

**Meeting:** Trust Board Meeting in Public

**Date:** Wednesday, 24 November 2021

**Time:** 9.00am – 11.30am

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

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

### General Business

09.05	3.	Patient Story	Discussion	Chief Nurse	Paper
09.20	4.	Minutes of the last meeting held on 29 September	Approval	Chair	Paper
	5.	Actions and Matters Arising	Approval	Chair	Paper
09.25	6.	Chief Executive's Report	Assurance	Chief Executive Officer	Paper
09.35	7.	Freedom to Speak Up Report	Assurance	Chief People Officer	Paper

### Performance

09.45	8.	Recovery Report	Assurance	Chief Operating Officer	Paper
	9.	Emergency Preparedness, Resilience and Response	Assurance	Chief Operating Officer	Paper
10.00	QUESTIONS FROM THE PUBLIC				

10.05	10.	Director of Public Health Annual Report 2021 – Domestic Violence and Abuse	Discussion	Director of Public Health	Paper
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10.20 COMFORT BREAK – 10 minutes

### Strategy

10.30	11.	Trust Board High Level Milestones Update		Director of Strategy	Paper
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### Finance

10.40	12.	Finance and Business Performance Committee Chair's Report	Assurance	Committee Chair	Paper
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### Quality

10.50	13.	Quality and Clinical Governance Committee Chair Report	Assurance	Committee Chair	Paper
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## Workforce

11.00	14.	Strategic Workforce Committee Chair Report	Assurance	Committee Chair	Paper
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## Risk and Governance

11.10	15.	Audit Committee Chair's Report	Assurance	Committee Chair	Paper
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	16.	Corporate Risk Register	Assurance	Chief Nurse	Paper
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	17.	Board Assurance Framework	Assurance	Trust Board Business Manager	Paper
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## Information

11.20	18.	BHPL Annual Report	Information	Commercial Director	Paper
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	19.	Safeguarding Annual Report	Information	Chief Nurse	Paper
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	20.	Information Governance DSP Toolkit Improvement Plan	Information	Director of Strategy	Paper
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	21.	Patient Experience Annual Report	Information	Chief Nurse	Paper
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	22.	Infection Prevention and Control Report	Information	Chief Nurse	Paper
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	23.	National Inpatient Survey Results	Information	Chief Nurse	Paper
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	24.	Safe (safest) staffing including maternity	Information	Chief Nurse	Paper
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	25.	Mortality Reduction Report	Information	Chief Medical Officer	Paper
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	26.	Harms Report	Information	Chief Medical Officer	Paper
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	27.	Trust Board Seal	Information	Trust Board Business Manager	Paper
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	28.	Board attendance record	Information	Trust Board Business Manager	Paper
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	29.	Private Board Summary Report	Information	Trust Board Business Manager	Paper
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	30.	Risks identified through Board discussion	Discussion	Trust Board Business Manager	Verbal
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ANY OTHER BUSINESS

QUESTIONS FROM THE PUBLIC

Date of Next Meeting:  
26 January 2022, 9am

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

Papers for Board meetings in public are available on our website [www.buckshealthcare.nhs.uk](http://www.buckshealthcare.nhs.uk)

## TRUST BOARD MEETINGS MEETING PROTOCOL

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

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

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

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

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

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

Hattie Llewelyn-Davies  
Chair

## THE SEVEN PRINCIPLES OF PUBLIC LIFE

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

### **Selflessness**

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

### **Integrity**

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

### **Objectivity**

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

### **Accountability**

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

### **Openness**

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

### **Honesty**

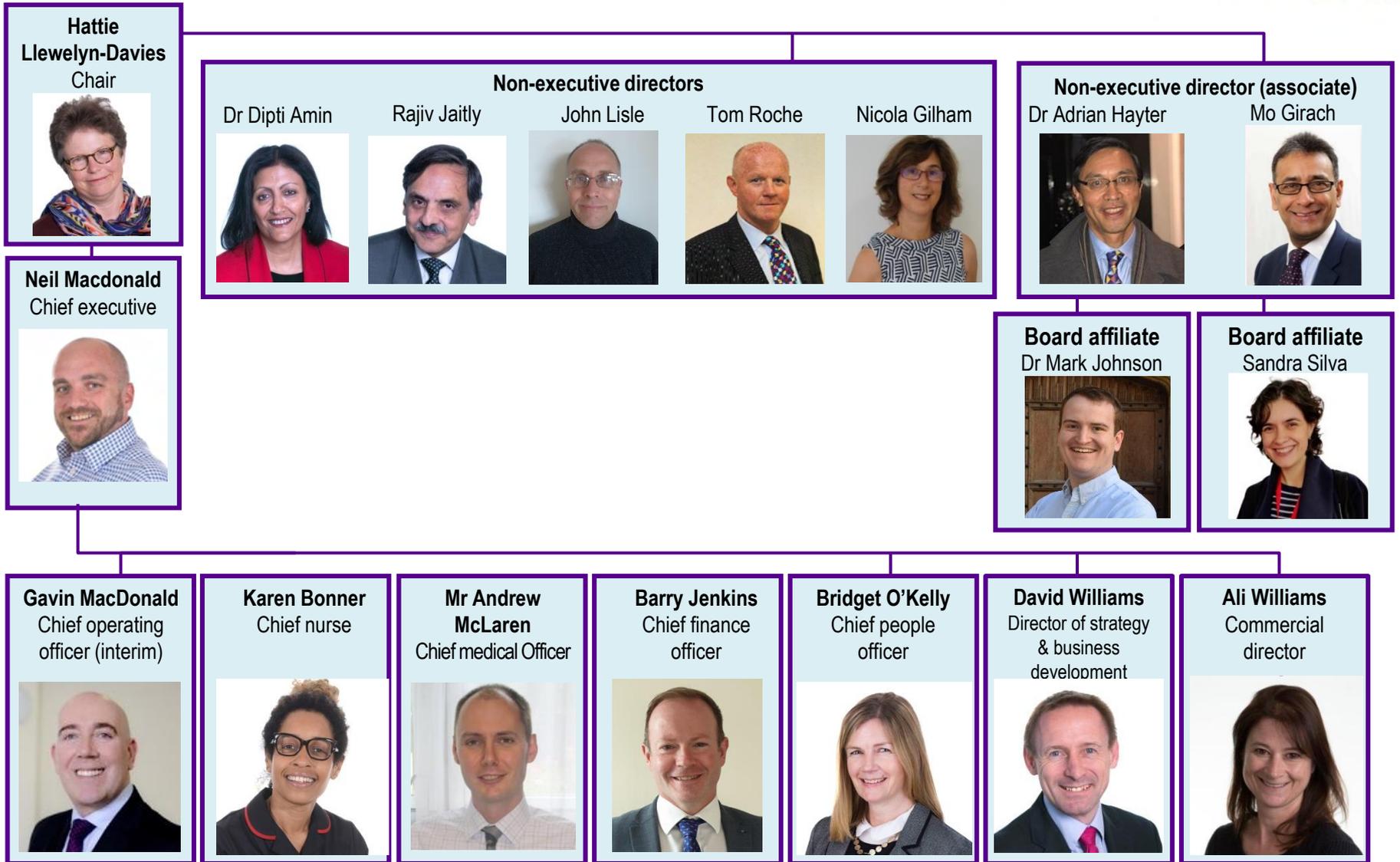
Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

