held to provide training, updates and review appraisals for quality assurance and will resume in 2021.

5.0 Quality Assurance

- 5.1 Quality assurance of medical appraisals was postponed during the pandemic due to limited appraisal activity and will resume in 2021. A Medical Appraisal Quality Assurance Assessment Tool (MAQAAT) is used to score and provide general comments on the quality of an appraisal. This is fed back to both the individual doctor and the appraiser for learning purposes.
- 5.2 All doctors are encouraged to provide feedback on their appraisal meeting via an electronic survey conducted by the online medical appraisal management system with L2P. The results are provided annually and contribute towards the appraiser's own appraisal discussion.
- 5.3 The medical appraisal and revalidation team attend NHS England RO & Medical Appraisal Leads Network Meetings to keep up to date with NHS England and GMC activity. Although not all RO networks have gone ahead during the pandemic, updates are circulated by email on a regular basis.

6.0 Access, security and confidentiality

- 6.1 There is no Patient Identifiable Data in appraisal records. Each doctor has their own electronic log in for the online medical appraisal management system with L2P.

Revalidation Recommendations

- 7.1 All revalidation recommendations are reviewed by the Revalidation Referral Group (RRG). The group members include the RO Divisional Chairs, Medical Education Director and Associate Medical Director. The RRG discussions resumed in August 2020 to manage the back log of revalidations following the GMC restarting revalidation recommendations.

8.0 Recruitment and Engagement, Background Checks

- 8.1 The Trust follows the NHS Employment Check Standards produced by NHS Employers for all recruitment of permanent staff, fixed term contracts temporary locum staff, students, trainees and locum bank doctors with a Trust contract.
- 8.2 In addition to a standard employment reference, a transfer of information from previous employers can be obtained for new appointments. Doctors working outside of the Trust either in another NHS organisation or private practice must declare such work in their appraisal whole scope of practice. An external practice form must be completed and signed off by each organisation where other work is undertaken to confirm any fitness to practice concerns. External Practice forms must be attached to the supporting information section of a doctor's appraisal.
- 8.3 GMC connect provides a connection history and establishes a doctor's movement within the medical field.

9.0 Monitoring Performance

- 9.1 All doctors are professionally accountable to the Chief Medical Officer.
- 9.2 Monitoring performance is undertaken by Job planning, management of complaints via Datix and a medical HR casework tracker.
- 9.3 Significant events are recorded as part of the annual medical appraisal. Discussions are about how events have led to a specific change in practice or demonstrate learning.

10.0 Responding to Concerns and Remediation

- 10.1 All medical Conduct, Capability, Ill health is managed by the medical HR team. The Appeals Policies and Procedures for Practitioners – Maintaining High Professional Standards (MHPS) outlines the process for dealing with serious concerns about a doctor's performance including conduct, capability and health issues. A case tracker is held within Medical HR.

11.0 Future Developments

- 11.1 NHSE's recommendation for medical appraisal for 21/22 is that the focus should be on a doctor's wellbeing. Doctors are asked to reflect in the appraisal on their

health and wellbeing in the context of the challenges presented by the Covid-19 pandemic.

Doctors are asked to discuss the following:

- How has the Covid-19 pandemic impacted you?
- How do you maintain your health and wellbeing, and what do you need to do differently (if anything)?
- Have you needed any support and, if so, was the help you needed available?

11.2 Letter from Professor Stephen Powis, National Medical Director, NHS England and NHS Improvement to Responsible Officers (RO) dated 30 April 2021. The letter outlines the recommendations for professional standards activities for 21/22. **Appendix 1.**

12.0 Recommendations

12.1 The board are asked to agree to this report.

12.2 The Chief Executive Officer is asked to sign a Statement of Compliance **Appendix 2** – (separately attached) Annex D – Annual Board Report and Statement of Compliance. This is to confirm the Trust has reviewed the content of the report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Appendix 1 - Letter from Professor Stephen Powis, National Medical Director, NHS England and NHS Improvement to Responsible Officers (RO) dated 30 April 2021

Classification: Official
Publications approval reference: C1231



To: Responsible Officers and Medical Directors
in England

NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

30 April 2021

Dear colleagues,

Professional standards activities in 2021/22

Further to my letters on [19 March 2020](#) and [3 September 2020](#) I am writing about professional standards activities as we enter a new appraisal year. Thank you to you and your teams for maintaining professional standards activities and supporting the Covid response in the way that you continue to do.

I have previously recommended to aim for full participation in appraisal by April 2021, with flexibility for doctors who need to be excused, or as soon as possible for those that have not done so. The [Appraisal 2020](#) model will remain the default model for doctors connected to NHS England and NHS Improvement. This is providing a useful development opportunity, supporting doctors through what has been a difficult time for many. I encourage responsible officers who have not yet done so to adopt it.

Feedback also suggests that the Appraisal 2020 model is a catalyst of professionalism as well as a vehicle for support. What comes next should therefore be a continued forward evolution to consolidate the benefits, whilst still ensuring that revalidation requirements are met. We are working on evaluation and next steps for appraisal and governance processes with partners across the UK, including the Academy of Medical Royal Colleges, GMC and BMA. We will work with you with a view to implementing these in 2022/23.

Last year we cancelled the 2019/20 Annual Organisational Audit and we are now standing down the 2020/21 exercise. However, organisations will still be able to report on their appraisal data and impact of the Appraisal 2020 model later in the year. The annual Board report and Statement of Compliance is being updated to support this. The date for submission of this report is 24 September 2021.

Because they are already covered in the annual Board report, the Framework for Quality Assurance (Annex B) Quarterly Reports will cease from 1 April 2021.

I hope this information provides a useful steer. Doctors and their colleagues in the workforce have risen magnificently to the challenges of the pandemic. By developing the Appraisal 2020 model and ensuring that the next steps consolidate its benefits we will serve not just the profession but their teams and, ultimately, patients.

Yours sincerely,

Professor Stephen Powis
National Medical Director
NHS England and NHS Improvement



A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

NHS England and NHS Improvement



A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

Publishing approval number: **000515**

Version number: 3.0

First published: 4 April 2014

Updated: February 2019

Prepared by: Lynda Norton, Claire Brown, Maurice Conlon

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact Lynda Norton on England.revalidation-pmo@nhs.net.

Contents

Introduction:	3
Designated Body Annual Board Report.....	5
Section 1 – General	5
Section 2 – Effective Appraisal	6
Section 3 – Recommendations to the GMC	7
Section 4 – Medical governance.....	8
Section 5 – Employment Checks	9
Section 6 – Summary of comments, and overall conclusion	9
Section 7 – Statement of Compliance	10

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and annexes A – G. Included in the seven annexes is the Annual Organisational Audit (annex C), Board Report (annex D) and Statement of Compliance (annex E), which although are listed separately, are linked together through the annual audit process. To ensure the FQA continues to support future progress in organisations and provides the required level of assurance both within designated bodies and to the higher-level responsible officer, a review of the main document and its underpinning annexes has been undertaken with the priority redesign of the three annexes below:

- **Annual Organisational Audit (AOA):**

The AOA has been simplified, with the removal of most non-numerical items. The intention is for the AOA to be the exercise that captures relevant numerical data necessary for regional and national assurance. The numerical data on appraisal rates is included as before, with minor simplification in response to feedback from designated bodies.

- **Board Report template:**

The Board Report template now includes the qualitative questions previously contained in the AOA. There were set out as simple Yes/No responses in the AOA but in the revised Board Report template they are presented to support the designated body in reviewing their progress in these areas over time.

Whereas the previous version of the Board Report template addressed the designated body's compliance with the responsible officer regulations, the revised version now contains items to help designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance¹. This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). Some of these points are already addressed by the existing questions in the Board Report template but with the aim of ensuring the checklist is fully covered, additional questions have been included. The intention is to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. In this way the two regulatory processes become complementary, with the practical benefit of avoiding duplication of recording.

¹ Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]

The over-riding intention is to create a Board Report template that guides organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

- a) help the designated body in its pursuit of quality improvement,
- b) provide the necessary assurance to the higher-level responsible officer, and
- c) act as evidence for CQC inspections.

- **Statement of Compliance:**

The Statement Compliance (in Section 8) has been combined with the Board Report for efficiency and simplicity.

Designated Body Annual Board Report

Buckinghamshire Healthcare NHS Trust 20/21

Section 1 – General:

The board / executive management team –of Buckinghamshire Healthcare NHS Trust can confirm that:

1. The Annual Organisational Audit (AOA) for this year has been submitted.

No

Date of AOA submission:

The 20/21 AOA has been postponed by NHS England and NHS Improvement due to the COVID-19 pandemic.

Action for next year:

Submit the AOA when it becomes available.

2. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Yes

Action from last year:

Dr Tina Kenny GMC No. 2555351, Responsible officer stepped down from the RO role on 31 March 2021.

Comments:

The interim responsible officer is Mr Andrew McLaren GMC No. 3277294 commencing 1st April 2021.

Action for next year:

None

3. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes

Action from last year:

An online medical appraisal management system was launched in June 2020. The new system provides evidence for the Responsible Officer to form the basis of a revalidation recommendation to the GMC and provide reporting on medical appraisal activity.

Comments:

The responsible officer is supported by a medical appraisal and revalidation team including a medical appraisal lead, a medical quality and development manager and administrator.

Action for next year:

None

4. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Yes

Action from last year:

An accurate record of doctors with a prescribed connection to Buckinghamshire Healthcare NHS Trust is maintained by the Medical Appraisal & Revalidation Team. The online medical appraisal management system streamlines medical appraisal & revalidation administration and reporting.

Comments:

The medical appraisal & revalidation database is audited on a monthly basis against GMC Connect and the Trust Electronic staff record.

Action for next year:

Continue to monitor medical appraisal & revalidation GMC connect activity.

5. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Yes

Action from last year:

Policies are reviewed and updated as and when required.

Comments:

An HR Policy and Governance team monitor policy reviews.

Action for next year:

Medical Appraisal & revalidation Policy is due to be reviewed/updated in 2021

6. A peer review has been undertaken of this organisation's appraisal and revalidation processes.

No

Action from last year:

None

Comments:

We have not had a peer review this year.

Action for next year:

None

7. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Yes

Action from last year:

We continue to monitor appraisal activity

Comments:

Processes are in place to engage with all doctors for medical appraisal compliance.

Action for next year:

To continue to monitor appraisal activity.

Section 2 – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Yes.

Action from last year:

2021 appraisal activity was cancelled for most doctors due to the Covid-19 outbreak. This was recorded as missed approved agreed by the RO.

Comments:

Doctors will need to reflect on their whole scope of practice since their last appraisal once appraisal activity resumes.

Doctors were provided with complaints/DATIX data throughout 20/21 to be discussed in their 21/22 appraisal. A process is in place for doctors to give assurance to the RO of their fitness to practice in external organisations where they also work in addition to work undertaken at Bucks Healthcare.

Action for next year:

Ensure all doctors undertake an annual appraisal from 1st April 2021.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year:

20/21 appraisal activity was cancelled due to the Covid-19 outbreak.

Comments:

This was recorded as missed approved agreed by the RO

Action for next year:

Medical appraisal activity resumes from 1st April 2021 for all doctors.

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Yes

Action from last year:

To be reviewed in 2021.

Comments:

A Medical Appraisal & Revalidation Policy is in place and was formally agreed September 2018 through the Trust's policy approval processes.

Action for next year:

The policy will be ratified by the Trust's policy approval committees following the review.

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Yes

Action from last year:

10 new appraisers were offered training in 2020 and existing appraisers offered appraiser refresher online e-Learning.

Comments:

Due to Covid-19 pressures training has been delayed for some appraisers which have been rescheduled for courses in 2021.

Action for next year:

All new appraisers to complete the training.

5. Medical appraisers participate in ongoing performance review and training/development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers² or equivalent).

Yes

Action from last year:

Appraiser networks and quality assurance meetings were cancelled due to the pandemic.

Comments:

Training workshops were provided for appraisers and doctors on the new online medical appraisal management system ahead of appraisals restarting from 1st April 2021

Action for next year:

Restart quarterly appraiser networks and quality assurance meetings.

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Yes

Action from last year:

Due to the pandemic there was no quality assurance undertaken using the Medical Appraisal Quality Assurance Assessment Tool (MAQAAT).

Comments:

Where a doctor did manage to have an appraisal, the appraisal was checked, reviewed and recorded as part of the normal reviewing appraisal process.

Action for next year:

To resume quality assurance using the Medical Appraisal Quality Assurance Assessment Tool (MAQAAT) in 2021.

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

² <http://www.england.nhs.uk/revalidation/ro/app-syst/>

² Doctors with a prescribed connection to the designated body on the date of reporting.

Yes

Action from last year:

Following the GMC postponing revalidations in early 2020 they then introduced flexibility for designated bodies to be able to submit a recommendation for those doctors who were ready to be revalidated.

Comments:

We restarted submitting revalidation recommendations from the end of July 2021.

Action for next year:

All revalidation recommendations to resume from 1st April 2021.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Yes

Action from last year:

Continue to communicate with all doctors about revalidation readiness.

Comments:

We support doctors to achieve revalidation readiness and discuss options to defer if necessary.

Action for next year:

Continue to engage with doctors.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Yes

Action from last year:

None

Comments:

There are effective clinical governance processes in place for doctors

Action for next year:

None

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Yes

Action from last year:

None

Comments:

Doctors are provided with information on complaints and DATIX reports for discussion at appraisal.

Action for next year:

Continue to provide doctors with complaints/DATIX report information.

3. There is a process established for responding to concerns about any licensed medical practitioner's¹ fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Yes

Action from last year:

None

Comments:

Any concerns regarding fitness to practise are dealt with under our Maintaining High Professional Standards policies and procedures. A case tracker is held within Medical HR to monitor case progress.

Action for next year:

Continue to track and monitor concerns.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors³.

⁴This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

Yes

Action from last year:

Employee Relations PSED report was suspended for 2020 due to the pandemic.

Comments:

The data is included in the PSED (public sector equality duty) reports together with non-medical activity.

Action for next year:

None

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation⁴.

Yes

Action from last year:

None

Comments:

A transfer of information is shared with/by other organisations when doctors move around. Doctors are required to obtain an external practice form if they work in other organisations. The form is completed by the other employers to confirm any fitness to practise concerns.

Action for next year:

Continue to gather the above information.

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Yes

Action from last year:

None

Comments:

⁴ The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: <http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents>

There are robust safeguard processes in place for responding to concerns about a doctor's practice.

Action for next year:

None

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Yes

Action from last year:

None

Comments:

We have rigorous pre-employment checks for licensed medical practitioners undertaken by the medical HR team.

Action for next year:

Continue to follow the NHS Employment Check Standards produced by NHS Employers for all recruitment

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

- General review of last year's actions - **It is a requirement that the Trust Board receives an annual report on medical appraisal and revalidation at the Trust board in the month of July.**
- Actions still outstanding - **None**
- Current Issues – **No issues**
- New Actions:
 - 1) **Submit an AOA (Annual Organisation Audit) to NHS England when required.**
 - 3) **Review and update Medical Appraisal & Revalidation Policy in 2021**

Overall conclusion:

Medical appraisal and revalidation were interrupted during 20/21 due to the Covid-19 pandemic, but this will resume from 1st April 2021. Arrangements are in place to ensure doctors are appraised and revalidated to a standard that meets the requirements of the RO regulations and are working effectively. We

closely monitor annual medical appraisal completion and are committed to continually improving and developing our systems to ensure potential non-engagement is dealt with quickly and effectively.

Section 7 – Statement of Compliance:

The Board / executive management team –of Buckinghamshire Healthcare NHS Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: **Buckinghamshire Healthcare NHS Trust**

Name: **Mr Neil Macdonald**

Signed:

Role: **Chief Executive Officer**

Date:

Meeting: Trust Board Meeting in Public

28 July 2021

Agenda item	Annual PSED Public & Patient Report 2020-2021
Board Lead	David Williams
Name of Author/s	Lesly Clifford, Dee Irvin
Attachments	
Purpose	Assurance
Previously considered	EMC and Quality Clinical Governance Committee

Executive Summary

- This report provides assurance to the Trust Board and to the Public that BHT is meeting its PSED obligations and continuing to promote an inclusive culture across the organisation.
- The report summarises our patient and public equality, diversity and inclusion activity in 2020/21. The Trust has a legal obligation, (under the Public Sector Equality Duty, as set out in the Equality Act 2010), to deliver equal access to fair and inclusive services and opportunities, but over and above our legal obligations, we as a Trust want to ensure that these basic principles are embedded in everything we do.

In 2019 the following equality objectives were set by our Trust Board for 2019-2023, in line with our PSED requirements. These are the equality objectives set for public and patients only:

- Reduce inequalities for patients with protected characteristics
- Engage isolated patient groups in Buckinghamshire
- Listen and act upon the patient voice

These objectives were developed following our EDS2 assessments undertaken in 2019.

Decision The Committee is requested to note the report findings.

Relevant Strategic Priority

Quality **People** **Money**

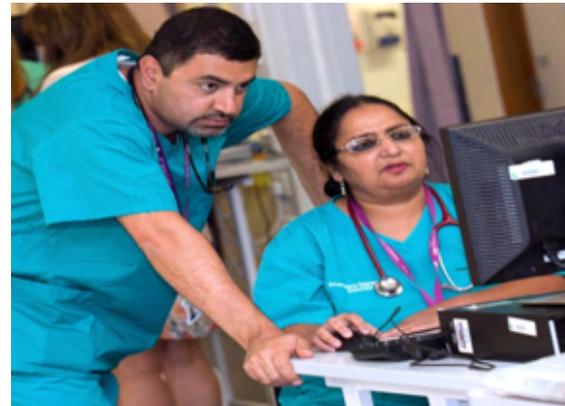
Implications / Impact

Patient Safety	Ensuring equitable treatment and accessibility of our services for our patients and members of our local community
Risk: link to Board Assurance Framework (BAF)/Risk Register	1.7 inequalities in access to care, 3.5 not realising potential as an anchor institution
Financial	N/A
Compliance Select an item. Select CQC standard from list.	Equality Duty and the Equality Act 2010
Partnership: consultation / communication	Public and Patient Equality, Diversity and Inclusion Group
Equality	Ensuring equitable treatment and accessibility of our services for our patients and members of our local community as part of our duties under

	Equality and Human Rights Commission (EHRC), Equality Act 2010.
Quality Impact Assessment [QIA] completion required?	N/A

Annual Patient & Public Equalities Report 2020/21

Buckinghamshire Healthcare NHS Trust



A Message from our Director of Strategy

Buckinghamshire Healthcare NHS Trust is committed to promoting Equality, Diversity, and Inclusion (ED&I), creating a diverse, accessible and inclusive organisation where everyone feels like they belong. We aim to ensure that respect for diversity and inclusion are embedded in all areas of the community we serve.

Our role is to ensure everyone working, living and visiting Buckinghamshire Healthcare NHS Trust has equal access to fair and inclusive services and opportunities. As part of our own objectives, core values and strategy, we are committed to:

- the elimination of discrimination
- reducing health inequalities by building community partnerships
- promoting equality of opportunity
- dignity & respect for all our patients, service users, their families, carers and our staff
- listening to our patients; and
- being a great place to work.

The pandemic has brought to the fore the issue of health inequalities with those from our Black, Asian & Minority Ethnic (BAME) communities, those with a disability or with underlying health conditions being disproportionately impacted by COVID-19. There has also been a significant impact on our children and young people.. One of our key objectives is for the Trust to take a leading role in the local community, not just in terms of delivering healthcare but also in terms of health education, prevention and providing local employment.

It is evident that parts of our communities find it more difficult to access health care and prevention services but also that they have a worse experience when they do so. A priority for us in the coming year is to work with our partners across Buckinghamshire to look at what more we can do to address these inequalities.

David Williams
Director of Strategy



David Williams
Director of Strategy

“It is evident that parts of our communities find it more difficult to access health care and prevention services but also that they have a worse experience when they do so. A priority for us in the coming year is to work with our partners across Buckinghamshire to look at what more we can do to address these inequalities.”

Executive Summary - How we met the PSED this year

As a publicly funded organisation, Buckinghamshire Healthcare NHS Trust (BHT) is required to publish information annually on how it has met the Public Sector Equality Duties (PSED) and taken steps to eliminate unlawful discrimination, advance equality of opportunity for people with protected characteristics and foster good relations between those who share protected characteristics and those who do not.

This report provides assurance to the Trust Board and to the Public that BHT is meeting its PSED obligations and continuing to promote an inclusive culture across the organisation. The report summarises our patient and public equality, diversity and inclusion activity in 2020/21. The Trust has a legal obligation, (under the Public Sector Equality Duty, as set out in the Equality Act 2010), to deliver equal access to fair and inclusive services and opportunities, but over and above our legal obligations, we as a Trust want to ensure that these basic principles are embedded in everything we do.

In 2019 the following equality objectives were set by our Trust Board for 2019-2023, in line with our PSED requirements. These are the equality objectives set for public and patients only:

- Reduce inequalities for patients with protected characteristics
- Engage isolated patient groups in Buckinghamshire
- Listen and act upon the patient voice

These objectives were developed following our EDS2 assessments undertaken in 2019.

Introduction

Our current Trust strategy was approved in 2016. It supported us on our journey to achieve a CQC rating of 'good' in 2019 ('outstanding' for caring) and to be part of one of the first wave integrated care systems in England.

Our organisation and system have moved on, not least in responding to the largest global pandemic for a century. We are updating our strategy to reflect the ways we have changed how we deliver care and how we want to change in the future to meet the needs of the population.

Our new Trust vision is **Outstanding Care, Healthy Communities and a Great Place to Work**.

It encapsulates our aspirations to be outstanding and reduce health inequalities. It is also clear on our focus on people. We are continuing to develop our compassionate culture valuing diversity and inclusion, involving and enabling everyone to be proud of the care we provide.

Introduction

A Buckinghamshire Integrated Care Partnership Plan linked to reducing health inequalities is being developed.

A Health and Well Being Strategy for Buckinghamshire has now been approved under three themes; Start, Live Well and Age Well with addressing health inequalities at the heart of the strategy Implementation plans and outcomes will be developed with partners over the next few months which will align with the actions outlined.

At a Trust level, a group has been established – the Public and Patient Equality, Diversity and Inclusion Group – to agree priorities, develop action plans and to monitor progress as we strive to reduce health inequalities and ensure all Buckinghamshire residents have equal access to fair and inclusive services and opportunities.

This reports outlines how the Trust has met its Public Sector Equality Duty, highlights some of the successes from 2020/21 as well as areas of focus for the year ahead.

What is the Public Sector Equality Duty?

The [Public Sector Equality Duty](#) (PSED) came into force across the UK in 2011, and is related to the Equality Act 2010. It means that public organisations have to consider all individuals when carrying out their day-to-day work – in shaping policy, in delivering services and in relation to their own employees. It requires that public bodies have due regard to the need to:

Special Duties

To ensure transparency, and to assist in the performance of this duty, PSED Special Duties also require public organisations to publish:

Information to demonstrate their compliance with the Equality Duty, at least annually

Equality objectives, at least every four years

Information relating to employees who share Protected Characteristics

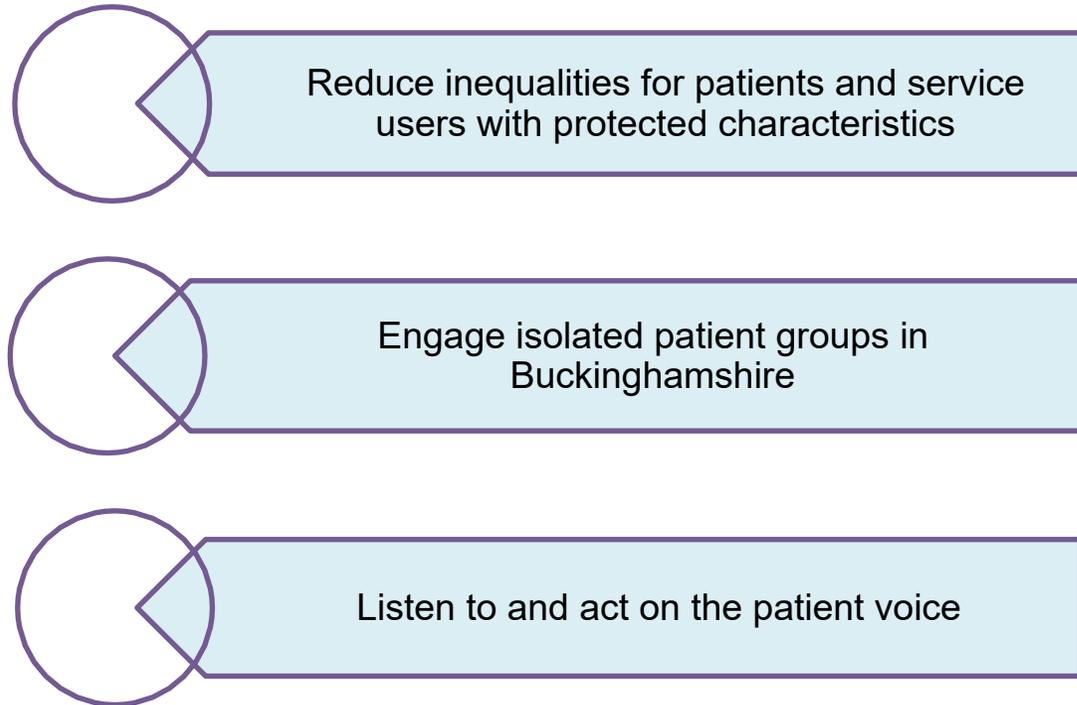
Information relating to service users who share protected characteristics

Protected Characteristics

There are 9 Protected Characteristics which are covered by the Equality Act 2010 and the PSED. Our report will provide an overview of our data and activities in relation to some of these characteristics.

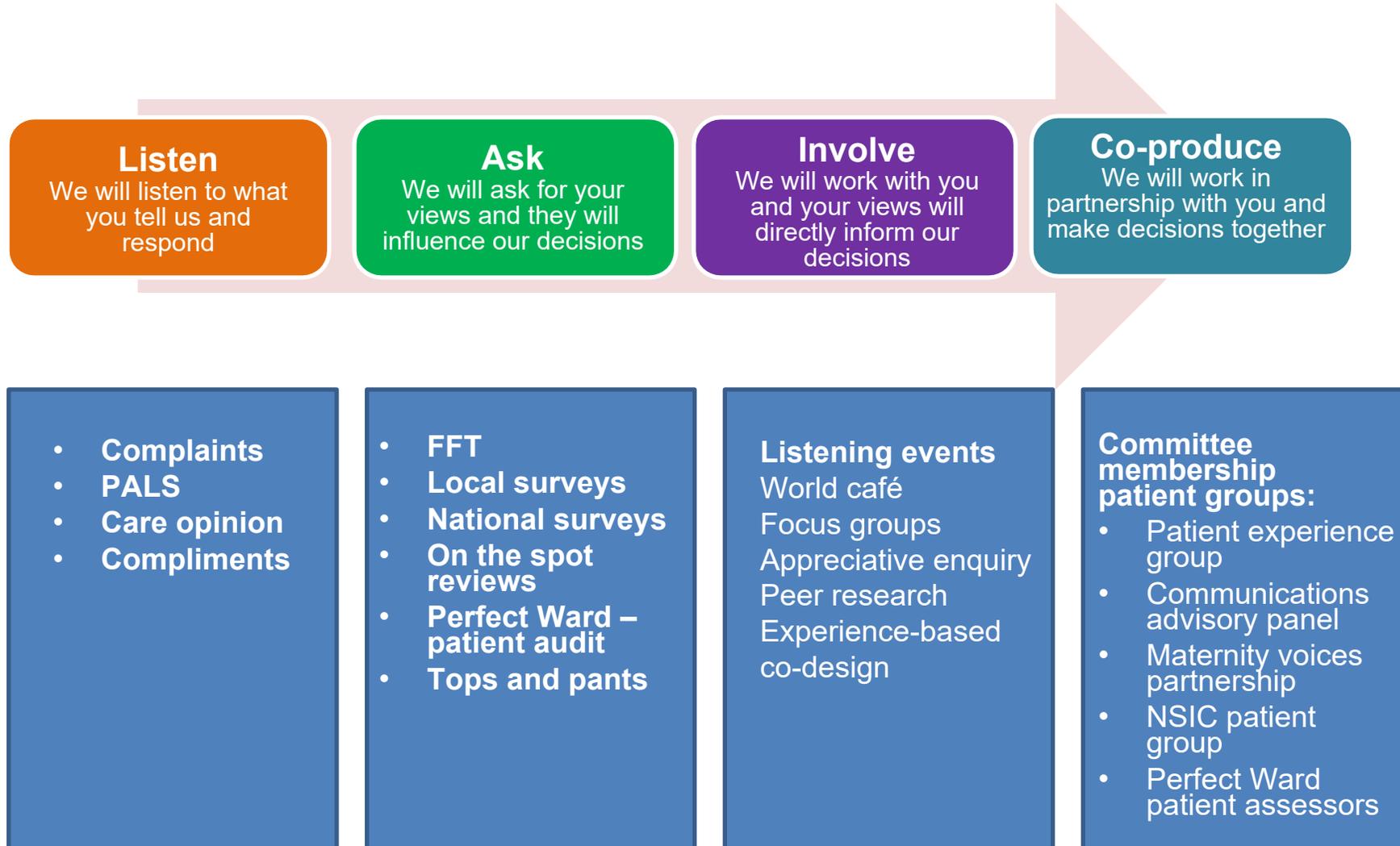
Our Equality, Diversity & Inclusion Objectives

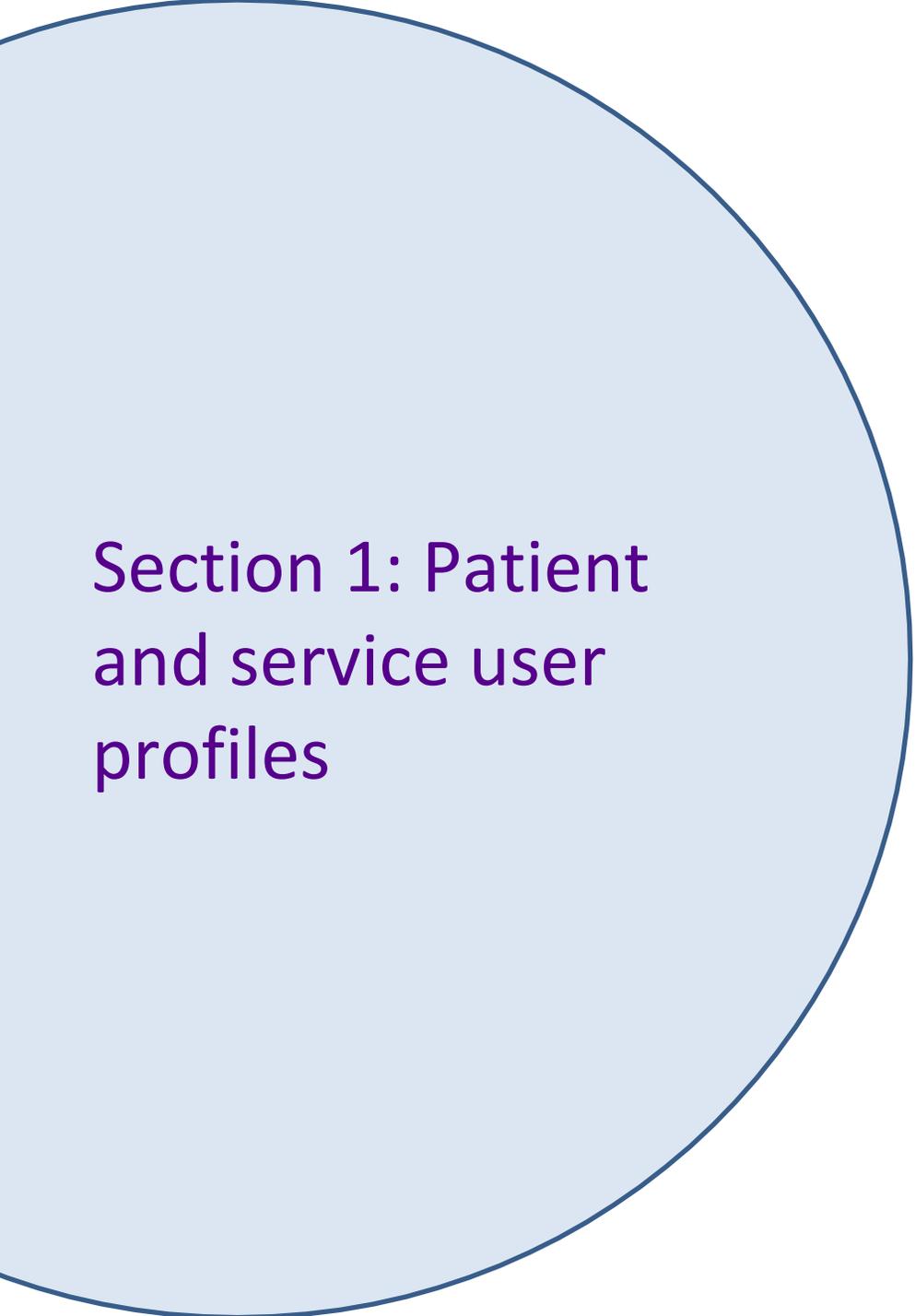
In 2019 the following equality objectives were set by our Trust Board for 2019-2023, in line with our PSED requirements.



These objectives were developed following our EDS2 assessments undertaken in 2019. EDS2 is a national tool designed to help NHS organisations in partnership with local stakeholders (patients and staff), to review and improve their performance for people with protected characteristics and to support them in the Public Sector Equality Duty. Its use is mandated by NHSI and the CQC and must then be used, in conjunction with the other information to inform the Trust's equality objectives.

Working in partnership with the public, our patients and service users





Section 1: Patient and service user profiles

Patient and service user profiles

- By looking at our patient and service user profile by protected characteristic we can look at which groups are accessing our services.
- It enables us to look at patterns of service uptake and understand our patient flows. This can help us identify and understand any potential inequalities of access. A heightened awareness can help us to take a more proactive approach in ensuring equity of access across all the protected characteristic groups.
- There is clear evidence that COVID-19 does not affect all population groups equally and as the nation received this information, the Trust responded, as part of a system wide campaign, to ensure we increased our ethnicity recording.
- Over the last year, the Trust has made progress in the accurate recording of patients' ethnicity. Whilst the number of admitted patients has reduced by 23.5% the volume of patients (change to positive –that do) that do not have an ethnic group recorded has been reduced by 54% to a total of 11,833. We still have work to do to increase ethnicity recording in outpatients, A&E and community services and this will be a priority in 2021/22.

Inpatients by gender

The proportion of female Inpatient activity has once again risen within the financial year 2020/21 to 56.5%. Maternity services during the pandemic remained open and may have contributed to this variance.

Inpatients by ethnicity

Over the last year, the Trust has made progress in the accurate recording of patients' ethnicity. Whilst the number of admitted patients has reduced by 23.5% the volume of patients that do not have an ethnic group recorded has been reduced by almost 54% to a total of 11,833.

Inpatients by age

Following historic patterns, splitting the Trust admissions by age shows little variance across the years. During last year there has been a slight movement from both the paediatric and 51 plus age bands in to the two central groups. This follows understandable patterns of different service pathways during the pandemic.

Outpatients by gender

As with inpatient activity, female attendances make up the larger part of outpatient activity, accounting for 56.2% of the Trust's outpatient activity. This is driven by the services provided within the Trust.

Outpatients by ethnicity

Patient volumes within ethnic groups are staying in line with previous years. This year shows a slight increase in almost all groups as a result of the ongoing work to better record ethnicity information. Overall, whilst the volume of patient appointments has dropped by 21% during the pandemic year, the Not Known and Not Stated groups have dropped by almost 35%.

Outpatients by age

There are slight movements in the overall age profile over the last five years with the 31-50 group dropping consistently and the over 51 age band increasing at a similar rate.

Patients who did not attend (DNA)

A DNA is defined as those patients who do not arrive for an appointment and do not notify the Trust in advance. This is different to cancellations which are recorded when patients notify the Trust in advance that they cannot attend and many of these appointments can be reallocated to other patients. These definitions remain the same as for previous years.

Outpatient DNAs by gender

Within the gender analysis, the gap remains the same with female DNA's still being slightly higher than male but in line with the appointment volume for each gender.