### **Leadership**

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

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

# Board of directors



**Meeting:** Trust Board Meeting in Public

**24 November 2021**

<b>Agenda item</b>	Patient experience video
<b>Board Lead</b>	Chief Nurse
<b>Type name of Author</b>	Amarjit Kaur- Head of Patient Experience and Involvement
<b>Attachments</b>	Link to film-Community nursing what it means to our patients
<b>Purpose</b>	Information
<b>Previously considered</b>	Quality Committee 15 November 2021

### Executive Summary

Indeep and Elaine talk about their experiences of community nursing.

[Community nursing: what it means to our patients - YouTube](#)

This patient experience video was discussed at the Quality and Clinical Governance Committee on 15 November 2021 where it was approved for referral to Board.

<b>Decision</b>	The Board is requested to endorse this story		
<b>Relevant Strategic Priority</b>			
<b>Outstanding Care</b> <input checked="" type="checkbox"/>	<b>Healthy Communities</b> <input type="checkbox"/>	<b>Great Place to Work</b> <input type="checkbox"/>	<b>Net Zero</b> <input type="checkbox"/>
<b>Implications / Impact</b>			
<b>Patient Safety</b>	Poor patient experience can be an indicator of safety concerns		
<b>Risk: link to Board Assurance Framework (BAF)/Risk Register</b>	Listening to the patient voice and a culture of quality improvement		
<b>Financial</b>	Potential litigation		
<b>Compliance</b> <small>Select an item.</small> <b>Person-centred Care</b>	Person centred care, safety, safeguarding, complaints		
<b>Partnership: consultation / communication</b>	We understand patient experience by listening to feedback from a variety of channels. We work in partnership with patients to improve services		
<b>Equality</b>	Working with key stakeholders in quality, safety and experience. 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.
<b>Quality Impact Assessment [QIA] completion required?</b>	N/A

**Meeting: Trust Board Meeting in Public**
**Date: Wednesday, 29 September 2021**
**Time: 9.00 – 11.30am**
**Venue: Virtual Meeting via MS Teams and streamed live to the public**
**MINUTES**
**Voting Members:**

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

**Non-Voting Members:**

Mr A Hayter (AH)	Associate Non-Executive Director
Dr M Johnson (MJ)	Board Affiliate
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:**

Miss J James (JJ)	Trust Board Business Manager
Mrs E Jones (EJ)	Senior Board Administrator (minutes)
Ms A Kaur (AK)	Head of Patient Experience and Involvement (for agenda item 3)
Ms F Westby (FW)	Paediatric Matron (for agenda item 3)
Ms V Sinfield (VS)	Paediatric Practice Development Nurse (for agenda item 3)
Mrs I Day (ID)	Director of Business Recovery (for Chief Operating Officer)
Ms T Charlton (TC)	Deputy Chief Nurse (observing)
Ms M Koronfel (MK)	FY2 Trainee Leadership Board (observing)
Mr W Preston (WP)	Deputy Commercial Director (for agenda item 8)
Ms D Begent (DP)	Quality Improvement Lead (for agenda item 9)
Ms L Monaghan (LM)	Matron Specialist Palliative Care (for agenda item 10)

**01/0921 Chair's Welcome, introductions and apologies**

The Chair welcomed everyone to the meeting.  
Apologies had been received from Mo Girach.

**02/09/21 Declarations of Interest**

There were no declarations of interest not previously recorded.

**03/09/21 Patient Story**

KB introduced a film which highlighted the experience of Ronnie, a paediatric oncology patient and his mother. After viewing of the film, FW and VS answered questions from Board Members.

AH recognised the integration of services with the acute teams working with the community nursing staff and queried how this could be shared with other teams so there were no divisions between hospital and community care. FW explained the teams were physically located together which was a strength, enabling face to face learning and sharing with each other.

JL recognised waiting times were tough especially for children and queried if the Trust collected data on achieving the times given to patients. FW assured the Board waiting times were met for paediatric patients.