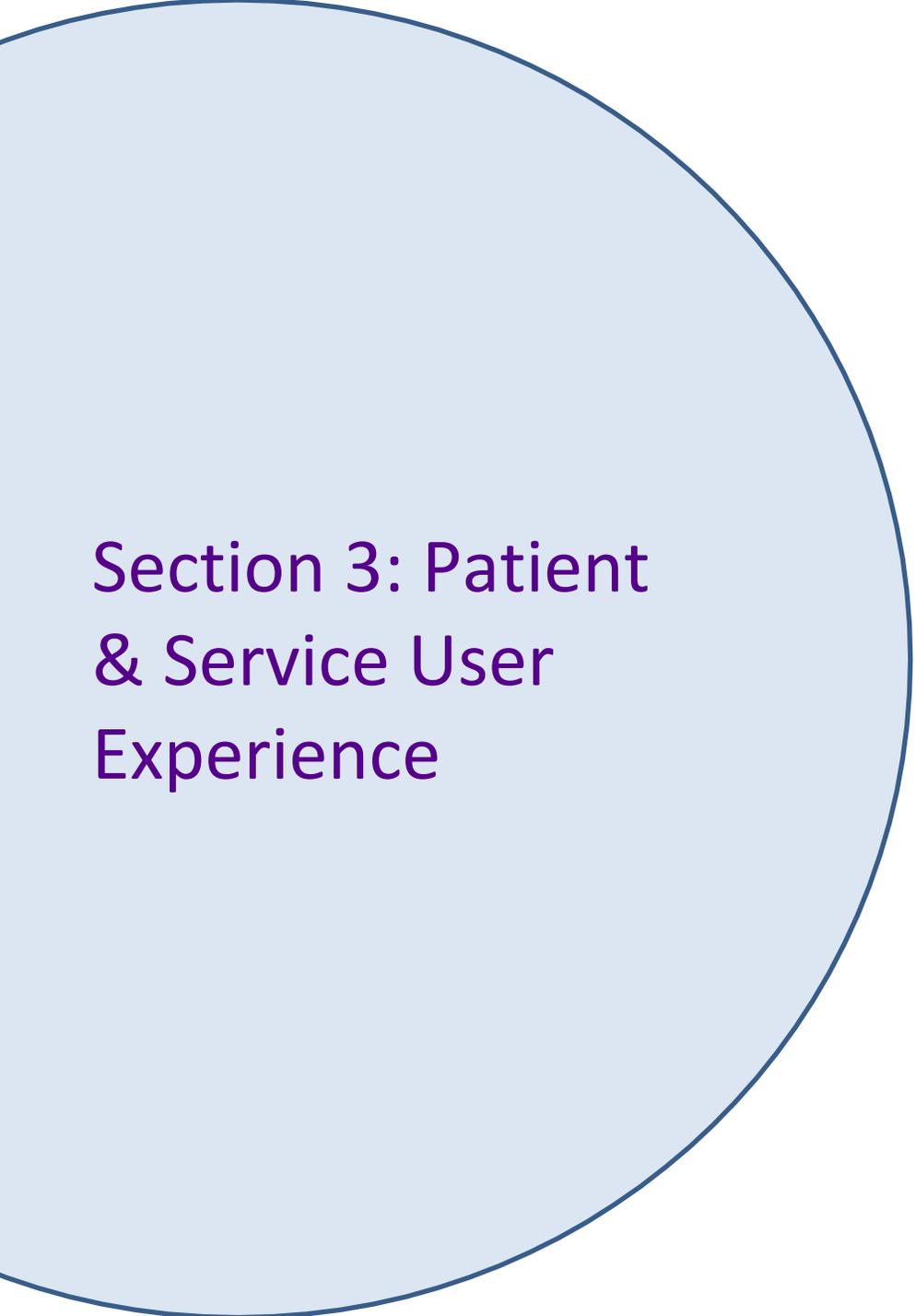
Outpatient DNAs by ethnicity

Outpatient DNAs by age

Interpretation service

- During 2020/21 we have translated over 43 different languages for patients; ensuring that they received full access to our services and clarity of understanding of their healthcare.
- There was a total of 3,062 requests for interpretation that were met during 2020/21 compared to 2,590 requests in 2019/20.
- Urdu, Polish and British Sign Language (BSL) are the top three most requested languages in the county.
- There was continued demand for interpretation into the Romanian language which was fourth.

Interpretation service



Section 3: Patient & Service User Experience

Patient experience groups

BHT's patient groups continued to meet virtually throughout the pandemic working with staff to ensure that excellent patient experience remained a priority throughout the pandemic.

National Spinal Injuries Centre (NSIC) Patient Forum

The NSIC Patient Forum was pleased to support the centre's transformation programme which reflected the priorities of the group.

Maternity Voices Partnership

The Maternity Voices Partnership helped us to ensure that the voice of women and birthing people has been heard throughout the year and kept our parents and families updated with any changes and support available. Going forward we will continue to work collaboratively to co-design services and will prioritise reaching out to lesser heard parents to ensure we provide inclusive, personalised maternity care.

Patient experience groups

Patient Experience Group

The Trust's Patient Experience Group moved from quarterly to weekly meetings. They were involved in co-producing the support package developed for patients. This included:

- 63 iPads and tablets were procured and enabled for video calls to allow for 'virtual visits' for patients and families
- A 'Letter to a Loved One' service was set up to allow friends and family to email in letters and photos which were colour printed and hand delivered to patients in our hospitals; over 600 have been delivered to date
- Over 2,000 comfort packs including toiletries, comb, ear plugs and non-slip socks were distributed to patients
- A priority for the year ahead is to ensure that our patient groups better represent the diversity of the communities we serve.

Equality monitoring of patient groups

Patient Advice & Liaison Service (PALS)

- PALS is a 'one-stop-shop' for patients, carers and relatives seeking advice and support on all aspects of healthcare. PALS aims to deal with concerns promptly and efficiently wherever possible, preventing matters escalating into formal complaints.
- Ensuring equity of access for enquirers is key for BHT, so our PALS and Complaints Officers are trained to be aware of any accommodations that may be needed to support enquirers with protected characteristics or additional needs.
- When complaint meetings are arranged, we ensure our meeting rooms are accessible to all and if mobility is severely reduced, we offer to meet in their homes. During the COVID pandemic we moved meetings to on-line.
- We have an “easy-read” leaflet for PALS to assist complainants in accessing our services and translation of PALS leaflets are offered on request.
- Every effort is made to signpost complainants to “The Advocacy People” (the local complaints advocacy service). This can be particularly helpful for complainants who may have a disability and have difficulty understanding or expressing themselves.
- Claims of discrimination relating to any of the protected characteristics outlined in any formal complaints are monitored via our subject coding and communicated to the Chief Executive, Chief Nurse and to divisional leads both at the time of the complaint and via monthly detailed Trust and divisional reports.

Equality monitoring PALS

- The service works on the principle that people can also contact anonymously, which makes robust equality monitoring more difficult. There are some system limitations which led to the implementation of an annual retrospective survey of those who have contacted the PALS service and provided contact details. The audit is no less than 300 as a sample group.
- The survey is made up of the equality monitoring questions shown below. This is undertaken annually and commenced in 2015. The survey for 2020/21 went out to 327 people and 121 (37%) people responded.

Equality monitoring PALS

Friends and Family Test

BHT patients and service users are given the opportunity to feedback on their care via an SMS which asks the question:

‘Overall, how was your experience of our service?’

This year, as a result of the pandemic, the mandatory national requirement to collect the Friends and Family Test (FFT) data was suspended. Whilst many trusts ceased collecting FFT feedback, BHT continued to ensure patients were able to continue to give their views through this challenging period.

One of the questions asked is ‘Overall how was your experience of our service?’. Experience is rated from very good to very poor. Patients are asked for demographic data, making it possible to understand patient satisfaction across a number of key protected characteristics.

The following charts show the response rates and satisfaction in 2020/21 by gender, age and ethnicity. Please note that they do not include the percentage of people who rated their experience as neither good nor poor.

Friends & Family Test respondents by age

Friends & Family Test satisfaction by age

The highest response rate was from the group aged 61 to 80 at 36.9% whilst the lowest was from those aged 17 to 30 with only 11.66% responding. Those in the older age groups were most satisfied; however, 4.4% of those aged under 16 rated their experience as poor.

Friends & Family Test respondents by ethnicity

Friends & Family Test satisfaction by ethnicity

White British & Irish patients and service users had the highest response rates, the lowest response rate at 9.44% is from those recorded as Pakistani or British Pakistani.

Of those patients who gave their ethnicity, the most satisfied were White British with Bangladeshi or British Bangladeshi patients reporting the lowest satisfaction with 13.46% saying that their experience had been poor or very poor followed by Pakistani or British Pakistani at 9.26%. Further work will be undertaken to try to understand why this is the case and to develop action plans to address any issues identified which has contributed to these scores.

Friends & Family Test respondents by gender

Friends & Family Test satisfaction by gender

The response rate from male and female patients was broadly similar at just under 27%. Male patients were slightly more satisfied with their experience with 92% rating their experience as good or very good compared to 91% of the female patients who responded.

Local surveys

- Each year the Trust conducts a number of local patient experience surveys to obtain feedback on specific services. These surveys may just focus on one aspect of a service e.g. the quality of verbal and written information provided or the whole care pathway from diagnosis to discharge.
- In 2020/21 thirteen of these local patient experience surveys were completed. Areas surveyed included:
 - Plastics Trauma Service
 - Endoscopy services
 - Women's Health – Physiotherapy service
 - Dermatology - Phototherapy
 - General Surgery – patient information
 - Paediatric Diabetes Services – Education sessions
 - Antenatal Screening
 - Voice Therapy
- Where appropriate these surveys collect data regarding the gender, age, ethnicity and long- term health of respondents.

Equality monitoring for local surveys

Formal complaints

In 2020/21 the Trust received 551 formal complaints compared to 643 in 2019/20 – a 14.4% decrease.

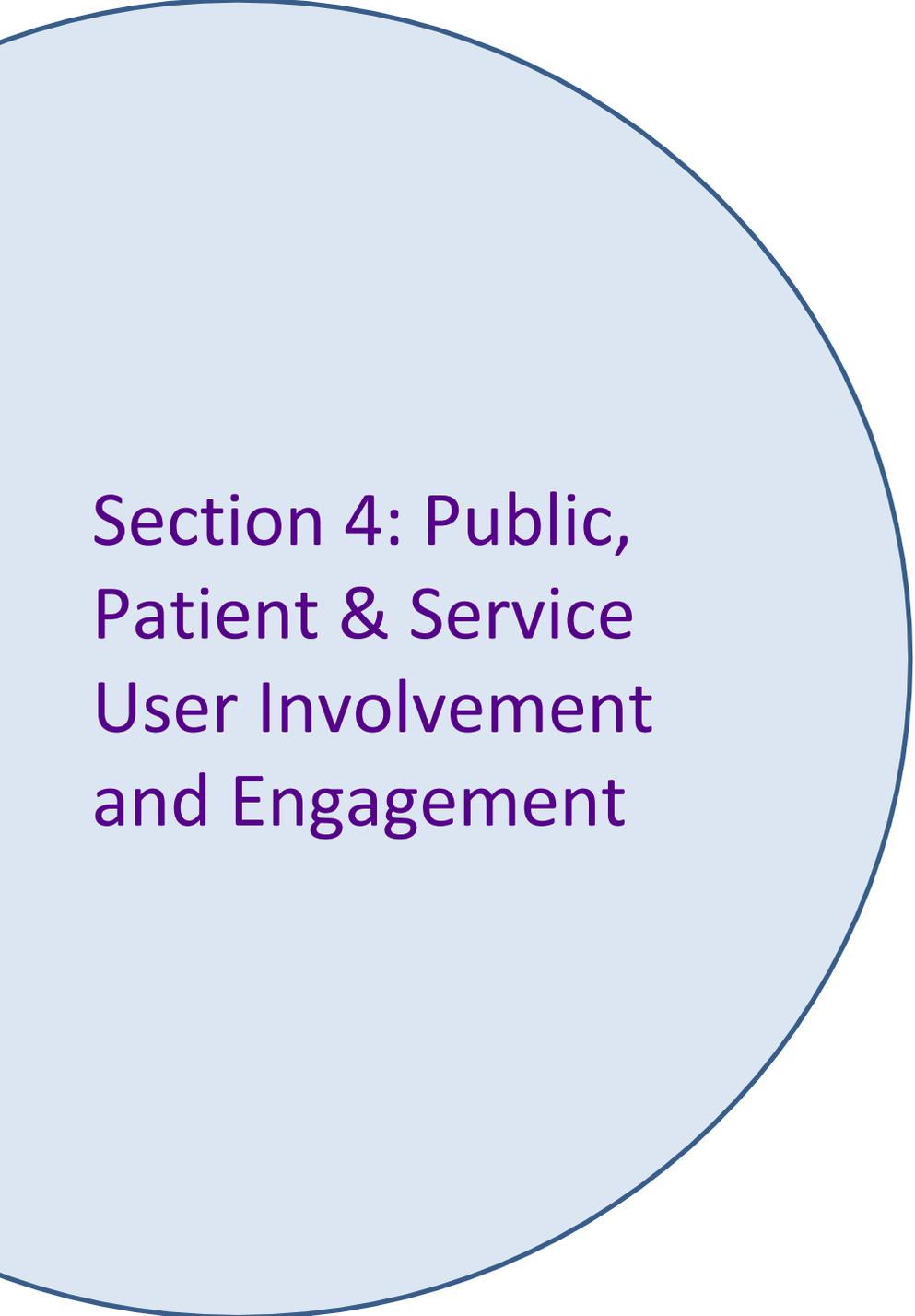
Formal complaints by age

The largest group of complaints in 2020/21 were received from those in the 65-79 age group. When a complaint is made by a visitor, patient or carer, we do not have access to age and so this is not recorded. 16 formal complaints did not have an age for the patient disclosed.

Formal complaints by ethnicity

The largest proportion of formal complaints were for White-British patients, in-line with the population the Trust serves. Just over 21% of patients who raised a complaint did not have their ethnicity recorded on their patient record.

Formal complaints by gender



Section 4: Public, Patient & Service User Involvement and Engagement

Public, patient and service user engagement and involvement

- The Trust is committed to involving the public, patients and service users in developing its services and influencing the strategic direction of the organisation.
- Equality monitoring for our corporate led public and patient engagement and involvement activity has helped us to:
 - demonstrate the representation of our engagement and involvement activity and the range of feedback from patients and the public
 - better evidence our outreach to seek people's views and the efforts made
 - identify which groups are underrepresented

Public engagement groups

Community Hub Stakeholder Group meetings

- The purpose of the Community Hub Stakeholder Group is to ensure experiences and feedback from patients, carers, service users and the public inform the development of community hubs so that they evolve in line with the needs of local residents.
- This group meets every 6 weeks and is chaired by the Chief Nurse from Buckinghamshire Healthcare Trust. We have 22 stakeholder members within the group with representatives from both Marlow and Thame Community hubs.
- During COVID-19 this group supported and helped the Trust further communicate key messages into the local communities they each represent. The Trust used these meetings during the pandemic to advise of changes in services both within the community hubs and acute hospital sites.

Public engagement groups

Communications Advisory Panel (CAP)

- CAP has 30 members in total and meet once a quarter. Patient information leaflets are sent to this group for approval every month.
- Objectives of CAP:
 - To scrutinise patient communication published by the Trust via online and offline channels (e.g. in print and on websites).
 - To provide constructive feedback and appropriate challenge to help improve the standard of public information provided by the Trust
 - To help shape the design and development of Trusts public publication templates and tools
 - To contribute ideas and suggestions in discussions with the Communications team about public/patient communication developments
 - To ensure all communication is: clear, written in plain English, contains helpful images or diagrams (if required), is easy to understand and navigate
- During 2020/21, CAP has reviewed 55 leaflets and has provided invaluable feedback on the development of the Trust's new website, which was launched in June 2021.

Equality monitoring for public engagement groups

Equality monitoring for public engagement groups

Public engagement programme

- In August 2020 we, along with our partners from the Integrated Care Partnership, launched phase 1 of a public engagement programme to ask people what they thought about changes we have made, or are considering, in health and social care. The engagement was designed with support from the Getting Bucks Involved Steering Group which includes members of patient participation groups, representatives from local charities and Healthwatch as well as members of the public.
- Engagement has focused on the following four themes:
 - **Digital Services:** accessing routine appointments by telephone, video or online
 - **Keeping People Safe:** delivering services differently to prevent the spread of infections
 - **Community services:** organisations working together to promote independence and deliver care in people's homes and communities
 - **Reducing health inequalities:** improving health for vulnerable groups and people living in deprived areas.
- Phase 1 was a survey which gathered data from over 2,800 respondents; the majority of whom were white females with an average age of 60. Phase 2 was designed to actively seek representation from a diverse range of Buckinghamshire residents, especially groups who are not often reached by such research, such as people living in areas of deprivation.
- The findings from the engagement programme have been shared and presented to the Health & Wellbeing Board and the Buckinghamshire Health & Adult Social Care Select Committee and will be used as the basis for further engagement with Buckinghamshire residents in the summer.

Public webinars

- In partnership with Healthwatch Bucks, the Trust hosted two free online events to keep the public informed during the pandemic for two areas which were of particular concern – cancer and surgery
- The aim for both events was to give people a chance to hear from a range of specialists and to ask them questions.
- A recording of the full presentation including slides and questions and answers were recorded and published on the Healthwatch and BHT websites
- Over 100 people attended and feedback was extremely positive:

“Well selected panel who were informative and clear in their communications.”

“Very informative speaker who covered a wide range of information in an accessible way.”

Research

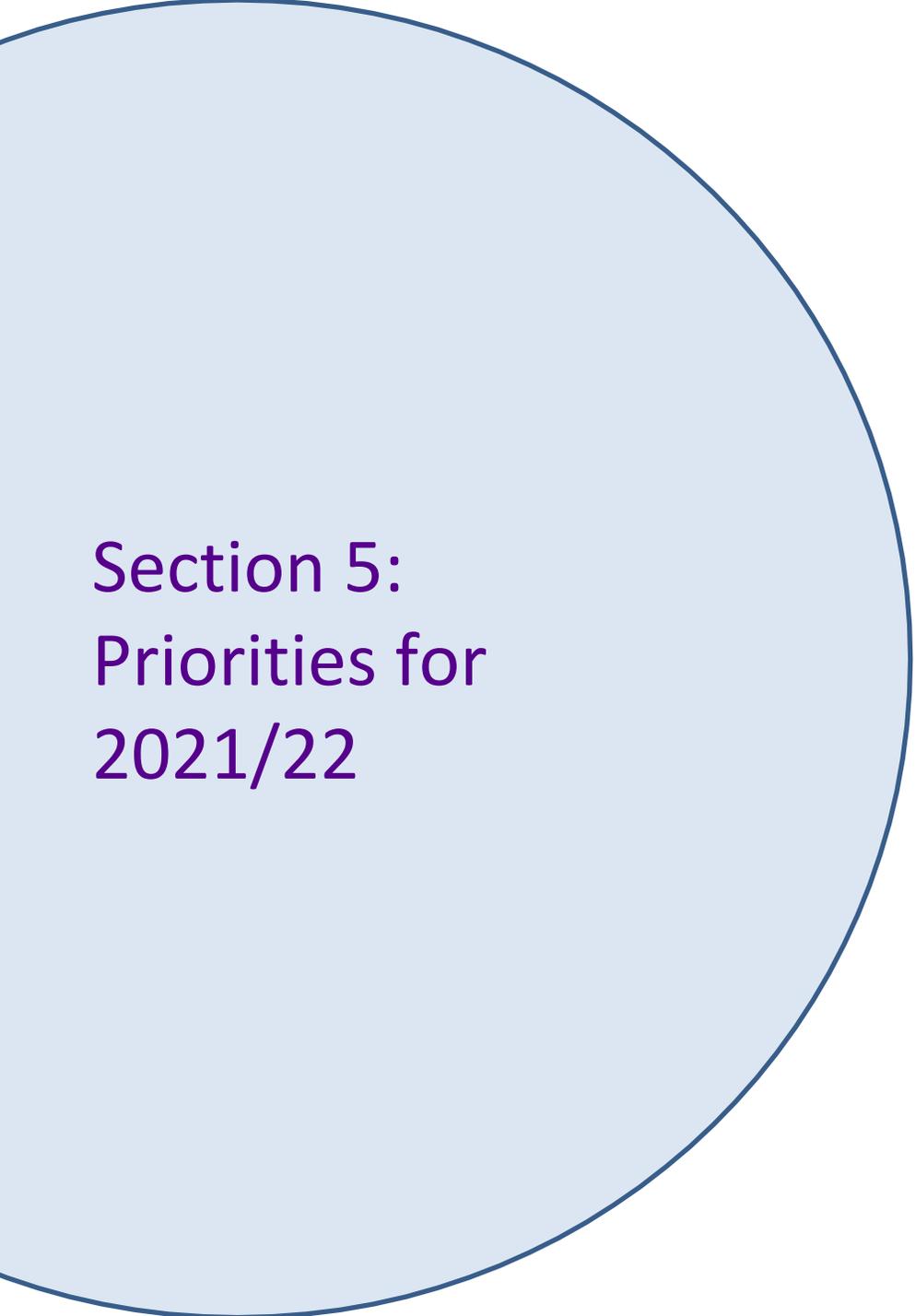
- Research has been at the forefront of the COVID-19 pandemic driving national policy and providing much needed evidence for novel treatments and preventative measures. Colleagues quickly adapted to delivery of the COVID-19 urgent public health studies, supporting critical care activity and vaccine studies. Since March 2020, the R&I Department has supported nine COVID-19 urgent public health research studies including RECOVERY, CCP-UK and GenOMICC studies.
- We have consistently been in the top 15 recruiting sites nationally thanks to the support of an excellent research team. Over 1,900 patients and 550 healthcare colleagues have willingly participated in COVID-19 studies playing a vital role in the fight against this disease.
- The Trust has sponsored six COVID-19 studies contributing to improved patient outcomes and has continued to support innovation projects through its partnership with Bucks Health and Social Care Ventures and Oxford Academic Health Science Network.
- The COVID-19 oximetry Co@H project enabled patients at risk across Buckinghamshire to safely self-monitor at home using pulse oximeters. Through this programme we successfully reduced mortality, hospital length of stay and pressure on critical care beds during the pandemic.

Heart of Bucks

- We know that certain communities are less likely to access our services, particularly preventative screening programmes that could identify cancer at an early stage.
- In November 2020, the Trust launched a new health initiative to improve cancer outcomes in partnership with Heart of Bucks (a community foundation which awards grants and loans to support essential local charities and community groups) and the Buckinghamshire Clinical Commissioning Group.
- The target areas for the project are central Aylesbury, High Wycombe and Chesham. This is a great opportunity for local grassroots organisations who really know their communities to demonstrate how important they can be in improving public health for all.
- Not for profit groups can apply for a grant of up to £7,500 to help them to develop and deliver innovative and creative solutions to improve cancer outcomes, particularly for groups that traditionally have poorer health outcomes including the homeless, people with learning disabilities, BAME communities and people with long-term mental illness. The first grant applications are currently being reviewed and successful applicants will be informed soon.

Antenatal newborn screening programme

- To gain a better understanding of specific inequities within antenatal screening services, the Trust's maternity unit was the first in the country to undertake a piece of work to look into the impact of age, ethnicity and language on accessing its services.
- Retrospective data from over 6,000 women was gathered from the Trust's electronic patient records systems looking at the period from 1 April 2018 to the 31 March 2019. Patient demographic factors were reviewed and compared against timeliness of initiation of antenatal care, timeliness of the fetal anomaly scan and consent for infectious diseases screening.
- This review showed that age, ethnicity, and language proficiency have an impact on attendance at antenatal screening appointments. Overall, women with ethnicities other than White British, women with a limited understanding of English, and mothers younger than 20 years old had larger proportions of late bookers (women initiating antenatal care after 13 weeks) and later attendance at anomaly scans. Late booking is a known risk factor in pregnancy.
- Amongst the 19 women who we have recorded as having declined screening, there was a higher proportion of women with a Mixed White and Black African, Bangladeshi, Chinese or Pakistani background.
- We will be working with local community groups to see more what we can do to promote the benefits of early access to maternity services,



Section 5: Priorities for 2021/22

Priorities for 2021/22

The Trust's has continued to make good progress towards achieving the equality objectives as set in 2019. However, the pandemic has brought to the forefront the issues of health inequalities. To address health inequalities in Buckinghamshire, the Trust will be focusing on the following key priorities during 2021/2022:

- Supporting system wide health prevention and promotion activities linked to reductions in cardio-vascular disease in specific areas and communities where inequalities are most apparent
- Supporting the '**Start Well**' action plan to promote maternal and child health and well being including prioritising support for vulnerable children and families
- Developing the Trust's role as an **anchor institution** to encourage wider employment opportunities for Buckinghamshire residents, promote health and well being and developing an inclusive, diverse and compassionate workforce
- Ensuring we evidence that we are recovering services from the COVID-19 pandemic inclusively and that no particular group or community is disadvantaged
- Improving our recording of ethnicity across all our services and actively use ethnicity data to assess the inclusiveness of all our services and target services to those most in need
- Ensuring that our patient groups better represent the diversity of the communities we serve.

Meeting: Trust Board Meeting in Public

28 July 2021

Agenda item	Health and Safety Annual Report	
Board Lead	Commercial Director	
Type name of Author	Health and Safety Manager	Property Services Risk Manager
Attachments	Health and Safety Annual Report	
Purpose	Assurance	
Previously considered	Health and Safety Committee on 22 April 2021 Executive Management Committee 6 July 2021 Strategic Workforce Committee on 12 July 2021	

Executive Summary

The purpose of this annual Health and Safety report is to update the Board on relevant issues for year 1st April 2020 – 31st March 2021. The report highlights any serious incidents that have occurred during this period and matters of relevance such as changes to health and safety legislation or best practice affecting the Trust. Key points of note are;

- Needlestick / Sharps injuries up nine percent when compared to 2019/20, but the direction of travel is down when compared over the previous five years
- Slips, Trips, Falls and collisions have reduced by 23% on the previous 12 months
- There were two fatal incidents last year, one concerning a patient fall from height and the other a loss of a colleague linked to coronavirus.
- The Health and Safety Executive has followed up on 2 RIDDOR incidents which are now completed.
- There have been no serious fire incidents on any Trust site in the last year
- New integrated fire alarm systems have been installed across Amersham and Wycombe sites
- Fire Warden training and evacuation drills have been implemented and these continue
- Staff training in most areas has not reached the target threshold of 90% (range 80-92%) due to the pandemic, this will be addressed in the coming year.

Decision	The Board / Committee is requested to note and comment
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Relevant Strategic Priority

Quality <input checked="" type="checkbox"/>	People <input checked="" type="checkbox"/>	Money <input type="checkbox"/>
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Implications / Impact

Patient Safety	Prevention of injury to patients
Risk: link to Board Assurance Framework (BAF)/Risk Register	This report does not have any links to the BAF
Financial	Reducing risk of claims/fines/litigation
Compliance Select an item. Select CQC standard from list.	Health and Safety at Work Act 1974 CQC Standards for Safety
Partnership: consultation / communication	This report has been shared with our staff side union colleagues
Equality	This report is inclusive of all staff and patient groups
Quality Impact Assessment [QIA] completion required?	Not required as this report is totally inclusive of all staff, patients and visitors

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HEALTH AND SAFETY ANNUAL REPORT 2020/2021

Executive Summary

This report outlines the health and safety performance at Buckinghamshire Healthcare Trust (BHT) for 2020/21. The purpose of the report is to inform the Health and Safety Committee and the Executive Management Committee / Trust Board of any health and safety issues, incidents and trends in the Trust since the last report and provide a general update on relevant health and safety developments.

In general, the majority of reported accidents or incidents report are showing reductions compared to previous years. There have been 18 incidents reported to the Health and Safety Executive in 2020/21 (see Appendix 1 for details) which is a similar number to the previous year. Sadly there were two fatal incidents this year, one a colleague linked to coronavirus and the other a patient fall from height.

The main area of continuing concern are the levels of verbal abuse and physical assault experienced by staff which are unacceptably high and a working group has been set up to attempt to identify and address the root causes of these. The incidence of Needlestick injuries have increased by 9%. Incidents involving slip trips and falls have reduced by 23% however six resulted in fractures. Both changes are considered to be due in part to the pandemic.

The pandemic has positively developed much closer working relationships with other Trust Departments – Occupational Health / Infection, Prevention Control, Human Resources as well as work at Divisional level. The health and safety team produced the 'Covid secure checklist' for all managers to complete to ensure compliance with the guidance provided by Health and Safety Executive, Public Health England, The Department of Health and other Government agencies. This involved providing advice on social distancing, room capacities, way finding, cleaning, oxygen monitoring, personal protective equipment, ventilation and conducting several Covid related investigations.

The Trust's health and safety management system is based on the Health and Safety Executives publication 'Managing for Health and Safety - HSG65' which treats good health and safety management as an integral part of management and not a standalone system. The report examines 'reactive data' and compares performance with previous years and 'pro-active data' from audits. This approach enables the Trust to set key objectives for the future in line with its vision and values.

Our objectives in the coming year are to focus resources on proactively undertaking audits and supporting our Divisional Teams to build a growing momentum of a health and safety culture at BHT. We have also implemented a new digital control of hazardous substances system (COSHH) which will be further rolled out this coming year.

1. Introduction

All organisations have a legal duty to put in place suitable arrangements to manage for health and safety. Ideally, this should be recognised as being a part of the everyday process of conducting business and/or providing a service, and an integral part of workplace behaviours and attitudes. Notwithstanding, a comprehensive legislative framework exists, within which the main duties placed on employers are defined and enforced.

Regardless of the size, industry or nature of an organisation, the keys to effectively managing for health and safety are:

- leadership and management (including appropriate and effective processes)
- a trained/skilled workforce
- an environment in which people are trusted and involved

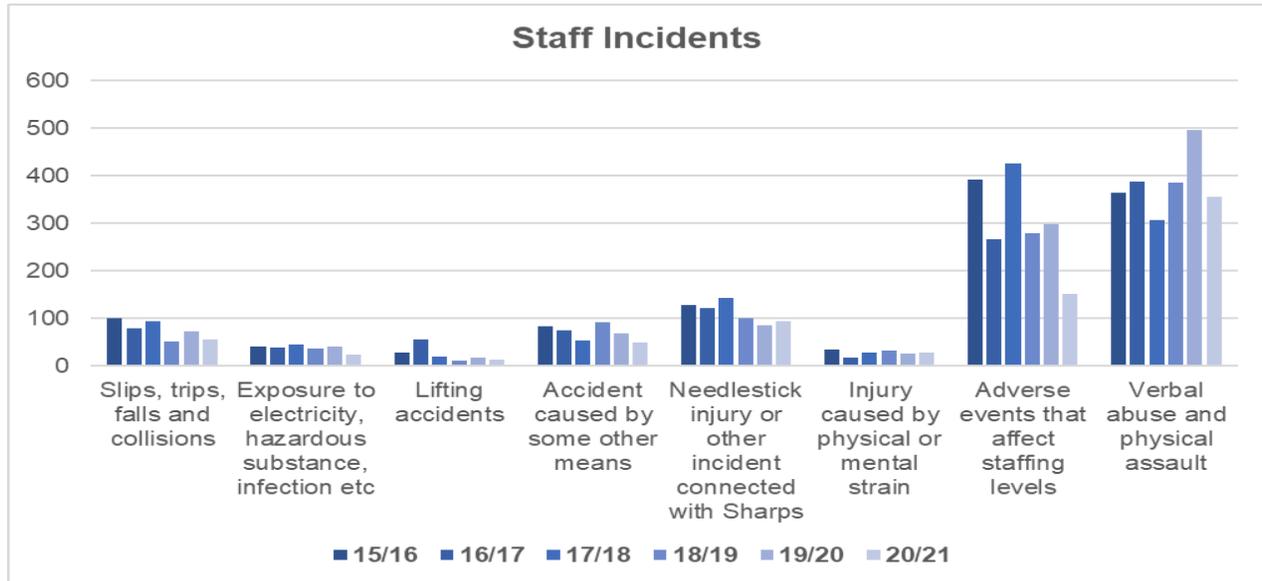
The Health and Safety Executive (HSE) are the regulatory body with responsibility for enforcing health and safety legislation. The HSE also fulfils a major role in producing advice on health and safety issues, and practical guidance on the interpretation and application of the provisions of the legislative framework.

The HSE provides guidance to support organisations of all sizes to effectively manage health and safety based on the principles of 'Plan, Do, Check, Act.' (PDCA). This is described in detail within the HSE's 'Managing for Health and Safety Guidance' (HSG65). The key components of the PDCA framework that is being applied within BHT are summarised, as follows:

- Plan - determine policy, plan for implementation
- Do - profile health and safety risks, organise for health and safety management, implement the plan
- Check - measure performance, investigate accidents and incidents
- Act - review performance, apply learning

2. Accidents/Incidents

Below is a summary of reported accidents/incidents to staff in the last six years by type. The main area of continuing concern are the levels of verbal abuse and physical assault experienced by staff. In general, the majority of reported areas are showing reductions compared to previous years.

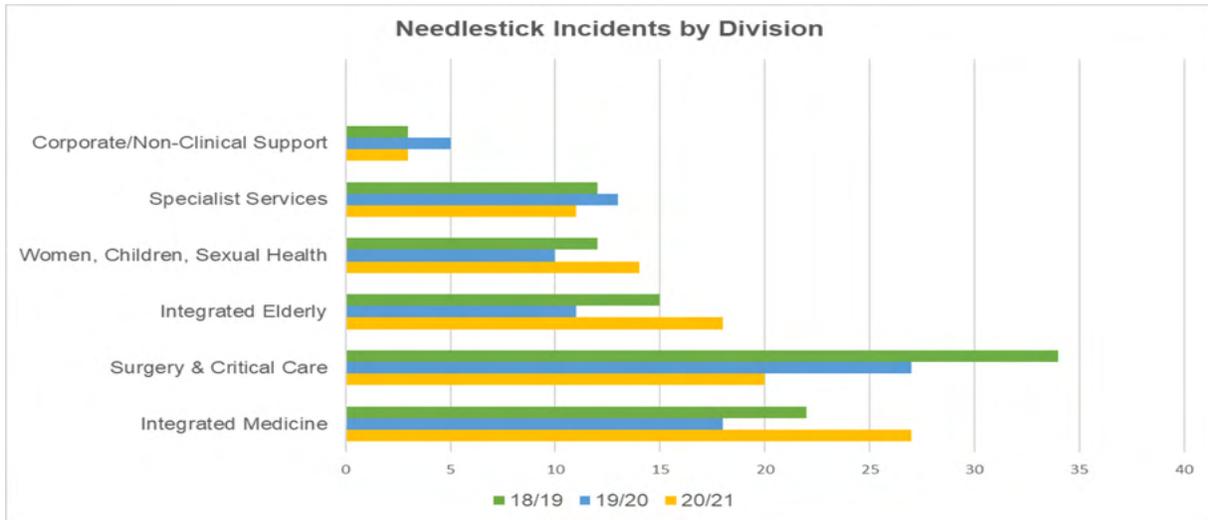


Needlestick / Sharps injuries which show an increase of nine percent when compared to 2019/20, but the direction of travel is down when compared over the previous five years in this category. Injuries that are caused by physical or mental strain show a strong percentage increase but in actual numbers remain relatively small and stable.

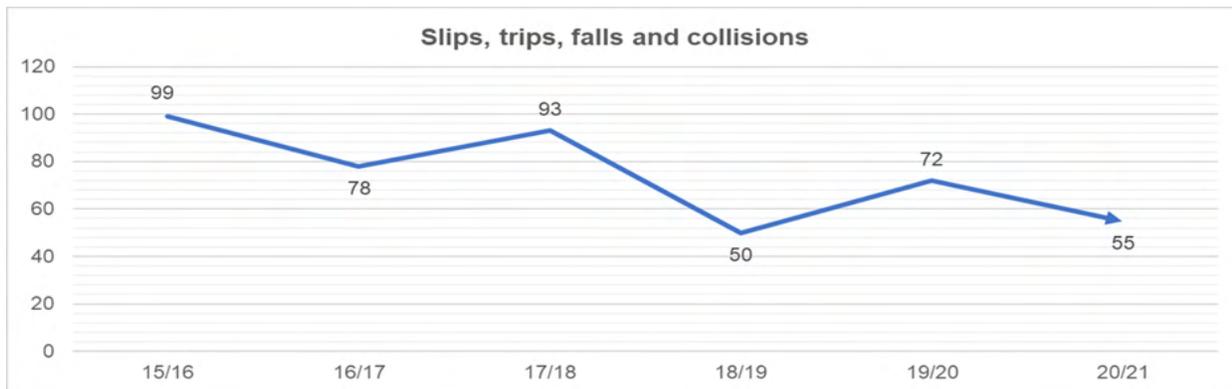
There has been nearly a 50% decrease in adverse events that affect staffing levels. This is linked to the pandemic response and the increase in staff numbers.

Adverse events that effect staffing levels	15/16	16/17	17/18	18/19	19/20	20/21	+/-
Slips, trips, falls and collisions	99	78	93	50	72	55	-23%
Exposure to electricity, hazardous substance, infection etc	40	38	44	36	41	24	-41%
Lifting accidents	28	56	19	10	16	13	-18%
Accident caused by some other means	82	75	52	91	67	48	-28%
Needlestick injury or other incident connected with Sharps	128	122	143	99	85	93	+9%
Injury caused by physical or mental strain	34	17	27	32	25	28	+12%
Adverse events that affect staffing levels	391	266	427	280	298	151	-49%
Verbal abuse and physical assault	364	388	306	385	497	355	-28%

The table below indicates Divisional reporting with regards to Needlestick injury. The Covid pandemic response has resulted in more activity in certain areas which may explain the variations.

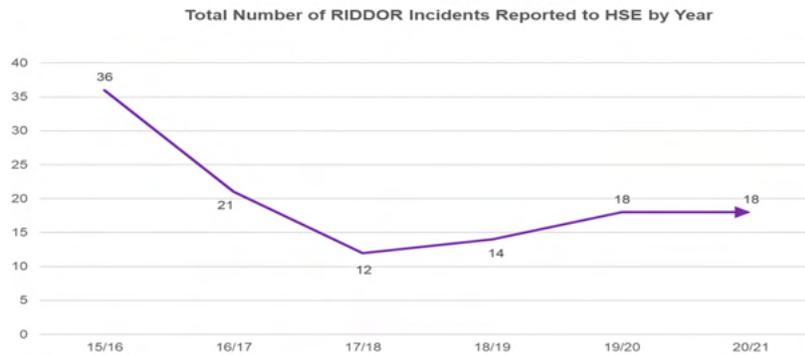


It is pleasing to note that Slips, Trips, Falls and collisions have reduced by 23% compared to the previous 12 months. The committee should note however, these incidents relate to nearly half the RIDDOR reports the Trust has made to the Health and Safety Executive.