DA commented on the positive experience which Ronnie and his mother had received at the Trust and queried how this was monitored for other patients. FW explained the caseload was divided between the community and acute clinic with specialist input from the beginning of treatment which provided patients with a small team of staff working with each family which provided a quality service. Formal feedback was received from patient families who were complimentary regarding the service and staff.

HLD recognised there were lessons to be learnt from the children's service which could be repeated in the adult's service and thanked the team, asking for thanks to be passed to Ronnie for sharing his experience.

**Action: KB to take forward learning from children's services re: integration into adult services.**

#### 04/09/21 Minutes of the last meeting

The minutes of the last meeting on 28 July 2021 were **APPROVED** as an accurate record.

#### 05/09/21 Actions and matters arising

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

#### 06/09/21 Chief Executives Report

NM highlighted the Trust was well into the recovery and restoration programme. There were significant challenges managing capacity and keeping patients safe particularly in urgent care and managing Winter. The waiting lists were reducing however there was still work to be done in these areas which would be a key focus for the Board. The Trust was subject to regulatory scrutiny and NM recognised the financial risk as the allocations for the second half of the year had not been received. The Board's focus was on staffing urgent care, medical workforce and critical care capacity and the overall cost of recovery and matching this to what was required of the Trust. It was a challenging period and NM noted he was very proud of the team who had put together a coherent plan for the organisation for the next five years. However, the operational pressure was a key focus for the Board going forward.

AH highlighted the performance inactivity for July and August versus last year due to Infection Prevention Control (IPC) arrangements and queried if the guidelines for relaxation of these rules in hospital would make a significant improvement and allow the ability to recover outpatient appointments and elective inpatient and day case procedures. NM explained the new guidelines were around social distancing, an enhanced cleaning programme and the rigour of pre-elective testing and were being mapped through to provide safe care and improve productivity. NM highlighted coming into the new financial year there had been a backlog of annual leave which had been taken over the summer. The organisation was working at 95% of productivity comparable to 2019 recognising the Trust needed to get to 120% in the next 6-8 months. It was important to find the physical and human resource to be able to achieve this and work was being undertaken with partners in the ICS and independent sector in this regard.

JL queried recovery regarding cancer and the capacity for managing this. NM stressed the importance of screening and returning to full accessibility. It was noted engagement was taking place with community groups and there were more urgent referrals from GPs. In addition, the emergency pathways were receiving late presentation of some cancers.

NG recognised the weariness of some staff and that pressures were remaining and stressed the importance of looking after staff. NG recognised the work being done to support the workforce in Occupational Health and the Thrive initiative. NG questioned what the key levers were in the Digital Strategy to enable agile working for both staff and patients and whether this work was being hampered by finances.

NM highlighted the challenges around workforce sustainability; the intense scrutiny to deliver and the ability to work with teams to sustain quality were the key areas of focus for the Board. NM expressed concern on the robustness of social care, and the impact on hospital beds, the Emergency Department and ambulances. In addition, there were challenges on the structural issue, the capacity mismatch and the challenges around finances and making good investments. The workforce was a common thread running through all these challenges. NM explained healthcare would be provided in a very different way than previously and the challenge was to work differently and adapt in the future. A part of this would be working digitally. There were big programmes to manage the infrastructure which would move to a full strategic case looking at pathway improvements. It was important to be data focused and there was more work to do to make technology work for the workforce ensuring it was reliable.

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

07/09/21

#### Buckinghamshire Healthcare Trust 2025 Strategy

DW presented the updated strategy to the Board which provided a framework for service strategies that helped to align plans and work towards the Trust's vision.

There had been extensive engagement with patients, colleagues and the community to have a vision and aspiration to provide outstanding care, have healthy communities and be a great place to work. The strategy was underpinned by the clinical strategy which would strengthen the emergency and urgent services to separate elective and routine services to reduce the backlog of elective care and provide prompt diagnostic care and allow community services to manage frailty and long-term conditions at home and to build rehab services.

The strategy would be enabled by investment in a digital future, allowing patients more control over their own care. In addition, investment in estates, and a continued focus on efforts to reduce waste and duplication was included. The milestones would be tracked through the transformation and Trust Boards.

HLD thanked DW and his team.

DA questioned how health inequalities were being addressed in terms of prevention and promoting wellbeing. DW noted this was part of the healthy communities with a community programme and working with public health recognising that prevention was key. There was a start well programme for children with support from health visitors and school nurses.

RJ requested the financial implications of the Strategy come back to the Board for oversight. DW noted the savings and capital implications and ongoing resourcing would be presented to the Board.

**Action: Financial implications of the Strategy to come back to Board - DW**

TR requested dying well was included in the Strategy. DW noted this was a critical part of the Strategy.

BOK highlighted many colleagues lived in the County and it was important to weave this through all the activities going forward.

NM requested a simple summary with a high-level progress against actions was brought to the Board on a quarterly basis.

**Action: A quarterly progress report on the Strategy performance against the timeline to come to Board - DW**

DW noted the next step would be to communicate the Strategy widely.

The Board **APPROVED** the Strategy.

08/09/21

### Net Zero Carbon Roadmap and Strategy

AW presented the Net Zero Carbon Roadmap and Strategy which was a requirement of all NHS Trusts. It was important as a Trust to reduce the current level of carbon output to support improving healthy communities. Only 23% of the total emissions were under the Trust's direct control to change. There was more work to do as a system as this needed to be fully embedded moving towards 2040. The Trust was required to provide quarterly returns on progress and an annual report would come to the Board.

RJ welcomed the report recognising the need to understand the financial implications including funding and savings and requested a report back on how this would be addressed. WP explained some schemes with funding were already in place such as the carbon energy fund at Wycombe. The roadmap would be broken down into small parts which would also have more than one outcome such as improved patient safety and pathways. HLD noted the ICS were looking at the overall picture.

**Action: Financial implications of the Roadmap to be brought to the Board - AW.**

TR stressed the importance of ensuring all colleagues understood the roadmap without diluting the leadership focus. AW noted the cover sheet for papers for Board and committees now included a net zero box as one of the strategic priorities. There was more work to do linked to the clinical strategy such as virtual outpatient appointments. It was important to keep this at the forefront and allow it to drive innovation, looking at it on a granular level such as job descriptions and recognising those who could make changes.

In addition, AW explained the roadmap would become part of the procurement process with suppliers needing to demonstrate their carbon footprint.

MJ commented on the cost of the roadmap which was competing against clinical priorities and queried how these actions would be prioritised. AW explained there would be grant funding for certain projects and weighing up of the benefits. WP noted there were small quick things to do such as the Trust's fleet of vehicles being electric and lots to do around digitalised clinical care and changing the way staff delivered care which would be a massive cultural change for both staff, visitors and patients.

NM noted the huge tactical and strategic opportunity for this to be the framework of the organisation recognising the appetite the workforce had to make this change and queried how the workforce could be engaged to make this part of their day to day jobs which delivered a message of improving the financial performance of the organisation as it was all linked to waste including what goes in the bin, missed appointments etc. There were lots of low-level changes to be made which would help the financial position of the Trust.

HLD highlighted the Board were supportive to approve the roadmap and asked for the financial implications to be built into the process. The Board would receive an annual report with regular reporting through Committees. the biggest challenge for the Board was around a change of culture and communications to take this forward. It was acknowledged there would additional external funding to achieve the roadmap and work was taking place with others to achieve this.

The Board **APPROVED** the Carbon Zero roadmap and Strategy for publication.

09/09/21

### Quality Improvement Strategy Update

DB explained the strategy had launched in January and updated the Board on the work being done to embed quality improvement through the organisation.

BJ noted a further session would be scheduled with the Board to look at the strategy in more detail.

The Board asked for the following areas to be discussed at the next session; benefits for patients, measurement for improvement, lean methodology, appreciative inquiry and pathway optimisation.

The Board **NOTED** the update.

#### 10/09/21 End of Life Care Strategy

KB highlighted the end of life care team had been rated outstanding by the Care Quality Commission.

LM updated the Board on the strategy and what had been achieved. The aim was for every patient within the last 12 months of life to be offered an individual care plan and a recent audit had shown an increase for the Trust for this compliance. There was coordination of care for patients at the end of life and a treatment escalation plan which was working well in the hospital and a plan to develop this in the community was in place. There had been an increase in the number of pharmacies holding end of life drug to allow for better access to community end of life drugs. The team had worked with the patient experience team through the pandemic to implement compassionate visiting. The aim was for more system wide working to identify gaps in the service and to identify solutions.

Congratulations were given to Helen Pegrum, Specialist Palliative Care Lead for the mention in the Health Service Journal for being one of the best places for Doctor training.

HLD noted the Strategy had been discussed at the Quality and Clinical Governance Committee and a previous Board Seminar.

NG highlighted the role of the medical examiner and the importance of their feedback and queried if this could be added to the Strategy. LM recognised the feedback needed to be triangulated with the bereavement survey and it would be discussed as to whether this should be included or kept separate.

RJ queried if there was a policy for palliative care at home and if this could be included. LM highlighted the strategy covered palliative care at home as the Trust was Integrated. Work was being done with Rennie Grove, another provider in the County, to streamline the work in the community and changes and improvements would be fed back.

HLD recognised dying well and end of life care was an intrinsic part of the Trust's overall Strategy.

The Board **NOTED** the report.

#### QUESTIONS FROM THE PUBLIC

There were no questions from the public.

#### 11/09/21 Integrated Performance Report

The Integrated Performance Report had been discussed at Executive Management Committee, Finance and Business Performance Committee and Quality and Clinical Governance Committee.

NG commented on the significant increase in referrals to the Community and exceeding expectations for the response rate which was a success. NG queried how the workforce

were coping with the levels in the demand in the community and if there could be some recognition of community in the performance slide in the CEO report.

**Action: Community to be included in the performance slide in the CEO report - NM.**

KB noted there was ongoing recruitment for Community with a specific targeted approach which had received a good response. In addition, rotational programmes were being considered. KB noted wellbeing was a focus across the organisation including Community.

HLD requested a presentation from Jenny Ricketts on the Community and how the integration was progressing.

**Action: Board presentation on Community and Integration and Service Development to be scheduled – KB / JJ**

JL recognised the good visibility of Refer to Treatment times and that it would be useful to see both the cancer and diagnostic waiting times including the longest times patients were waiting. ID noted the waiting times for cancer and diagnostics would be picked up in the IPR next month, noting the Trust was aiming to be below six weeks for all patients waiting for diagnostics.

**Action: IPR to include diagnostic and cancer waits – ID**

AH highlighted the risks around domiciliary care, and how this would affect the Trust's performance and what system support was in place and whether there was an emergency preparedness plan for the winter if required. NM noted the care sector resilience was a huge national issue and the Trust was working with local commissioning colleagues to extend the length of contracts to provide assurance.

BOK highlighted the improvement in the position of the 104 week waits since the papers had been published. ID noted this was a continued focus for the Trust and all patients now had dates and levels had been reduced.