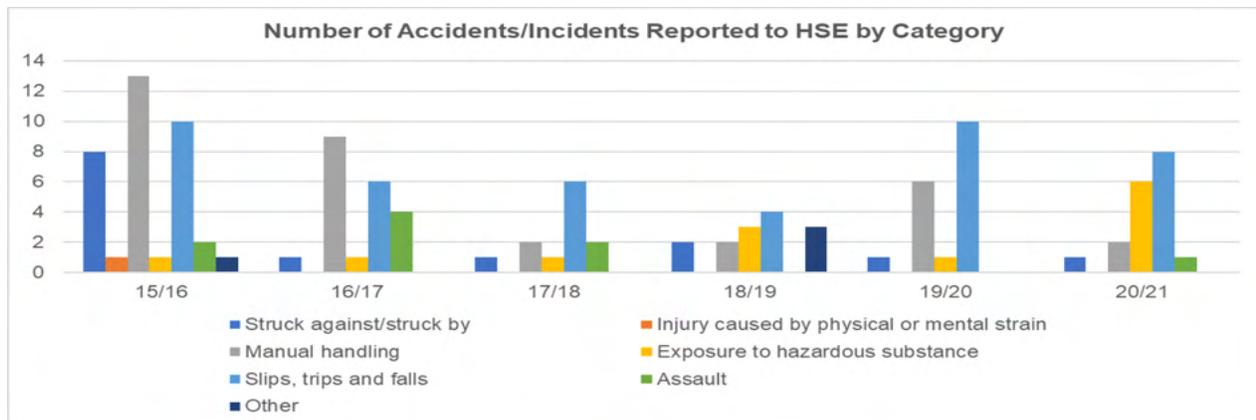


3. RIDDOR Incidents

The information below gives an overview of incidents reported to the HSE under RIDDOR for the last six years.



There have been 18 RIDDOR incidents reported to the Health and Safety Executive in 2020/21 (see Appendix 1 for details). Seven of these were in the slips, trips and falls category which resulted in six fractures. The Committee will note that sadly there were two fatal incidents this year, one a patient fall from height and the other a colleague linked to coronavirus.



4. Training

Very little training has occurred face to face this year due to compliance of Covid protocols. All Induction and Health and Safety training has been conducted online. Divisional compliance with the Health and Safety module is detailed below.

Division	Staff Count	Compliant	% target 90%
Corporate	699	624	89%
Division Integrated Medicine	1010	858	85%
Surgery & Critical Care	1279	1115	87%
Specialist Services	925	842	91%
Integrated Elderly Care	832	746	90%
Women's, Children's & Sexual Health	939	866	92%
TOTAL	5684	5051	89%

5. Requests for information and / or visits from the HSE

The Health and Safety Executive (HSE) is a UK government agency responsible for the encouragement, regulation and enforcement of workplace health, safety and welfare, and for research into occupational risks in Great Britain. It is a non-departmental public body of the United Kingdom with its headquarters in Bootle, England. They investigate reportable injuries, diseases, dangerous occurrences and concerns raised by workers, the public or others to improve health and safety standards in the workplace. This allows them to determine root causes, share lessons, identify what actions a duty holder needs to take to prevent any recurrence and where appropriate, gather evidence to bring a prosecution.

The HSE have contacted the Trust on two occasions this year:

1) Cytotoxic Medication Spillage – Stoke Mandeville Hospital

In January 2019 there was an accident at Stoke Mandeville Hospital involving the release of chemotherapy drugs. Three members of staff and a patient became contaminated. The Health and Safety Executive carried out a formal investigation, interviewing several Trust staff. The Trust internal investigation and subsequent action plan was reviewed by the Inspector and they informed the Trust on 21st July 2020 that no further action against the Trust would be taken.

2) Asbestos

An HSE Inspector visited the Trust in April, responding to representative body concerns over the management of asbestos. A notice was issued detailing aspects of the Trust's 'Asbestos Register' and 'Instructions to contractors'. A new Asbestos policy and Asbestos management plan has been produced to satisfy all aspects of the notice.

6. Health and Safety Update

6.1 Covid-19

This year has been unprecedented regarding the impact the Covid-19 pandemic has had on all departments within the Trust and the Health and Safety team is no exception. The unexpected demands on a small department have been challenging.

Over the last 12 months, the team has produced the 'Covid secure checklist' for all managers to complete to ensure compliance with the guidance provided by Health and Safety Executive, Public Health England, The Department of Health and other Government agencies. This involved providing advice on social distancing, room capacities, way finding, cleaning, oxygen monitoring, personal protective equipment, ventilation and conducting several Covid related investigations. This work has not been carried out in isolation and has resulted in closer working relationships with other Trust Departments – Occupational Health / Infection, Prevention Control, Human Resources as well as work at Divisional level.

6.2 Health and Safety Annual 'Self-Assessment'

The 'principle of prevention' is a key tool in the Trust's Health and Safety Management system. Pro-active health and safety audits are aimed at resolving any issues before an accident and incident occurs. The audit was designed to ensure managers reported on their:

Management Systems – e.g. Risk assessments, safety culture, staff induction, incident reporting

General Workplace – clean and tidy, storage space, welfare facilities, temperature, lighting

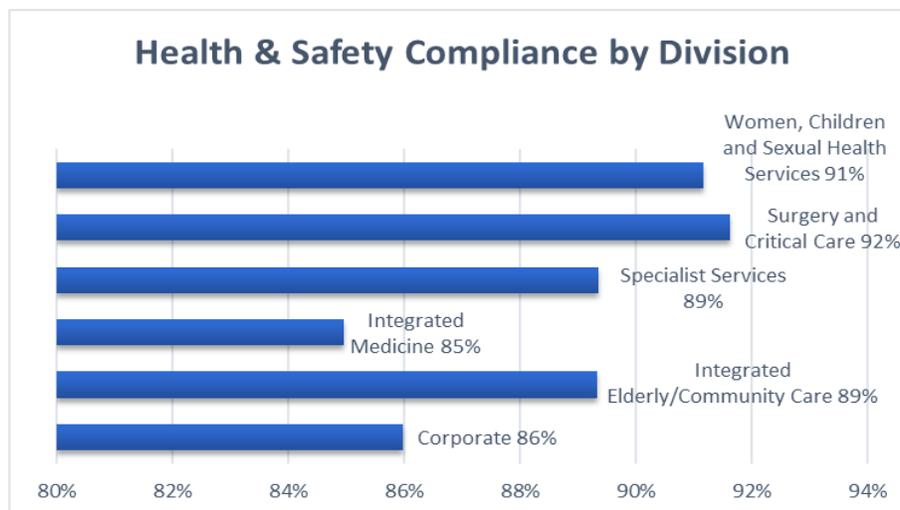
Equipment – risk assessed, inspected and maintained, display screen

Emergency procedures – Fire, First Aid, Security, Business Continuity

Staff Training – statutory and mandatory, role specific

The self-assessment audit was carried out in the Autumn of 2020, with 87 returns being received in the department. The outcomes were presented at the February 2021 Health and Safety Committee. Managers reported a compliance level of 89% when answering the 90 questions.

The common areas of non-compliance were the non-completion of lockdown procedures / exercises, anti-ligature risk assessments and a general lack of storage space. The Health and Safety Team are currently reinforcing these results by carrying out independent audits across various sites in the Trust.



6.3 Policies agreed at Health and Safety Committee 2020/21:

BHT Pol 126 – Fire Safety Policy

BHT Pol 095 – Handling of Healthcare Waste Policy

BHT Pol 136 – Policy for the use of Lasers Intense Light Sources

BHT Pol 169 – Asbestos Policy and Management Plan

BHT Pol 212 – Missing Patient Policy

6.4 A digital COSHH management system has been procured by the Trust. Seven members of staff across all Divisions have received training on the system. This project has stalled due to the pandemic and staff availability, but it is anticipated to be rolled out across all Divisions in the summer.

Appendix 1

Date	RIDDOR Category	Type of Incident	Nature of injury	Cause of injury / Incident
April 2020	Dangerous Occurrence	Occupational exposure to Coronavirus	None	Unsafe PPE – Tiger Eye Goggles DoH letter refers
April 2020	Dangerous Occurrence	Occupational exposure to Coronavirus	None	Unsafe PPE – Tiger Eye Goggles DoH letter refers
April 2020	Dangerous Occurrence	Occupational exposure to Coronavirus	None	Unsafe PPE - Tiger Eye Goggles DoH letter refers
April 2020	Dangerous Occurrence	Occupational exposure to Coronavirus	None	Unsafe PPE - Tiger Eye Goggles DoH letter refers
07/04/20	Dangerous Occurrence	Occupational exposure to Coronavirus	None	Patient accidentally spat tea into HCA face
14/05/20	Specified Injury	Trip	Fracture	Staff member stumbled in corridor – Fractured ankle
14/05/20	Fatal	Occupational exposure to Coronavirus	Disease	Death due to possible occupational exposure to a biological agent
21/05/20	Specified Injury to Member of the Public	Trip	Fracture	Tripped over raised edge of ramp – fractured neck of femur
19/07/20	Fatal	Fall from Height	Multiple	Patient fall from Ward balcony
27/07/20	Specified Injury	Slip	Fracture	Slipped on wet floor and landed on coccyx – fractured back
09/08/20	Over 7 Day	Staff abuse	Fracture	Aggressive patient kicked out and broke finger
17/09/20	Over 7 Day	Slip	Bruising	Hip plan due to slip on wet floor
04/10/20	Over 7 Day	Moving / Handling	Back pain	Back injury lifting patient
02/12/20	Over 7 Day	Equipment failure	Concussion	Medical warming equipment fell on head
24/12/20	Specified Injury	Trip	Fracture	Fractured wrist after trip over trolley
28/12/20	Over 7 Day	Moving / Handling	Back pain	Back pain due to turning patients

21/01/21	Specified Injury	Fall	Fracture	Fractured Ulna due to fall
25/01/21	Specified Injury	Slip	Fracture	Fractured wrist after slipping on ice

Meeting: Trust Board Meeting in Public

28 July 2021

Agenda item	Modern Slavery Act 2015
Board Lead	Chief Executive
Type name of Author	Associate Director of Communications & Engagement
Attachments	Modern Slavery Statement
Purpose	Information
Previously considered	None

Executive Summary

To provide the Board with an overview of the Modern Slavery Act 2015, the implications for the Trust and to seek approval for a Modern Slavery Statement for publication on the Trust's public website.

The Modern Slavery Act was passed by Parliament in March 2015. The provisions of the Act came into effect in October 2015. The Trust is required to produce an annual public statement of the actions it has taken to meet requirements under the Act.

The Act consolidated slavery and trafficking offences, strengthened powers of enforcement and introduced tougher penalties. It also included a transparency clause requiring all UK based businesses with a turnover of over £36m or more to make an annual statement on the steps it has taken in the previous financial year to ensure its business and supply chains are free from Modern Slavery, which the Act defines as slavery, servitude, forced or compulsory labour and human trafficking. The statement should be Board approved, signed by a Director and must be published on an organisation's website.

Decision	The Board is asked to note the Modern Slavery Statement 2021/22 for publication on the Trust Website	
Relevant Strategic Priority		
Quality <input type="checkbox"/>	People <input checked="" type="checkbox"/>	Money <input checked="" type="checkbox"/>
Implications / Impact		
Patient Safety	Potential victims have a 1 in 5 chance of contact with the NHS and staff receive training on how to take action as appropriate	
Risk: link to Board Assurance Framework (BAF)/Risk Register	The Trust could receive adverse publicity and enforcement action if it fails to meet the requirements of the Act.	
Financial	The Trust must meet procurement requirements under the Act. The Legislation can impose fines for non-	

	compliance. The procurement department follow the appropriate guidance.
Compliance Select an item. Select CQC standard from list.	In meeting the requirements of the Act the Trust meets is legislative obligations and several of the CQC requirements such as <i>safety and dignity and respect</i> .
Partnership: consultation / communication	Consultation has taken place with the Procurement lead, Workforce Team and Safeguarding Lead
Equality	This report does not have any detrimental impact on any protected characteristics. It provides positive reinforcement of the need to protect vulnerable individuals.
Quality Impact Assessment [QIA] completion required?	N/A

Modern Slavery Act 2015 Section 54 - Slavery and Human Trafficking Statement

Modern Slavery Act 2015 Section 54 - Slavery and Human Trafficking Statement

Buckinghamshire Healthcare NHS Trust (BHT) aims to follow good practice and take all reasonable steps to prevent slavery and human trafficking. We are committed to ensuring that all of our employees are aware of the Modern Slavery Act 2015 and their safeguarding duty to protect and prevent any further harm and abuse when it is identified or suspected that the individual may be or is at risk of modern slavery/human trafficking.

We are committed to ensuring that no modern slavery or human trafficking takes place in any part of our business or our Supply chain. This statement sets out actions taken by BHT to understand all potential modern slavery and human trafficking risks and to implement effective systems and controls. Section 54 of the Modern Slavery Act 2015 requires all organisations to set out the steps the organisation has taken during the financial year to ensure that slavery and human trafficking is not taking place in any of its supply chains, and in any part of its own business.

Trust Structure and Principle Activities

BHT is a major provider of integrated hospital and community services for people living in Buckinghamshire and the surrounding area, including Thame (Oxfordshire), Tring (Hertfordshire) and Leighton Buzzard (Bedfordshire), providing care to over half a million patients every year.

We are recognised nationally for our urology and skin cancer services and are a regional specialist centre for burns care, plastic surgery, stroke and cardiac services and dermatology. In addition we provide specialist spinal services at our world renowned National Spinal Injuries Centre for patients from across England and internationally.

We are part of the Buckinghamshire Integrated Care Partnership which comprises of:

- Buckinghamshire Healthcare NHS Trust;
- NHS Buckinghamshire Clinical Commissioning Group (CCG);
- Oxford Health NHS Foundation Trust;
- South Central Ambulance Service NHS Foundation Trust;
- Buckinghamshire Council;
- FedBucks GP federation.

The Buckinghamshire Integrated Care Partnership (ICP) is part of the wider Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (ICS).

We procure goods and services from a range of providers. Contracts vary from small one-off purchases to large service contracts. All spend, aside from a few exceptions such as rates, is paid via PO. The Applicable Contract Terms Policy applies to any NHS organisation and states that where an NHS body issues a PO the standard Terms & Conditions apply.

The top 80% of suppliers nationally affirm their own compliance with the modern slavery and human trafficking act within their own organisation, sub-contracting arrangements and supply chain.

Organisational policies in relation to slavery and human trafficking

BHT has internal policies and procedures in place that assess supplier risk in relation to the potential for modern slavery or human trafficking.

BHT Safeguarding Standard Operating Policy and procedure includes information on modern day slavery/human trafficking.

The BHT Incident Reporting Policy states that colleagues should report incidents of all types and this includes concerns regarding modern slavery and human trafficking. By using the local risk management system (Datix) appropriate teams, including safeguarding and Freedom to Speak Up Guardian are made aware.

All colleagues have access to the BHT Safeguarding team for support and guidance when they are concerned about modern day slavery or trafficking.

BHT also has one full-time and four part-time Freedom to Speak Up Guardians who will provide support to the individual raising a concern. Colleagues are provided with this information at corporate induction.

Trust activities and policies are required to have an Equality Impact Assessment (EQIA) completed.

Assessing and managing risk and due diligence processes in relation to slavery and human trafficking

We are committed to ensuring that there is no modern slavery or human trafficking in our supply chains or in any part of our business.

The Trust reviews its Modern Slavery and Human Trafficking Statement on an annual basis and presents it at a Board meeting in Public. This demonstrates a public commitment, ensures visibility and encourages reporting standards.

To identify and mitigate the risks of modern slavery and human trafficking in our own business and our supply chain:

- The Trust adheres to the National NHS Employment Checks/Standards (this includes employees UK address, right to work in the UK and suitable references).
- The Trust has systems to encourage the raising and reporting of concerns and the protection of whistle-blowers.
- The Trust purchases a significant number of products through NHS Supply Chain, whose 'Supplier Code of Conduct' includes a provision around forced labour. Other contracts are governed by standard NHS Terms & Conditions. High value contracts are effectively managed, and relationships built with suppliers.
- The majority of our purchases utilise existing supply contracts or frameworks which have been negotiated under the NHS Standard Terms and Conditions of Contract, these all have the requirement for suppliers to have suitable anti-slavery and human trafficking policies and processes in place. Where a suitable framework exists, we use them in preference to tendering. These are run by NHS procurement entities and are governed by NHS Standard Terms & Conditions.
- All suppliers are required by law to comply with the provisions of the UK Modern Slavery Act (2015). This will be reinforced where appropriate by Standard Selection Questionnaires as part of tender processes along with use of NHS Standard Terms and Conditions either direct with suppliers or through framework agreements.

Effective action taken to address modern slavery - Performance Indicators

The Trust is committed to social and environmental responsibility and has zero tolerance for Modern Slavery and Human Trafficking. Any identified concerns regarding Modern Slavery and Human Trafficking are escalated as part of the organisational safeguarding process. This statement is made pursuant to section 54(1) of the Modern Slavery Act 2015 and constitutes BHTs slavery and human trafficking statement for the current financial year.

All employees have a personal responsibility for the successful prevention of slavery and human trafficking with the procurement department taking responsibility for overall compliance.

A Freedom to Speak Up Report is submitted to the Board on a 6-monthly basis which includes an overview of the number of concerns raised by colleagues and the category that they fall into.

Training on modern slavery and trafficking

Safeguarding training is mandatory for all colleagues and includes information on trafficking and modern-day slavery in order to promote the knowledge and understanding of escalating concerns via the Home Office national referral mechanism/duty to notify process.

Conclusion

The Board is asked to note this statement to be published on the Trust's website.

Meeting: Trust Board Meeting in Public

28 July 2021

Agenda item	Learning lessons to improve our people practice	
Board Lead	Bridget O'Kelly	
Type name of Author	Desh Tatla	
Attachments	Appendix 2: Evidence of Trust's progress against 7 People Practice recommendations	
Purpose	Assurance	
Previously considered	Executive Management Committee Strategic Workforce Committee, 12 July 2021	

Executive Summary

This paper is in response to the review by Baroness Dido Harding following the tragic event of staff member at a London Trust entitled "Learning lessons to improve our people practices". The purpose of the paper is to give assurance to the Board around the next steps and recommendations made.

In view of this, the report sets out several actions that will be taken to further improve our people practices. We have reviewed our policies and approach against the recommendations. In most areas we are aligned with the guidance outlined in appendix 1. The paper also identifies areas for further improvement and plans to be put in place.

Please note that the Trust is required to publish its Standards of Behaviour and Conduct Policy (formerly known as the Disciplinary policy) on the Trust's external website. This policy has been through the Trust's usual approval processes.

Decision	For assurance		
Relevant Strategic Priority			
Quality ☒	People ☒	Money ☒	
Implications / Impact			
Patient Safety	To ensure we have the workforce to deliver outstanding and safe care		
Risk: link to Board Assurance Framework (BAF)/Risk Register	4.1 Pandemic-related negative impact on morale, wellbeing and retention 4.3 Variations in organisational culture and behaviours 4.8 The organisation is not always inclusive and does not always treat people equally		
Financial	Cost of temporary staffing, bank and agency. Non-compliance cost of Legal advice and potential for legal claims, Employment Tribunals.		