BJ updated the Board on the finances noting breakeven at month 5 and the year to date plan to recover £7.5m with an underlying deficit of £2.5m including the annual leave accrual from last year. The Capital was slightly behind plan due to Paediatrics Emergency Department which was being expediated. The biggest financial risk notwithstanding the underlying deficit was the ability to generate capital which required support from the regulator and the BOB integrated care system to generate the capital needed. The budget rules for the second half of the year (H2) guidance had not been received however the Trust was likely to forecast a deficit for H2 and this would form part of the Board to Board assurance required from the Trust by the regulator.

The Board **NOTED** the Integrated Performance Report.

12/09/21

Winter Resilience Plan

ID updated the Board recognising the risk around the resilience of the Trust's staff, care homes and domiciliary care and the impact on the Trust's bed capacity in managing the winter surge and any additional surge due to Covid or other infection risks which was being worked through. There was a plan in place for paediatric capacity for winter which would open on 11 October.

NM highlighted the volume of demand coming through the front door and other parts of the system particularly primary care which would be helped by the Urgent Treatment Centre modelling and funding agreements which would happen in the next five to six weeks. There was an outflow challenge and also pressures in social care. NM provided assurance the Trust was doing all the actions set out which were required noting a ten-point plan had been received from the regulator which would be included in the plan.

**Action: Provide assurance the NHSE ten-point plan was incorporated in the winter plan - ID**

NM noted there was no quantitative assurance around demand numbers capacity and flow, and this would need to be followed up through the Finance and Business Performance Committee (F&BP) with a range of scenarios.

**Action: Scenario planning against the winter plan to go to F&BP - ID**

Regarding the People element of the IPR, BOK noted the flu and COVID-19 booster vaccine service was now available for staff. In-house counselling was available to support with psychological well-being and there had been an increase in international key workers who would provide support over the winter.

The Board **NOTED** and recognised the risks and capacity issues in the delivery of the plan.

#### 13/09/21 Quality and Clinical Governance Committee Chair's Report

DA noted the Quality and Clinical Governance Committee had asked for a harms assessment to come to the next meeting.

The Board **NOTED** the report.

#### 14/09/21 Infection Prevention and Control (IPC) Monthly Report

KB highlighted IPC remained a key focus and acknowledged there had been a slight increase in infections in the maternity service. Work was ongoing to ensure learning was embedded in the organisation. It was noted compliance with hand hygiene and PPE was low and was an ongoing focus with reaffirming guidelines and weekly monitoring to ensure compliance. There had been a slight increase in C. difficile cases noting the Trust was not an outlier and the use of antibiotics during the pandemic was being reviewed to ascertain if this was a contributing factor.

JL asked for assurance the Trust was compliant with NICE guidance. KB noted the Trust was working hard to ensure compliance with all NICE guidance and a report would go to Quality and Clinical Governance Committee (Q&CGC) to provide assurance.

**Action: A report on compliance with NICE guidance to go to QCGC and then Board - KB**

AH asked for assurance antimicrobial stewardship was embedded in Trust prescribing. KB noted this was an ongoing piece of work which would be aided by electronic prescribing when this was available.

The Board **NOTED** the report and the ongoing risks.

#### 15/09/21 Finance and Business Performance Committee Chair's Report

NG noted the committee had asked for further analysis of the pay overspends to come to a future meeting and that the recovery plan would be discussed over the next few months.

The Board **NOTED** the report.

#### 16/09/21 Charitable Funds Committee Chair's Report

The Board **NOTED** the report and progress was being made on the strategy.

#### 17/09/21 Strategic Workforce Committee Chair's Report

The Board **NOTED** the report.

HLD thanked the organisers of the event the previous day which had been held to thank the winners of the staff awards.

#### 18/09/21 Workforce Race and Equality Standard and Workforce Disability Equality Standard Action Plans

BOK noted the paper included the impact of COVID-19 on the action plans and the progress made on the ethnic make-up of the Board and the fairness and transparency of the recruitment process.

The Board **APPROVED** the action plan and delegated authority to the Strategic Workforce Committee to review the report.

#### 19/09/21 Audit Committee Chair's Report

RJ updated the Board on the Value for Money report noting the format had changed and the Auditors were now required to report on whether any risks had been identified on three main areas; financial sustainability; governance; improving economy efficiency and effectiveness. The Auditors had reported they had not found any of those risks and therefore a clean report had been received.

HLD thanked the Audit Committee and Finance Team.

The Board **NOTED** the report.

#### 20/09/21 Corporate Risk Register (CRR)

KB highlighted there were three new risks on the CRR, and three risks had been removed. Work was being undertaken to align the CRR with the BAF.

RJ noted he was pleased with the development of both the CRR and the BAF.

The Board **NOTED** the report.

#### 21/09/21 Board Assurance Framework (BAF)

JJ informed the Board the BAF had been to various Committees for review, it was a new style report and improvements would continue to be made as suggested.

RJ noted the wording on risk 3.4 needed to reflect the risk was related to capacity and not the growth in Buckinghamshire in terms of housing. JJ confirmed this had been updated and would be reflected in the next report.

The Board **NOTED** the report.

#### 22/09/21 Care Quality Commission Improvement Plan

KB noted the plan had been reviewed by the Quality and Clinical Governance Committee.

The Board **NOTED** the report.

#### 23/09/21 Infection Prevention and Control Annual Report

The Board **APPROVED** the report and benchmarking would be included in further reports.

#### 24/09/21 Research and Innovation Annual Report

AM highlighted the work had continued throughout the pandemic including 131 research studies with 3520 new participants. JL highlighted the report provided an opportunity to attract staff with this work.

The Board **NOTED** the report

#### 25/09/21 Organ and Tissue Donation Annual Report

AM noted 7 generous organ donations had resulted in 17 patients receiving a lifesaving operation.

AM noted the change to opting out rather than opting into organ donation which had occurred over the last year. AM stressed the importance of letting loved ones know ones wishes regarding organ donation. DA thanked the team which had allowed the work to continue through the pandemic.

The Board **NOTED** the report.

26/09/21 Non-Executive Director Responsibilities

The Board **NOTED** the report and that membership of Buckinghamshire Healthcare Projects Limited would be discussed at the next Nomination and Remuneration Committee.

27/09/21 Board Attendance Record

The Board **NOTED** the report.

28/09/21 Private Board Summary Report

The Board **NOTED** the report.

29/09/21 Risks identified through Board discussion

JJ noted the risks identified through Board discussion as follows:

- Disproportionately long waits in comparison to peers
- Additional scrutiny from regulators
- Overall workforce resilience
- Absence of H2 guidance for Finance
- Delivery of Trust and Net Zero Carbon strategies related to finance implications
- Sustainability of improvement related to recovery resulting from the impending winter months, bed capacity and lack of physical space and the local and national situation related to domiciliary care providers
- Potential harm to patients who were late presenters and/or undiagnosed cancers
- Compliance with NICE guidance, particularly related to infection control

30/09/21 Any other Business

There was no other business.

31/09/21 QUESTIONS FROM THE PUBLIC

There were no further questions from the public.

**Date of next Meeting: Public and Private Trust Board Meeting: 24 November 2021 at 9am**

Action Log



Buckinghamshire Healthcare  
NHS Trust

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 September 2021	Update November 2021	RAG	Date closed
11/09/2021	29/09/21	Integrated performance report	Board presentation on Community and Integration and Service Development to be scheduled	Chief Nurse	TBC	Not due	?Deadline	Red	
06/07/2021	28/07/21	Chief Executives Report	Staff resilience risk to be discussed at Strategic Workforce Committee and then at Board.	Chief People Officer	29/09/21	Discussed at Strategic Workforce Committee on 13 September and a verbal update will be given at the board meeting.	This will be considered as part of the new IPR in January 2022. Staff health & wellbeing remains a standing agenda item at SWC	Amber	
07/07/2021	28/07/21	Integrated performance report	Key strategic metrics to be highlighted in the IPR	Chief Operating Officer	27/10/21 26/01/22	Not due	Work is underway on the development of a new IPR template. For January Board.	Amber	
03/09/2021	29/09/21	Patient Story	KB to take forward learning from children's services re: integration into adult services.	Chief Nurse	24/11/21	Not due	KB to share the learning and provide minutes of discussion	Amber	
07/09/2021	29/09/21	Buckinghamshire Healthcare Trust 2025 Strategy	Financial implications of the Strategy to come back to Board	Director of Strategy	24/11/21 26/01/22	Not due	As per strategy milestones document - work underway to develop Trust financial strategy; date revised to Q4 due to scale of work required to develop workstreams to address the deficit	Amber	
08/09/2021	29/09/21	Net Zero Carbon Roadmap and Strategy	Financial implications of the Roadmap to be brought to Board	Commercial Director	24/11/21 26/01/22	Not due	Requires further conversation to clarify the action - TBA	Amber	
11/09/2021	29/09/21	Integrated performance report	Community to be included in the performance slide in the CEO report	Chief Executive Officer	26/01/22	Not due	Not due	Amber	
11/09/2021	29/09/21	Integrated performance report	IPR to include diagnostic and cancer waits	Chief Operating Officer	27/10/21 26/01/22	Not due	Work is underway on the development of a new IPR template. For January Board.	Amber	
12/09/2021	29/09/21	Winter Resilience Plan	Scenario planning against the winter plan to go to F&BP	Chief Operating Officer	24/11/21	Not due	BHT participated in a regional winter exercise in November 2021 where winter plans were tested against several scenarios. Output from this will be taken to F&BP.	Amber	
14/09/2021	29/09/21	Infection Prevention Control Monthly Report	A report on compliance with NICE guidance to go to Q&CGC and then Board	Chief Nurse/ Chief Medical Officer	26/01/22	Not due	Not due	Amber	

12/09/2021	29/09/21	Winter Resilience Plan	Provide assurance the NHSE ten-point plan was incorporated in the winter plan	Chief Operating Officer	24/11/21	Not due	Ten point plan incorporated with a weekly review; the output of which goes to the BHT Incident Management Team, the Bucks System Cell (both weekly) and the UEC Board.		19/11/21
05/07/2020	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	Being presented at the September Finance and Business Performance Committee.	Presented September F&BP		24/11/21
07/09/2021	29/09/21	Buckinghamshire Healthcare Trust 2025 Strategy	A quarterly progress report on the Strategy performance against the timeline to come to Board	Director of Strategy	24/11/21	Not due	On agenda		24/11/21
Completed Actions									
	30/09/2020	CEO report	DG to ensure good communication with patients on waiting lists	Chief Operating Officer	25/11/2020				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				CLOSED 14/07/2021

**TRUST BOARD MEETING IN PUBLIC  
24 NOVEMBER 2021  
CHIEF EXECUTIVE'S REPORT**

**Introduction**

This report aims to 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 four fantastic winners of our Trust CARE value awards for September (Appendix 1), and a summary of Executive Management Committee and Transformation Board meetings over the last two months to provide oversight of the significant discussions of the senior leadership team in other areas (Appendix 2).

To recognise and remember the strength and kindness of Buckinghamshire through the COVID-19 pandemic, Nightingale's rainbow, a rainbow structure located at Stoke Mandeville Hospital, has been built in collaboration with Florence Nightingale Hospice Charity. At 5.5 metres tall and 8.3 metres wide, the rainbow is the first permanent tribute to the COVID-19 response in the county.