Compliance Select an item. Staffing	Compliance with employment law, ACAS guidance, case law and best practice. CQC well led organisation Regulation 18.
Partnership: consultation / communication	Engagement with Trade Unions
Equality	<p>We are required to report on our Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) data on an annual basis. Reports have shown disparity in experience of our BAME colleagues in relation to disciplinary cases.</p> <p>Our WRES 2021 data demonstrates that significant improvements have been made this year in relation to equal outcomes from disciplinary processes and we have achieved parity of outcomes for disciplinaries.</p>
Quality Impact Assessment [QIA] completion required?	N/a

Learning lessons to improve our people practice

1.0 Introduction

Following an independent report into a tragic event involving a staff member at a London NHS Trust, Baroness Harding wrote to Trust Chief People Officers (see Appendix 1) to set out guidance relating to management and oversight of local investigation and disciplinary procedures.

This report outlines for the Board where the Trust's processes and procedures are already in line with the guidance and will also sets out additional next steps in order to further improve our people practices and embed a Restorative Just Culture approach in the organisation.

Restorative Just Culture (RJC) aims to create an environment to better support staff when things go wrong and to encourage learning from incidents. In most cases, this means a shift from identifying a specific individual to blame to understanding the incident and whether systematic issues have contributed in any way.

Restorative Just Culture is not a replacement for HR process, and where there are clear conduct issues, these will need to be dealt with in line with usual policy. What it does however, is create an environment of psychological safety where issues can be raised without fear of escalation or blame. The aim is to create a culture of continued learning and quality improvement with the goal of providing great patient care.

In light of the above a key part of this work is the review of the disciplinary policy which has been renamed The Standards of Behaviour and Conduct Policy. Review of the policy will be iterative as we embed a Just Culture approach. This approach has been agreed in collaboration with Staff Side and is going through the appropriate approval processes.

2.0 Seven Areas of Guidance

A guidance document included within the letter sets out of 7 key areas of focus for improvement and 5 specific issues see appendix 1. A review of how we are meeting these 7 key areas including the specific issues is outlined in appendix 2.

3.0 Next Steps

Many of the recommended actions set out in the guidance document are already in place within the Trust, whilst recognising there are areas where further improvements can be made. Three key areas have been identified for further review and potential improvement include:

- Reviewing the plurality of decision making at all stages of the Trust's formal processes.
- Ensuring the Trust's training offer in respect of dealing with employee relations matters is of sufficient quality and quantity.
- Reviewing the rigour with which decision in relation to suspension are taken to ensure that where possible the least restrictive course of action is taken.

In order to take these forward we will progress the following actions:

- Consider any further amendments to the Standards of Behaviour and Conduct policy as we embed a Restorative Just Culture approach.

- Review policy against the NMC’s “best practice guidance on local investigations” which has been published this year.
- Develop a Trust’s *Early Intervention and Resolution* process to provide for an initial review to be undertaken to determine whether the matter can be resolved without recourse to a formal investigation.
- Review the current level and scale of training provision and explore options to improve this.
- Review and update the ER triage vetting form.
- Consider what further action can be taken to support the health and wellbeing of employees involved in investigations as part of the development of the Wellbeing Approach.
- Currently there is an annual review of the WRES and WDES data. Going forward employee relations case data will be reported quarterly at divisional integrated performance reviews by Executive colleagues.
- Employee relations data related to disciplinary cases submitted to Trust Board six times a year.

4.0 Recommendation

The Board is asked to note the report against the work undertaken in relation to the 7 key areas and support the next steps.

To:
NHS trust and NHS foundation trust chairs and chief executives

24 May 2019

Dear colleagues

Learning lessons to improve our people practices

I am writing to share with you the outcomes of an important piece of work recently undertaken in response to a very tragic event that occurred at a London NHS trust three years ago.

In late 2015, Amin Abdullah was the subject of an investigation and disciplinary procedure. The protracted procedure culminated in Amin's summary dismissal on the grounds of gross misconduct. Tragically, in February 2016 just prior to an arranged appeal hearing, Amin took his own life. This triggered the commissioning of an independent inquiry undertaken by Verita Consulting, the findings of which were reported to the board of the employing Trust and to NHS Improvement in August 2018. The report concluded that, in addition to serious procedural errors having been made, throughout the investigation and disciplinary process Amin was treated very poorly, to the extent that his mental health was severely impacted. Verita's recommendations were accepted by the Trust, in full, and have largely been implemented.

Subsequently, NHS Improvement established a 'task and finish' Advisory Group to consider to what extent the failings identified in Amin's case are either unique to this Trust or more widespread across the NHS, and what learning can be applied. Comprising of multi-professional stakeholders and subject matter experts representing both the NHS and external bodies, together with an advocate for Amin's partner, the Group conducted an independent analysis of both the Verita findings and several historical disciplinary cases, the outcomes of which had attracted criticism in Employment Tribunal proceedings and judgements. HR directors of provider organisations were advised of the Group's activity and invited to share details of any local experiences and/or examples of measures being taken to improve the management of employment issues.

The analysis highlighted several key themes associated with the Verita inquiry which were also common to other historical cases considered. Principal among these were: poor framing of concerns and allegations; inconsistency in the fair and effective

NHS England and NHS Improvement

Page 5 of 9

application of local policies and procedures; lack of adherence to best practice guidance; variation in the quality of investigations; shortcomings in the management of conflicts of interest; insufficient consideration and support of the health and wellbeing of individuals; and an over-reliance on the immediate application of formal procedures, rather than consideration of alternative responses to concerns.

The NHS England and NHS Improvement People Committees in Common received a detailed report on the outcomes of the Advisory Group's activities, which included recommendations that aim to ensure the captured learning is used to best effect in informing positive changes across the NHS. The Committees recognised that, sadly, Amin's experiences are far from unique and acknowledged there needs to be greater consistency in the demonstration of an inclusive, compassionate and person-centred approach, underpinned by an overriding concern to safeguard people's health and wellbeing, whatever the circumstances. This view certainly echoed many of the comments we have received from across the NHS during our recent People Plan engagement.

Some of the proposed recommendations will require further discussion with key stakeholders, including regulatory and professional bodies (in particular, I am keen that consideration and assessment of the 'health' of organisational culture, including aspects relating to the management of workplace issues, is given more prominence in the 'well-led' assessment domain). The majority, though, can be immediately received and applied.

Enclosed with this letter is additional guidance relating to the management and oversight of local investigation and disciplinary procedures which has been prepared based on the Advisory Group's re-commendations. You will recognise the guidance as representing actions characteristic of responsible and caring employers and which reflect our NHS values. I would ask that you, your HR team and your Board review them and assess your current procedures and processes in comparison and, importantly, make adjustments where required to bring your organisation in line with this best practice. I would draw your attention to item 7 of the guidance and ask you to consider how your Board oversees investigations and disciplinary procedures. Further, with respect to any cases currently being considered and all future cases, I would ask you to review the following questions (and, where necessary, take corrective action in response):

- Is there sufficient understanding of the issues or concerns, and the circumstances relating to them, to justify the initiation of formal action?
- Considering the circumstances, in the eyes of your organisation and others external to it, would the application of a formal procedure represent a proportionate and justifiable response (i.e. have other potential responses and remedies, short of formal intervention, been fully assessed before being discounted)?
- If formal action is being or has been taken, how will appropriate resources be allocated and maintained to ensure it is conducted fairly and efficiently; how are you ensuring that independence and objectivity is maintained at every stage of the process?
- What will be the likely impact on the health and wellbeing of the individual(s) concerned and on their respective teams and services, and what immediate and ongoing direct

support will be provided to them? Further, how will you ensure the dignity of the individual(s) is respected at all times and in all communications, and that your duty of care is not compromised in any way, at any stage.

- For any current case that is concluding, where it is possible that a sanction will be applied, are similar questions being considered?

In highlighting these issues, which I know will be important to you and your teams, I would like to thank all those colleagues who directly contributed to and informed the work completed by the Advisory Group. I would particularly like to acknowledge the endeavours of Amin's partner Terry Skitmore and his advocate Narinder Kapur, without whose dedication and sacrifices the Amin Abdullah inquiry and subsequent development work by NHS Improvement would not have taken place.

I know that we are all keen to ensure we treat our people fairly and protect their wellbeing. Implementing the attached guidance consistently well across the NHS will contribute to that goal. It is tragic that we are learning these lessons after Amin's death, but we owe it to him and the others who have suffered in similar circumstances to act now.

Thank you for your attention to these vital issues.

Best wishes



Baroness Dido Harding

Chair, NHS Improvement

Enclosure:

Additional guidance relating to the management and oversight of local investigation and disciplinary procedures

Copies:

Chair, Care Quality Commission

Chair, NHS Providers

Chair, Nursing and Midwifery Council

Chief Executive, NHS Employers

Additional guidance relating to the management and oversight of local investigation and disciplinary procedures

Adhering to best practice

- a) The development and application of local investigation and disciplinary procedures should be informed and underpinned by the provisions of current best practice, principally that which is detailed in the Acas 'code of practice on disciplinary and grievance procedures' and other non-statutory Acas guidance; the GMC's 'principles of a good investigation'; and the NMC's 'best practice guidance on local investigations' (when published).
- b) All measures should be taken to ensure that complete independence and objectivity is maintained at every stage of an investigation and disciplinary procedure, and that identified or perceived conflicts of interest are acknowledged and appropriately mitigated (this may require the sourcing of independent external advice and expertise).

Applying a rigorous decision-making methodology

- a) Consistent with the application of 'just culture' principles, which recognise that it is not always appropriate or necessary to invoke formal management action in response to a concern or incident, a comprehensive and consistent decision-making methodology should be applied that provides for full and careful consideration of context and prevailing factors when determining next steps.
- b) In all decision-making that relates to the application of sanctions, the principle of plurality should be adopted, such that important decisions which have potentially serious consequences are very well informed, reviewed from multiple perspectives, and never taken by one person alone.

Ensuring people are fully trained and competent to carry out their role

Individuals should not be appointed as case managers, case investigators or panel members unless they have received related up to date training and, through such training, are able to demonstrate the aptitude and competencies (in areas such as awareness of relevant aspects of best practice and principles of natural justice, and appreciation of race and cultural considerations) required to undertake these roles.

Assigning sufficient resources

Before commencing investigation and disciplinary procedures, appointed case managers, case investigators and other individuals charged with specific responsibilities should be provided with the resources that will fully support the timely and thorough completion of these procedures. Within the overall context of 'resourcing', the extent to which individuals charged with such responsibilities (especially members of disciplinary panels) are truly independent should also be considered.

Decisions relating to the implementation of suspensions/exclusions

Any decision to suspend/exclude an individual should not be taken by one person alone, or by anyone who has an identified or perceived conflict of interest. Except where immediate

safety or security issues prevail, any decision to suspend/exclude should be a measure of last resort that is proportionate, timebound and only applied when there is full justification for doing so. The continued suspension/exclusion of any individual should be subject to appropriate senior-level oversight and sanction.

Safeguarding people's health and wellbeing

- a) Concern for the health and welfare of people involved in investigation and disciplinary procedures should be paramount and continually assessed. Appropriate professional occupational health assessments and intervention should be made available to any person who either requests or is identified as requiring such support.
- b) A communication plan should be established with people who are the subject of an investigation or disciplinary procedure, with the plan forming part of the associated terms of reference. The underlying principle should be that all communication, in whatever form it takes, is timely; comprehensive; unambiguous; sensitive; and compassionate.
- c) Where a person who is the subject of an investigation or disciplinary procedure suffers any form of serious harm, whether physical or mental, this should be treated as a 'never event' which therefore is the subject of an immediate independent investigation commissioned and received by the board. Further, prompt action should be taken in response to the identified harm and its causes.

Board-level oversight

Mechanisms should be established by which comprehensive data relating to investigation and disciplinary procedures is collated, recorded, and regularly and openly reported at board level. Associated data collation and reporting should include, for example: numbers of procedures; reasons for those procedures; adherence to process; justification for any suspensions/exclusions; decision-making relating to outcomes; impact on patient care and employees; and lessons learnt.

Appendix 2

SECTION A: Evidence of Trust's progress against 7 People Practice recommendations:	
Learning Lessons to improve People Practice	Evidence of Trusts compliance'
<p>1) Adhering to best practice</p> <p>a) The development and application of local investigation and disciplinary procedures should be informed and underpinned by the provisions of current best practice, principally that which is detailed in the Acas 'code of practice on disciplinary and grievance procedures' and other non-statutory Acas guidance; the GMC's 'principles of a good investigation'; and the NMC's 'best practice guidance on local investigations' (when published).</p> <p>b) All measures should be taken to ensure that complete independence and objectivity is maintained at every stage of an investigation and disciplinary procedure, and that identified or perceived conflicts of interest are acknowledged and appropriately mitigated (this may require the sourcing of independent external advice and expertise).</p>	<p>The Trust's Standards of Behaviour and Conduct Policy (formerly <i>Disciplinary Policy</i>) is in line with current best practice as set out in the ACAS "Code of practice on disciplinary and grievance procedures" and is our first iterative review over the next 18 months to align with a Just Culture approach and to meet the requirements of Baroness Harding review.</p> <p>For Medical and Dental staff, <i>Conduct, Capability, ill health and Appeals Policy and Procedure for Practitioners</i> incorporates the nationally agreed "Maintaining High Professional Standards in the Modern NHS" (MHPS)". The Medical Director and/or Medical Staffing team seek independent advice from the Practitioner Performance Advice Service (PPAS), at key stages of employee relations case particularly at the start.</p> <p>The Trust ensures that independence and objectivity is maintained at all stages of the processes by appointing investigating officers, and panel members who have had no previous involvement in the matters in question, and by ensuring that companions to interviewees are not witnesses in their own right.</p> <p>Where appropriate, external advice is sought and specialist panel members are appointed in matters of clinical judgement. Occasionally external investigating officers are also appointed, as appropriate, to ensure objectivity.</p>
<p>2) Applying a rigorous decision-making methodology</p>	<p>In the spirit of seeking to resolve matters at the lowest possible level and as close to the issue as possible the Trust's Standards of Behaviour and Conduct policy provides for an initial fact-finding to be undertaken to ascertain whether the matter can be dealt with less</p>

<p>a) Consistent with the application of ‘just culture’ principles, which recognise that it is not always appropriate or necessary to invoke formal management action in response to a concern or incident, a comprehensive and consistent decision-making methodology should be applied that provides for full and careful consideration of context and prevailing factors when determining next steps.</p> <p>b) In all decision-making that relates to the application of sanctions, the principle of plurality should be adopted, such that important decisions which have potentially serious consequences are very well informed, reviewed from multiple perspectives, and never taken by one person alone.</p>	<p>formally or whether a full investigation is required. This initial informal fact finding is undertaken and then discussed with the Human Resources team. Where appropriate, options to manage informally are encouraged with alternatives such as behavioural agreements in the policy. If it is deemed a formal investigation is required a disciplinary triage form is completed and submitted to an independent panel away from the service to review and approve. This provides another level of independence in the decision-making process. The panel consists of Assistant Director of HR, Deputy Chief Nurse and Trust E, D and I lead.</p> <p>In cases where an investigation is deemed necessary, an independent investigating officer is appointed to undertake the investigative work. On conclusion of an investigation the investigating officer determines whether there is a case to answer and if so, whether the formal resolution fast track route may be offered or whether full hearing or meeting is required.</p> <p>Should the case proceed to a hearing, a different manager is nominated as Panel Chair and is supported by a different HR colleague. Similarly, in the event of an appeal, this is heard by a different Appeal Panel Chair and different HR support, neither of whom have had any prior involvement in the process.</p>
<p>3) Ensuring people are fully trained and competent to carry out their role</p>	<p>Training sessions for managers involved in investigations and hearings was delivered by Capsticks in 2018/19 attended by c150 managers. The Peak 1 Leadership program was launched in June 2021 and covers training for managers on the Standards of Conduct</p>

<p>Individuals should not be appointed as case managers, case investigators or panel members unless they have received related up to date training and, through such training, are able to demonstrate the aptitude and competencies (in areas such as awareness of relevant aspects of best practice and principles of natural justice, and appreciation of race and cultural considerations) required to undertake these roles.</p>	<p>and Behaviour policy. Local HR bitesize sessions are delivered to new managers addressing management concerns on HR policies (covering capability and conduct issues). Capsticks is developing a suite of webinars for manager to access training on investigations and chairing panels with follow-up Q & A sessions with the HR team. Managers are coached and supported by the HR team when leading on investigations and chairing panels.</p>
<p>4) Assigning sufficient resources</p> <p>Before commencing investigation and disciplinary procedures, appointed case managers, case investigators and other individuals charged with specific responsibilities should be provided with the resources that will fully support the timely and thorough completion of these procedures. Within the overall context of 'resourcing', the extent to which individuals charged with such responsibilities (especially members of disciplinary panels) are truly independent should also be considered.</p>	<p>Appointment of investigating officers and Chairs of panels is undertaken by the HR team and relevant Divisional leads, using the list of trained staff and managers with appropriate experience. An aspect of the investigating officer's role is to facilitate time for the investigation and report-writing to be undertaken. The Chief People Officer writes to managers undertaking investigation reminding them of their responsibility to adhere to policy principles and timescales.</p> <p>A member of the HR team is assigned to support each investigating officer and a different HR team member sits on panels at all levels to provide advice and support.</p>
<p>5) Decisions relating to the implementation of suspensions/exclusions</p> <p>Any decision to suspend/exclude an individual should not be taken by one person alone, or by anyone who has an</p>	<p>Decisions on exclusion of medical or dental staff are taken by the Medical Director in consultation with Assistant Director of HR, in accordance with MHPS.</p> <p>Decisions on suspension for other clinical staff groups are taken by the Chief Nurse in consultation with Assistant Director of HR.</p>

<p>identified or perceived conflict of interest. Except where immediate safety or security issues prevail, any decision to suspend/exclude should be a measure of last resort that is proportionate, timebound and only applied when there is full justification for doing so. The continued suspension/exclusion of any individual should be subject to appropriate senior-level oversight and sanction.</p>	<p>Suspensions for non-clinical staff is taken by the Chief People Officer in consultation with Divisional Senior Leadership teams. Every effort is made to avoid suspension/exclusion, including redeployment, restrictions of duties and are kept under review by the investigating officer. Decision to suspend is never taken unilaterally.</p>
<p>6) Safeguarding people’s health and wellbeing</p> <p>a) Concern for the health and welfare of people involved in investigation and disciplinary procedures should be paramount and continually assessed. Appropriate professional occupational health assessments and intervention should be made available to any person who either requests or is identified as requiring such support.</p> <p>b) A communication plan should be established with people who are the subject of an investigation or disciplinary procedure, with the plan forming part of the associated terms of reference. The underlying principle should be that all communication, in whatever form it takes, is timely; comprehensive; unambiguous; sensitive; and compassionate.</p> <p>c) Where a person who is the subject of an investigation or disciplinary procedure suffers any form of serious harm, whether physical or mental, this should be treated as a ‘never event’ which therefore is the subject of an immediate independent investigation commissioned and received by the</p>	<p>Employees who are subject to investigations are informed at the outset of the support available via Health and Well Being and Occupational Health, to whom they may self-refer, or a management referral may be made. In cases where an employee appears distressed at the outset, a management referral is made to Occupational Health for advice and support. Employees are informed that access to Occupational Health support is available at any time.</p> <p>At the outset of any investigation a meeting is held with staff of the investigation to inform them of the reasons for the investigation and the process to be followed, and this is confirmed in writing, together with the allegations. The Investigating Officer role includes the responsibility for regular communications with the employee throughout the investigation to keep them informed of progress. Where an employee is suspended, the investigating officer is also responsible for keeping the employee informed of progress in the investigation.</p> <p>For any employee suspended an automatic referral is made to health and well-being to provide support. The wellbeing team will contact the</p>

<p>board. Further, prompt action should be taken in response to the identified harm and its causes.</p>	<p>individual within 48 hours of the referral and will be given a named contact. Employee is also provided with a copy of the BHT Wellbeing Guide which includes details of the help and support available through the Trust. This includes VIVUP the Trust Employee Assistance programme who can also provide support for staff suspended outside of normal working hours.</p> <p>Where physical or mental health affects an employee's ability to take part in a disciplinary process, reasonable adjustments are made to support them to take part or, if necessary, delay the investigation to enable them to take part.</p> <p>A named contact person from the employee's department is assigned to the suspended employee to maintain contact and provide regular service updated. This named contact will be separate from any investigation.</p>
<p>7) Board-level Oversight</p> <p>Mechanisms should be established by which comprehensive data relating to investigation and disciplinary procedures is collated, recorded, and regularly and openly reported at board level. Associated data collation and reporting should include, for example: numbers of procedures; reasons for those procedures; adherence to process; justification for any suspensions/exclusions; decision-making relating to outcomes; impact on patient care and employees; and lessons learnt.</p>	<p>Data relating to suspensions, which includes number and duration of suspensions, is reported at Trust Board bi-monthly. Clinical (non-medic) employee relations case work is reviewed by the Chief Nurse office on a monthly basis this includes details, duration and timescales of case work.</p>

Meeting: Trust Board in Public

28 July 2021

Agenda item	COVID-19 Vaccination programme summary
Board Lead	Bridget O'Kelly, Chief People Officer
Type name of Author	Tina Kenny, Director of Clinical Partnerships Tunde Adewopo, Divisional Director SSD Karon Hart, Deputy Director for Workforce and Wellbeing Amanda Hodges, Lead Programme Manager Alicia Siraj, Joint Operational Lead- Covid- 19 Vaccinations
Attachments	N/A
Purpose	Information
Previously considered	Executive Management Committee Strategic workforce Committee

Executive Summary

The NHS launched a national vaccination programme for COVID-19 in Dec 2020. In response to this we opened our BHT hospital vaccine hub in January 2021.

The vaccine is offered to people based on the advice of the Joint Committee on Vaccination and Immunisation (JCVI) priority for groups of people at risk. Therefore, our Hospital hub focused on all BHT colleagues in phase 1, followed by Health and Social Care Workers across Bucks in phase 2 (supported through the instigation of a Bucks Allocation HUB).

A Trust multi-disciplinary team initially led by Occupational Health was mobilised and formed into an effective vaccine delivery team, later joined by colleagues from the Local Authority and from the Clinical Commissioning Group (CCG).

The governance arrangements were established internally to BHT via a daily vaccine huddle, overseen by a Steering Group formed by the Integrated Care System for Buckinghamshire, Oxfordshire and Berkshire West (BOB).

To date, we have safely vaccinated 88% of trust staff with their first dose and 79% with their second dose. There is a difference in uptake of the vaccine by staff of different ethnicities. We have engaged widely to reduce this gap.

Overall, we administered c24,500 vaccines (including health and social care colleagues).

There were no serious vaccine incidents and the patient satisfaction rate survey result was over 99%. This extraordinary effort is due in no small part to the daily dedication of the team, which was determined to offer a safe, high quality service, based on the latest guidance and evidence, to all vaccinees. The broad expertise, enthusiasm, energy and commitment of this team was fundamental to its success.

SWC took partial assurance from this paper. The Committee was concerned at the reported low uptake of the second doses for colleagues of BAME background. As at 15 July, uptake is as set out in the table below. The Occupational Health team continue to work to close this gap.

Staff group ethnicity	First dose	Second dose
All staff	89%	85%
White British	93%	90%
All BAME	87%	82%
Black British/Black	79%	72%

Decision	The Board is requested to NOTE the paper.	
Relevant Strategic Priority		
Quality ☒	People ☒	Money ☒
Implications / Impact		
Patient Safety	Any impacts on patient safety are identified and addressed as part of the Trust and divisional integrated performance review process. Incidents are shared within the system and region for rapid learning	
Risk: link to Board Assurance Framework (BAF)/Risk Register	1.1 Inadequate staff resources to deliver outstanding quality care (insufficient levels of qualified, experienced staff and training opportunities) 2.7 Gaps in workforce supply: local/SE region cost of living prohibitive and national workforce shortages in some professions	
Financial	Funding provided through national allocation	
Compliance NHS Regulation	National JCVI and NHS guidance	
Partnership: consultation / communication	This programme involved close and regular collaboration within BHT, across the Bucks system and in BOB ICS.	
Equality	The vaccination programme was open to all staff. Initially uptake did reflect the national data on vaccine hesitancy being higher in BAME colleagues, however a comprehensive comms and support programme put in place to support any colleagues with questions or concerns, including linking into our staff networks.	
Quality Impact Assessment [QIA] completion required?	This is a nationally mandated programme. All decisions were flowed through both the BOB and trust command and control structures.	

Buckinghamshire NHS Trust Vaccination Programme, Winter20/21

Introduction

This paper summarises the COVID-19 vaccination programme for all BHT colleagues and colleagues within the Buckinghamshire wider health and social care system. This initiative sits within the context of the national immunisation programme for COVID-19 and all national guidance and updates are implemented at each stage of the vaccine programme.

The NHS is currently offering the COVID-19 vaccine to people in England, via hospitals (Hospital Hubs - HH) at local GP centres run by individual practices or primary care networks (PCNs), at larger vaccination centres and at centres run by community pharmacies.

The vaccine is being offered to people based on the advice of the Joint Committee on Vaccination and Immunisation (JCVI). The JCVI has described an order of priority for groups of people at risk. (Appendix One)

When the vaccine programme commenced on 8 December 2020, two vaccines had gained approval from the Medicines and Healthcare Regulatory Authority (MHRA) to be used for this purpose. They were the Pfizer-BioNTech (PB) and Oxford/AstraZeneca (AZ) vaccines. Each vaccinee was required to be given two doses 11 /12 weeks apart. The PB vaccine had specific conditions for use, its delivery is complex and it and could not easily be transported.

The Trust was invited to develop a hospital hub from scratch to offer the PB vaccine to people in group 2 who are frontline health and social care workers.

Operating model

The hospital hub vaccine delivery team included key leads and specialists from Occupational Health, Pharmacy, Temporary Staffing, Procurement, Estates, Finance, IT, Communications and HR. The MDT vaccine leads met daily for a 'vaccine huddle' Social care and CCG partners attended where necessary. (Appendix 2)

The team developed and adapted an operating model, standard operating procedures, managed challenges with vaccine supply and quality control as well as developing a rapid escalation training programme across pharmacy sites in Buckinghamshire. A knowledge sharing group consisting of clinical specialists was set up at the beginning of the programme to offer scrutiny and assurance on clinical elements ensuring these were consistent with clinical opinion across BOB and nationally.

After an assessment of options for booking system, we opted to use the booking and recording system for the vaccinations developed by East Kent NHS Trust . This system was offered to Trusts at no costs and we were already using it to log lateral flow test results.

To support vaccination of social care colleagues, Vaccine team leads worked with colleagues from Bucks County Council (BCC) to set up an allocation bureau process, which met daily to plan the social care roll out. In order to accommodate the specific needs of this cohort of vaccinees, a call centre was set up by BCC to facilitate bookings on the East Kent system.

Across both hubs at Stoke Mandeville and Amersham staffing was covered through substantive, bank and agency, on a rota basis to cover 7 day operating model. Also 34 volunteers supported the vaccination process.

Governance

Internally, to enable prompt decision making, a daily vaccine huddle was held with key leads, chaired by BHT Medical Director. Decisions for escalation were fed into the Trust's COVID-19 command and control structure. The regional governance arrangements were overseen by a Steering Group formed by the Integrated Care System for Buckinghamshire, Oxfordshire and Berkshire West (BOB) and by the Bucks Vaccination Cell. (Appendix 3)

National and regional guidance which required an immediate response from the Trust was received on a 7-day week basis for five months and was centrally managed by our PMO lead and cascaded accordingly.

All vaccination records were recorded, mostly at Point of Care, on the National Immunisation and Vaccination System (NIVs), under the oversight of the Occupational Health team and clinical operational leads. We followed national guidance in all our processes for recording vaccine status.

Vaccine Hesitancy, Uptake and Communication

Vaccine hesitancy is the delay in acceptance or refusal of vaccines despite the availability of vaccination services. The Office for National Statistics reported in December 2020 an overall 22% negative vaccine sentiment, with 44% vaccine hesitancy expressed by Black or Black British adults.

Trust data demonstrated this pattern was mirrored in Trust staff when the programme began.

The Trust team set out to ensure that all invitees had the information they required to make their decision about receiving the vaccine. This was delivered through a comprehensive communication plan, using different communication channels, designed to reach all health and social care staff and were supported by the Trust staff BAME network in particular. This included screensavers, leaflets, posters, videos and webinars. A resource library, open to all, was created to ensure that colleagues had access to the latest reports and guidelines to enable them to make an informed decision about the vaccine.

Webinars addressed a range of issues including pregnancy, fertility, allergy and other safety concerns and areas of interest – on two occasions, Professor Andrew Pollard, the director of the Oxford vaccine group and chair of the JCVI attended. Two webinars were designed specifically to address the concerns of BAME colleagues and featured vaccine experts, faith leaders, trust network leads, community influencers. All sessions were recorded and made available on the Trust intranet and all included opportunity for questions and answers

There were daily communications via the trust COVID-19 brief and silver command meetings to ensure consistent messaging within BHT. We also shared communications resources across the system. A dedicated phone line into the vaccination team to address concerns was set up.

During the week of 8 March, c1,000 front-line staff who had not yet received a first vaccine had personal contact from the Vaccine team or Occupational Health department to understand and address any outstanding concerns. There was an increase in uptake following this initiative, coinciding at this point with the introduction of the AZ vaccine. This also enabled us to record the status for those vaccinated elsewhere.

Our current overall uptake in BHT is 88% first dose and 79% second dose. Through addressing concerns, the uptake rate across staff groups and the BAME ‘gap’ reduced from 9% to 3%.

Division x ethnicity	White British	White other	Asian British/Asian	Black British/Black	Mixed ethnicity	Any Other Ethnic Group	Not stated	Grand Total
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Total %_1st dose	93.0%	82.7%	85.4%	74.5%	82.7%	93.2%	57.1%	88.1%
Total %_2nd dose	86.2%	74.3%	74.1%	58.9%	70.9%	76.9%	41.0%	79.0%

The programme was so far delivered c24,500 vaccinations. (Appendix 4)

Vaccines delivery

The vaccines were delivered from a HH, which was a repurposed room within the Stoke Mandeville Hospital postgraduate education centre. At its maximum capacity, this hub delivered over 500 vaccines per day. A second Hospital Hub was established in Amersham Hospital and opened on the 1 February. Its capacity was 330 per day as an average.

Phase one of the programme delivered a first vaccine of PB to BHT colleagues and Buckinghamshire health and social care workers from 4 January – 20 March 2021. Phase two of the programme, to deliver second vaccines of PB, ran from 22 March – 30 April

The Stoke Mandeville Hospital HH was closed at the end of April. The Amersham Hub closed 23rd April 2021.

In phase three, which started on 1 March, Occupational Health offered alternative provision for staff for whom Pfizer was contra-indicated (under JCVI guidelines) and for new starters to the Trust who were unvaccinated. In the first 2 months of this being operational almost 500 staff received a first dose of AZ through this pathway, with second doses administered the week of 17 May.

We did then receive updated guidance from JCVI on the usage of AZ, with changes to age group profile as a contra-indicator, which was widely publicised both nationally and through our BHT comms. Firstly, for under 30's and then for under 40's. This led us to strengthen use of partner pathways within Bucks system, to provide Pfizer vaccinations for BHT colleagues, where clinically indicated.

Vaccinees

Included in the vaccine numbers are Trust and other health and social care colleagues, volunteers, Sodexo and other contracted staff, NHSP and agency colleagues, staff from St Johns Ambulance, South Central Ambulance Service and frontline responders.

The team also delivered vaccinations across all trust sites to eligible long stay patients who would otherwise have missed out on a vaccine invitation.

DNA (did not attend) Rates

Following learning from neighbouring Trusts, who found higher DNA rates than for the first vaccine invitation, we implemented a "pull" model of issuing a specific appointment for second vaccinations. As a result, our second vaccine DNA rate was 2.9%, one of the lowest DNA rates in the country.

Funding

The programme is nationally funded through NHS England and Improvement (NHSEI). This includes additional temporary staff costs, staff overtime, and backfilled permanent staff.

Patient satisfaction, clinical incidents and wastage

All vaccinees were asked to complete a satisfaction questionnaire. The feedback was consistently high at a score of 4.9 out of 5. The main themes highlighted were that vaccinees felt very safe, and that the service was efficient, well organised and they were given all the

time they required. The patient satisfaction survey result was over 99 % satisfied (Appendix 5) There were no serious

vaccine incidents.

The team's priority was to maximise the use of vaccines and across the entire programme, less than 5 usable doses were wasted. 2 vials (6 doses) dropped and 6 vials unused due to impurity issues.

Trust vaccine team support to system and national partners

Trust colleagues have forged strong working relationships with staff from partner organisations in Buckinghamshire which has been a contributing factor to the success of the vaccination programme across the county.

Trust colleagues were not only involved in the development of the two Hospital Hubs, but were a key source of advice and support to others setting up vaccine hubs. The trust site at Chalfont Hospital was used by one of the Primary Care Network (PCN) for their vaccine programme; estates and clinical expertise was provided to the PCN and other vaccination sites across Buckinghamshire, particularly during their set up period. Support for others included:

- Sharing trust developed risk assessments with others.
- Supported the setup of IT services across all Buckinghamshire vaccination centres.
- Trust pharmacy team instrumental in setting up vaccination centres across Buckinghamshire.
- Sharing Trust standard operating procedures, particularly for pregnant women, across Buckinghamshire and BOB
- Initial approach to patients who may have an allergic response shared regionally.
- Pharmacy team developed a ward process shared with Watford and Leicester hospitals

Next Steps

The Occupational Health department and key members of the vaccine delivery team are now considering requirements for a national booster programme in Autumn. We are awaiting guidance from national team – as delivery plans will be impacted by multifarious considerations, including:

1. Size of cohort we need to vaccinate.
2. Time given to complete the programme.
3. Which vaccine will be supplied.

Conclusion

The success of the trust vaccination programme to vaccinate health and social care colleagues has been down to a truly collaborative effort across the trust and our wider system partners.

The commitment of the trust team and the team of volunteers which supported the programme has been remarkable and has allowed the programme to flourish.

We will continue to work closely with our partners and support them while their vaccination programmes continue. Senior programme leads still attend Bucks system and BOB governance meetings.

We are making preparations for a booster vaccine programme which is widely anticipated to be needed for Autumn 2021, we are awaiting details from the national team.

Appendix one

JCVI Priority Groups

Priority Group	Risk Group
1	Residents in a care home for older adults and their carers
2	All those 80 years of age and over and frontline health and social care workers
3	All those 75 years of age and over
4	All those 70 years of age and over and clinically extremely vulnerable individuals
5	All those 65 years of age and over
6	All individuals aged 16 years to 64 years with underlying health conditions which put them at higher risk of serious disease and mortality
7	All those 60 years of age and over
8	All those 55 years of age and over
9	All those 50 years of age and over

Appendix two

Hospital Hub Vaccination Team

BHT Core Team
Director of Clinical Partnerships (then Medical Director)
Chief People Officer
Divisional Director of Specialist Services
Deputy Director of Workforce
Chief Pharmacist
Lead Program Manager

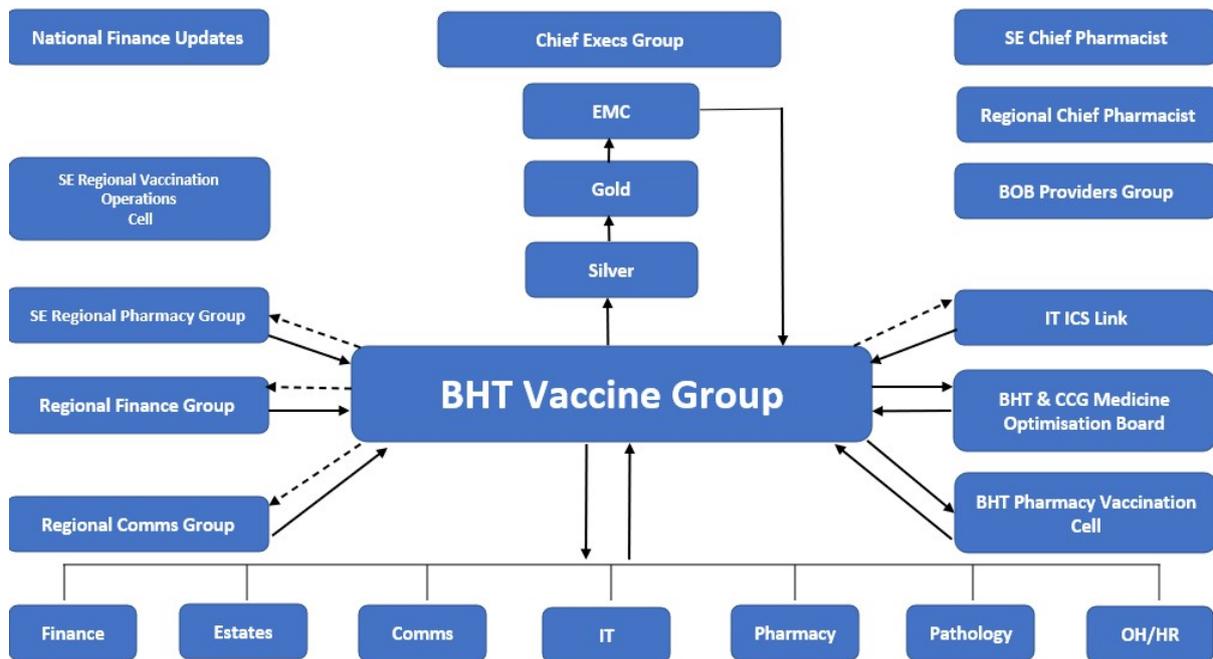
Associate Director of Communications & Engagement
Head of Occupational Health and Wellbeing
Operational Lead – Covid 19 Vaccination Program
Operational Lead – Covid 19 Vaccination Program
Operational Lead – Covid 19 Vaccination Program
Clinical Programme Lead
Head of Operations Property Services
Divisional Accountant
Associate Director of IT Strategy and Delivery
IT Lead

BHT Key Contributors
Infection Prevention & Control Nurse
Head of Service – Radiology and Pathology
Head of Nursing – Infection Prevention and Control
Transformation Programme Director
Patient Access
Divisional Chief Nurse
Head of Procurement
Emergency Planning Officer
Consultant Microbiologist
Temporary Staffing Manager
Associate Director Pharmacy
Library and Knowledge Services Manager

External Partnerships

Associate Director Medicines Optimisation Buckinghamshire CCG
Programme Manager BCC
Civil Contingencies Officer BCC
Interim Chief Finance Officer CCG
Head of PCN Delivery and Development CCG

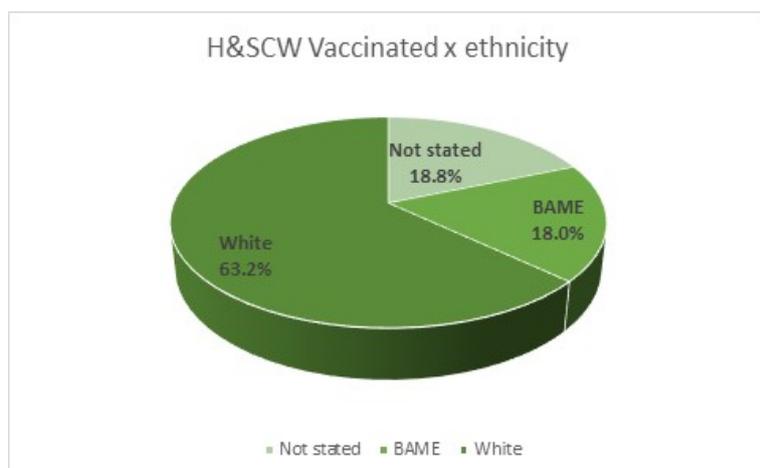
Appendix three – Governance Structure



Appendix 4

The following shows numbers vaccinated and the split between the 2 vaccines.