The impact of the COVID-19 pandemic is still being felt by many people and has resulted in financial difficulties for some of our most vulnerable residents. Although it was a privilege to volunteer last month at Aylesbury Foodbank sorting and labelling food, I was saddened to learn about the increased dependence on foodbanks over the last two years for local families. Where possible and affordable, I would encourage you to donate food for those who rely on the kindness of our community.

Whilst COVID-19 cases are beginning to fall in Buckinghamshire after a rise last month, cases are still prevalent locally and present in our hospitals. Visiting restrictions are still in place and patients, service users and visitors are required to continue to follow social distancing rules when visiting any healthcare setting as well as wearing facemasks to protect our patients and colleagues. Vaccinations are a key part of our plans to keep people safe and well this winter. I would encourage you to book in for your flu and COVID vaccinations, if you are eligible, and please encourage your neighbours, friends and loved ones to do so too.

Whilst the Trust is continuing to make progress, we are very aware that people are having to wait longer than we would like for elective procedures, diagnostic tests and in our Emergency Department. Following the 'Board to Board' process I described in my last report, regular meetings with the regulators have continued and recovery is a key focus at each Trust Board meeting.

The national planning guidance was published at the end of September for the second half of this financial year. Working with our system colleagues, Integrated Care System financial and operational plans were submitted last week, and more detailed Trust plans will be submitted this week.

A System Development Plan has been written for the Buckinghamshire, Oxfordshire and Berkshire West ICS which sets out the approach and plan for transition to the Integrated Care Board (ICB) as a statutory NHS Body on 1 April 2022 and its relationship with the Integrated Care Partnership (ICP). Significant progress has been made in system integration and development in recent months including progress with recruitment to senior leadership roles and preparations for the changes required ahead of the next financial year.

Following the distressing case recently in the news involving mortuary incidents at Kent and Sussex Hospital and Tunbridge Wells hospital; whilst we are confident that we have robust procedures and policies in place, in line with guidance from NHS England and NHS Improvement (NHSE/I) we are going through an assurance process to assess and improve the security of our mortuaries as well as compliance with Human Tissue Authority guidance. This review will be completed by the end of this month.

**Quality, performance and recovery**

The Trust Improvement Plan has been launched this month with six key areas of focus now reported into the Executive Management Committee each week: governance, quality and safety, operational recovery, finance, people and leadership and culture. Each of these areas has an executive lead, associated workstreams, management of identified risks to delivery and trajectories for improvement.

Teams across the Trust continue to work incredibly hard to support recovery of elective services, alongside Integrated Care System (ICS) colleagues and with support from the independent sector. Our activity levels against 2019/20 activity remain a key focus, in line with the Elective Recovery Fund (ERF) initiative. Since May 2021,

elective and day case activity has remained between 80% and 100% of 2019/20 activity in the same months, against the increased 95% additional tariff payment threshold funded at system level.

We have successfully been reducing the number of patients with extended wait times and are forecasting zero patients waiting over 104 weeks for planned care from January 2022 and no increase going forwards in the number of patients waiting over 52 weeks. Indicative figures for October show both long wait metrics to be in line with trajectories.

High performance in cancer services remains a priority and I am pleased to report achievement of the Two Week Wait target for first appointments for three consecutive months. This was 94% in August and 96% in September, against the 93% target. We have also continued to achieve the Faster Diagnosis Standard which means patients who are referred to us for suspected cancer have a timely diagnosis. The non-site specific pathway, previously known as the vague symptoms pathway, is now operating against revised and improved protocols which reflect national guidance. The development of this pathway is crucial for the safe management of suspected cancers. Sustainable workforce measures are now in place and an extensive validation exercise will be completed by the end of this month with formal reporting to the National Cancer Registration and Analysis Service recommencing in the last quarter of this financial year.

In September I wrote about our Community Diagnostic programme. I am pleased to share that we have opened a new diagnostic centre at Amersham Hospital. The centre will enable the Trust to offer more appointments for tests such as X-rays, ultrasounds and blood tests, reducing wait times and making it easier for the local community to access these services closer to home. In the future it is also planned that we will offer tests and examinations for patients referred for investigation of heart and respiratory problems. The centre will also further support the improvements being made to diagnostic wait times.

Our pressures with urgent and emergency care performance continue to be reflected across Trusts at regional and national level, particularly with the Emergency Department (ED) 4-hour performance target of 95%. There continues to be increased demand in the afternoons and evenings with a high number of walk-in patients of lower acuity presentations. An Urgent Treatment Centre model at the ED front door is planned to launch at the end of this month and will significantly help manage the increased demand. This will enable the management of minor illness and injury through a different pathway, allowing the ED to focus on the most acutely unwell patients. A key area of focus is on safely reducing delayed ambulance handovers which have increased. Disappointingly, the number of patients waiting over 12 hours in ED has also been increasing. A plan is underway to increase the number of beds in wards to help improve flow in the department to prevent ambulances being delayed on arrival at the hospital and enable patients to be seen more quickly.

Earlier this month we held an Emergency Department Day to focus on how improvements can be made in the department and to find solutions to address workforce challenges. The day was facilitated by Dan Boden, NHSE/I Emergency Medicine Regional Advisor for the South East and it was very helpful to learn from his experiences. We are also in the process of arranging a further visit from the NHSE/I regional Emergency Care Intensive Support Team (ECIST) to discuss surge and escalation planning, criteria to admit and clinical review of standards.