	Total vaccinated to date – 24,497
First dose	12,762
Second dose	11,735
Pfizer	23,973
AZ	524
Of which BAME colleagues	3642



Appendix 5- Patient satisfaction results

Stoke Mandeville summary of scores				
Average Score	4.9			
Breakdown of satisfaction score				
Very satisfied (5)	8205	94.41%		
4	364	4.19%		
Satisfied (3)	68	0.78%		
2	10	0.12%		
Very unsatisfied (1)	44	0.51%		
Breakdown of survey questions				
	Yes		No	
< 15 minute waiting?	7609	97.54%	192	2.46%
ID checked?	7583	97.14%	223	2.86%
Vaccination history discussed?	7686	98.58%	111	1.42%
Sufficient information received?	7738	99.19%	63	0.81%

Amersham summary of scores		
Average Score	4.9	
Breakdown of satisfaction score		
Very satisfied (5)	601	92.60%

4	38	5.86%
Satisfied (3)	4	0.62%
2	0	0.00%
Very unsatisfied (1)	6	0.92%
Breakdown of survey questions		
	Yes	No
< 15 minute waiting?	587 96.71%	20 3.29%
ID checked?	632 99.68%	2 0.32%
Vaccination history discussed?	629 100.00%	0 0.00%
Sufficient information received?	646 100.00%	0 0.00%

Meeting: Trust Board in Public

28 July 2021

Agenda item	Guardian of Safe Working Hours – Annual Report
Board Lead	Bridget O’Kelly
Type name of author	Dr Nav Bahal
Attachments	Exception Report 2020-21 Annual Summary
Purpose	Assurance
Previously considered	Executive Management Committee; Strategic Workforce Committee

Executive Summary

This report has been provided to the Board as required by Schedule 5, Paragraph 39 of the Terms and Conditions of Service (TCS) for NHS Doctors and Dentists in Training (England) 2016 (Version 8).

This report summarises the progress made by the Trust in promoting a reporting culture amongst junior doctors. This paper sets out where concerns have been raised and the steps that have been taken.

- The Emergency Department Core Trainee Rota has breached the weekend working limit for some of the doctors
- Work schedules and rotas: The Trust performed poorly on this metric and many junior doctors did not receive these in time
- COVID Rotas – All junior doctors have returned from escalation and redeployment rotas

Decision	The Committee is requested to note the contents of this report
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Relevant strategic priority

Quality People Money

Implications / Impact

Patient Safety	The GSWH is a key role in promoting patient safety
Risk: link to Board Assurance Framework (BAF)/Risk Register	1.1 Inadequate staff resources to deliver outstanding quality care (insufficient levels of qualified, experienced staff and training opportunities) 2.7 Gaps in workforce supply: local/SE region cost of living prohibitive and national workforce shortages in some professions
Financial	Funding for recruitment (Section 2.2) and extra remuneration (Section 2.4)
Compliance <small>Select an item.</small>	The Trust is required to meet the Terms and Conditions of Service (TCS) for NHS Doctors and Dentists in Training (England) 2016.
Partnership: consultation / communication	Liaising with rota co-ordinators, SDU leads, DME, FTSUG and Junior Doctor Forum. Promoting reporting culture amongst staff.
Equality	An analysis of the last quarter’s exception report data has been carried out by ethnicity and gender. The data demonstrates that c70% of all exception

	reports were made by female trainees, whilst they make up c56% of the trainees. The data also indicates that c43% of all exception reports were made by BAME trainees, which is comparable to the overall trainee workforce (45%)
Quality Impact Assessment [QIA] completion required?	N/A

1 Introduction/Position

- 1.1 This report has been provided to the Board as required by Schedule 5, Paragraph 39 of the Terms and Conditions of Service (TCS) for NHS Doctors and Dentists in Training (England) 2016 (Version 8).
- 1.2 This report summarises the progress made by the Trust in promoting a reporting culture amongst junior doctors. This paper sets out where concerns have been raised and the steps that have been taken.
- 1.3 The previous report covered the academic year (August 2019-July 2020). From this report on, the fiscal year will be used, and the report submitted after Q4. Therefore, data for this year (April 2020-21) overlaps that in the last report.
- 1.4 In the year 2020-21, 395 exception reports were submitted.

Fiscal Year	Exception Reports
2020-21	395
2019-20	458
2018-19	334
2017-18	446
2016-17* (Started in August 2016)	57

- 1.5 Data and breakdown on exception reports is provided in a quarterly report to Strategic Workforce Committee.

2 Problem

2.1 Work Schedules and Rotas

As of August 2020, the requirements for the provision of information from employing organisations to trainees at 8 weeks and 6 weeks prior to commencement in post, as contained within the Code of Practice was made contractual. The Trust performed poorly on this metric and many junior doctors did not receive these in time. As such some were left without rotas or appropriate pay upon joining the Trust.

This is dependent on Health Education England (HEE) meeting their contractual obligation of providing the names of the new doctors 12 weeks in advance. This is not always the case and any delays mean the departments are not aware of the number of new doctors they will be receiving. Departments being unable to produce rotas impacts on Medical HR being able to produce work schedules.

In addition, there appears to be a lack of expertise in some departments around the Trust on how to use the Allocate software which can cause delays with the rotas being produced. It is some years since Allocate was introduced to the Trust and the training and expertise which was provided at that time has been diluted due to staff turnover. Some further investment in training would be beneficial for the current rota co-ordinators and new staff in Medical HR.

To ensure departments are aware of the contractual obligation a joint communication message from the Guardian of Staff Working and the Medical HR Manager is sent around prior to the annual August and February intakes.

2.2 Emergency Medicine Core Trainee/Foundation Year 2 Rota

This rota breached weekend frequency limits in October 2019 and has continued to do so. The weekend frequency is 1 in 2.2 and higher than the 1 in 3 limit (although this is permitted for the FY2 doctors on the rota). The rota had been compliant with safe working limits until the

maximum weekend frequency changed when the terms and conditions of service were updated.

2.3 COVID-19 Rotas

For a period in 2020, departments were permitted to breach certain safe working limits within the 2016 TCS to produce emergency rotas. 3 rotas (all in Integrated Medicine and breaching weekend frequency limits) did so and returned to being compliant with 2016 TCS safeguards by the agreed deadline of 5th August 2020.

2.4 Remuneration for COVID-19 weekend frequency breaches

There had been no national guidance as to how doctors referred to in Section 2.3 who had worked greater than '1 in 2' weekends should be remunerated for this increased frequency of weekend working during these exceptional circumstances. NHS Employers and BMA had advised Trusts to reach agreement, via the established local negotiation structures, on an appropriate remuneration for this increased weekend working.

3 Solutions

3.1 Work Schedules and Rotas

In conjunction with Medical HR we have created a standing reminder which is sent out to all those responsible with a timetable. In April 2021 there was a failure to adhere to this standard on a rota which had been affected by redeployment, but this has been addressed. For August 2021, work schedules and rotas have all gone out on time across specialties.

3.2 Emergency Medicine Core Trainee/Foundation Year 2 Rota

A solution has been presented by the Deputy Divisional Director for Integrated Medicine – and will be included in the business planning for next year.

3.3 COVID Rotas

All junior doctors have returned from escalation and redeployment rotas.

3.4 Remuneration for COVID weekend frequency breaches

The BMA requested a 25% supplement (the existing maximum was paid at 15%) and this was accepted at JCNC (Joint Consultation and Negotiating Committee) in August 2020.

4 Action required from the Board

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

Meeting: Trust Board Meeting in Public

28 July 2021

Agenda item	Board Attendance Record	
Board Lead	Chief Executive Officer	
Type name of Author	Senior Board Administrator	
Attachments	None	
Purpose	Information	
Previously considered	N/A	

Executive Summary

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

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

Quality <input checked="" type="checkbox"/>	People <input checked="" type="checkbox"/>	Money <input checked="" type="checkbox"/>
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Implications / Impact

Patient Safety	Patient safety concerns are discussed by all members of the Board
Risk: link to Board Assurance Framework (BAF)/Risk Register	Board risks are discussed by all members of the Board
Financial	Financial information is presented and discussed by all Board members
Compliance <small>Select an item. Select CQC standard from list.</small>	Compliance information and concerns are presented when appropriate and discussed by all Board members
Partnership: consultation / communication	Not Required
Equality	Equality, Diversity and Inclusion information and compliance is identified in all Board reports and discussed by members of the Board
Quality Impact Assessment [QIA] completion required?	Not Required

Board Attendance Record: May 2021 to July 2021

	Strategic Workforce Committee		Finance and Business Performance Committee			Quality & Clinical Governance Committee		Organ & Tissue Donation Committee	Charitable Funds Committee	Audit Committee					Trust Board		
	10 May	12 Jul	19 May	15 Jun	20 Jul	5 May	23 Jun	5 May	15 Jun	4 May	6 May	25 Jun	1 Jul	9 Jul	26 May	30 Jun	9 Jul
Hattie Llewelyn-Davies Trust Chair *	✓	✓		✓	✓	✓	x (due to change in date)								✓	x	✓
Neil Macdonald, Chief Executive Officer *			✓	✓	✓	✓	x				✓			✓	✓	x	✓
Dipti Amin NED*						✓	✓	✓		✓	✓	x (due to short notice)	✓	x (due to short notice)	x	✓	x (due to short notice)
Karen Bonner Chief Nurse *	✓	x				✓	✓						✓	✓	✓	✓	✓
Dan Gibbs Chief Operating Officer*			✓	✓	✓	✓	✓					✓		✓	✓	✓	✓
Nicola Gilham NED*			✓	✓	✓				✓	✓	✓	✓	✓	✓	✓	✓	✓
Mo Girach Associate NED						✓	✓								x	✓	✓

	Strategic Workforce Committee		Finance and Business Performance Committee			Quality & Clinical Governance Committee		Organ & Tissue Donation Committee	Charitable Funds Committee	Audit Committee					Trust Board		
	10 May	12 Jul	19 May	15 Jun	20 Jul	5 May	23 Jun	5 May	15 Jun	4 May	6 May	25 Jun	1 Jul	9 Jul	26 May	30 Jun	9 Jul
Adrian Hayter Associate NED						✓	✓								✓	✓	✓
Rajiv Jaitly NED *			✓	✓	✓					✓	✓	✓	✓	✓	✓	✓	✓
Barry Jenkins Director of Finance*			✓	✓	✓				✓	✓	✓	✓	✓	✓	✓	✓	✓
John Lisle NED *			✓	✓	✓					✓	✓	✓	✓	x (due to short notice)	x	✓	x (due to short notice)
Andrew McLaren Chief Medical Officer *			✓	x	x	x	✓	x							✓	x	✓
Bridget O'Kelly Chief People Officer	✓	✓													✓	✓	✓
Tom Roche NED*	✓	✓	✓	✓	✓					✓	✓	x (due to short notice)	✓	✓	✓	✓	✓
Sandra Silva Board Affiliate	✓	✓				✓									✓	✓	✓
David Williams Director of Strategy & Business	✓	✓	✓	✓	x							✓	✓	✓	✓	✓	✓

	Strategic Workforce Committee		Finance and Business Performance Committee			Quality & Clinical Governance Committee		Organ & Tissue Donation Committee	Charitable Funds Committee	Audit Committee					Trust Board		
	10 May	12 Jul	19 May	15 Jun	20 Jul	5 May	23 Jun	5 May	15 Jun	4 May	6 May	25 Jun	1 Jul	9 Jul	26 May	30 Jun	9 Jul
Development																	
Ali Williams Commercial Director			✓	✓	✓										✓	✓	✓

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

Meeting: Trust Board Meeting in Public

28 July 2021

Agenda item	Private Board Summary 26 May & 30 June 2021	
Board Lead	Chief Executive Officer	
Type name of Author	Senior Board Administrator	
Attachments	None	
Purpose	Information	
Previously considered	N/A	

Executive Summary

The purpose of this report is to provide a summary of matters discussed at the Board in private on the 26 May & 30 June 2021. The matters considered at these sessions of the Board were as follows:

- Summary of Buckinghamshire, Oxfordshire and Berkshire West (BOB) Integrated Care System Leaders and Buckinghamshire Integrated Care Partnership CEOs' meetings
- Patient Safety and Safeguarding / Vulnerable Patients Surveillance Report
- Excluded Practitioners
- Buckinghamshire Healthcare Projects Limited
- Annual Report
- Draft Buckinghamshire, Oxfordshire & Berkshire West ICS; 2021/22 Priorities and Operational Planning
- BHT Strategy 2025 'Outstanding care, healthy communities and a great place to work'
- Financial Plan and Strategy
- Board Assurance Framework
- Quality Accounts
- Maternity Incentive Scheme
- External Reviews
- Robot Business Case
- Integrated Performance Report and Recovery and Renewal

Decision	The Board is requested to note the contents of the report.		
Relevant Strategic Priority			
Quality <input checked="" type="checkbox"/>	People <input checked="" type="checkbox"/>	Money <input checked="" type="checkbox"/>	
Implications / Impact			
Patient Safety		Aspects of patient safety were considered at relevant points in the meeting	
Risk: link to Board Assurance Framework (BAF)/Risk Register		Any relevant risk was highlighted within the reports and during the discussion	
Financial		Where finance had an impact, it was highlighted and discussed as appropriate	
Compliance Select an item. Select CQC standard from list.		Compliance with legislation and CQC standards were highlighted when required	

	or relevant
Partnership: consultation / communication	N/A
Equality	Any equality issues were highlighted and discussed as required.
Quality Impact Assessment [QIA] completion required?	N/A

Acronym 'Buster'

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

B

- BBE - Bare Below Elbow
- BHT – Buckinghamshire Healthcare Trust
- BME - Black and Minority Ethnic
- BMA - British Medical Association
- BMI - Body Mass Index
- BOB – Buckinghamshire, Oxfordshire, Berkshire West
- BPPC – Better Payment Practice Code

C

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

D

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

E

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

F

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

G

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

H

- HAI - Hospital Acquired Infection
- HASU - Hyper Acute Stroke Unit
- HCA - Health Care Assistant
- HCAI - Healthcare-Associated Infection
- HDU - High Dependency Unit
- HEE – Health Education England
- HETV - Health Education Thames Valley
- HMRC – Her Majesty's Revenue and Customs

- HSE - Health and Safety Executive
- HSLI – Health System Led Investment
- HSMR – Hospital-level Standardised Mortality Ratio
- HWB - Health and Wellbeing Board

I

- ICS – Integrated Care System

M

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

J

- JAG - Joint Advisory Group

K

- KPI - Key Performance Indicator

L

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

M

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

N

- NBOCAP - National Bowel Cancer Audit Programme
- NCASP - National Clinical Audit Support Programme
- NED - Non-Executive Director

- NHS – National Health Service
- NHSE – National Health Service England
- NHSE/I – National Health Service England & Improvement
- NHSI – National Health Service Improvement
- NHSLA - NHS Litigation Authority
- NICE - National Institute for Health and Care Excellence
- NICU - Neonatal Intensive Care Unit
- NMC - Nursing and Midwifery Council
- NNU - Neonatal Unit
- NOGCA - National Oesophago-Gastric Cancer Audit
- NRLS - National Reporting and Learning System / Service

O

- O&G - Obstetrics and Gynaecology
- OBC - Outline Business Case
- ODP - Operating Department Practitioner
- OHD - Occupational Health Department
- OOH - Out of Hours
- OP - Outpatient
- OPD - Outpatient Department
- OT - Occupational Therapist/Therapy
- OUH - Oxford University Hospital

P

- PACS - Picture Archiving and Communications System / Primary and Acute Care System
- PALS - Patient Advice and Liaison Service
- PAS - Patient Administration System
- PBR - Payment by Results
- PBR Excluded – Items not covered under the PBR tariff
- PDC - Public Dividend Capital
- PDD - Predicted Date of Discharge
- PE - Pulmonary Embolism
- PFI - Private Finance Initiative
- PHE - Public Health England
- PICC - Peripherally Inserted Central Catheters
- PID - Patient / Person Identifiable Data
- PID - Project Initiation Document
- PLACE - Patient-Led Assessments of the Care Environment
- PMO - Programme Management Office
- PPE - Personal Protective Equipment
- PP – Private Patients
- PPI - Patient and Public Involvement
- PSED - Public Sector Equality Duty

Q

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

R

- RAG - Red Amber Green
- RCA - Root Cause Analysis

- RCN - Royal College of Nursing
- RCP - Royal College of Physicians
- RCS - Royal College of Surgeons
- RIDDOR - Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
- RTT - Referral to Treatment

S

- SAU - Surgical Assessment Unit
- SCAS / SCAmb - South Central Ambulance Service
- SHMI - Summary Hospital-level Mortality Indicator
- SI - Serious Incident
- SIRI - Serious Incident Requiring Investigation
- SIRO – Senior Information Risk Owner
- SID - Senior Independent Director
- SLA - Service Level Agreement
- SLR - Service-Line Reporting
- SLT / SaLT - Speech and Language Therapy
- SMR - Standardised Mortality Ratio
- SoS - Secretary of State
- SSI(S) - Surgical Site Infections (Surveillance)
- SNAP - Sentinel Stroke National Audit Programme
- STF – Strategic Transformation Fund
- STP - Sustainability and Transformation Plan
- SUI - Serious Untoward Incident

T

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

U

- UGI - Upper Gastrointestinal
- UTI - Urinary Tract Infection

V

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

W

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

Y

- YTD - Year to Date