## Learning

In September we recorded five instances of *clostridioides difficile* infection and seven in October. We reported zero instances of MRSA bacteraemia infection in the same months. In September we recorded 396 births and 443 in October; in the same months we recorded 97 and 87 deaths, respectively. I am disappointed to report we had 3 never events in October which are being fully investigated: a retained swab during surgery, the wrong lens (ophthalmology) and unintentional connection of a patient to piped air.

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 September and October we recorded 48 and 55 formal complaints respectively. Overall excellence report numbers have been increasing with 53 received in September and 74 in October. The following is an example of the personal care we aspire to deliver at all times:

*“A collaborative episode of care between ITU (Intensive Therapy Unit) and Paediatrics ensured the best outcome for the patient. Joint working and clear communication enabled excellent care. The Outreach team provided excellent support to Paediatrics on ward 3. This ensured the patient stayed local to their family, avoided transfer to an outside Trust and provided an exceptional patient pathway. Staff on ward 3 felt well supported to provide safe care.”*

## **People**

The government has announced all individuals undertaking CQC regulated activities in England must be fully vaccinated against COVID-19 no later than 1 April 2022 to protect patients, regardless of their employer, including secondary and primary care. The requirement will be for patient facing colleagues and volunteers to have both doses of the COVID-19 vaccine, unless a person is medically exempt. The COVID-19 booster and flu vaccination will not be mandatory. We are awaiting national guidance for further details (at the time of writing) and will update colleagues as we receive more detailed information.

Building on the success of our bullying & harassment poster campaign, “Be a buddy, not a bully” there were a series of events last week for national anti-bullying week. Some of these were locally run and others delivered by NHS England and NHS Improvement’s Civility and Respect team.

The Trust’s Embrace network has been marking Black History Month through a series of local, national and collaborative events which have been well supported. I was proud to see Karen Bonner, Chief Nurse, celebrated in the HSJ as one of the 50 most influential Black, Asian and Minority Ethnic Leaders in the NHS. Karen has around 25 years’ experience as a nurse and has been at our Trust for just over a year, having joined in the midst of the pandemic. Members of the Embrace network also organised Diwali celebrations for colleagues to mark the festival of new beginnings and the triumph of good over evil and light over darkness.

October was Freedom to Speak up month and the national campaign this year was “Speak Up, Listen Up and Follow Up”. Our fantastic Freedom to Speak Up team organised an extensive programme of 34 activities, opportunities and new training for teams and individuals to get involved in across the Trust which I enjoyed being a part of, alongside other executive colleagues. Safeguarding week also took place last week. There were a series of national and regional webinars to mark the week, highlighting a range of topics relating to both child and adult safeguarding which colleagues attended.

I attended our annual Healthcare Support Worker Conference on 8 November. There were a number of external and internal speakers and stalls covering a range of available support. I was pleased to open the conference and have the opportunity to recognise the great achievements of support workers within the Trust, alongside executive colleagues.

Finally, I am delighted to announce Andrew McLaren’s appointment to the permanent Chief Medical Officer role after a rigorous recruitment process. Andrew is already known across the organisation, having worked in the Trust as a surgeon for the last 20 years and has held a number of leadership roles in the Trust during this time. Andrew has a strong interest in improving clinical pathways and focusing on better outcomes for patients and has proven himself a great addition to the Board in his role as Interim Chief Medical Officer since April. I am also pleased to welcome Gavin MacDonald as Interim Chief Operating Officer. Gavin has extensive NHS experience in senior leadership roles across various organisations and I am grateful for his leadership at this busy time. I am delighted to have Gavin and Andrew as part of the executive team.

## **Proud to be BHT**

Following the recent UN climate change conference (COP26), there has been an increased focus on the effects of climate change which impact both population and individual health. Nationally, the NHS has committed to net zero emissions for care provided by 2040, and zero emissions by 2045. In line with this we have developed a Trust roadmap which has been published on our website.

Two weeks ago, we also marked World Quality Week; a celebration of how quality improvement can improve products, services, systems and processes to make sure they’re as fit and effective as possible. Our theme for the week was quality improvement’s role in sustainability and there were a number of events in the week across a variety of topics. To launch the week I visited the Healthy Living Centre Community Café where our Trust Hospital Food and Drink Strategy working group learned about low carbon eating. 80% of the lunch ingredients were supplied by the Buckinghamshire Food Partnership. The week ended with the launch of the new Trust Small Steps to Sustainability initiative– an invitation for colleagues to pitch ideas for new projects to make the Trust more sustainable.

I am delighted the fantastic contribution of Trust volunteers has been recognised and shortlisted for two awards at the Helpforce Champions Awards 2021. Abi Gibbs and Hugh Chamberlain have been shortlisted for the ‘Volunteer of the Year’ award following their incredible work to transform the Haleacre Garden at Amersham Hospital into a restful and relaxing space for colleagues to recharge their batteries. The Spinal Cord Injury Patient Education Team have been shortlisted for the ‘Celebrating Inclusion and Diversity in Volunteering’ award.

Last month I was pleased to join Richard Harrington, CEO for the Buckinghamshire Local Enterprise Partnership for the official opening of the Buckinghamshire Health Research and Innovation Centre at Stoke Mandeville Hospital. This impressive building hosts our Research and Innovation team who I mentioned in my last report as having registered their 1000<sup>th</sup> research study. An example of one of these important studies is the GenOMICC trial which is the largest consented research study in the history of UK critical care medicine. It leads the way in genetic discovery in COVID-19, has found 25 genetic associations with critical illness and has informed the selection of drugs in large scale clinical trials and continues to find new insights into the molecular mechanisms of the disease. Our ICU Research Nurse has received a personal accolade from the Chief Investigator of the GenOMICC trial for her outstanding contribution and hard work during the last few years to ensure that the research program continued, despite all the challenges faced during the pandemic.

The Trust's Age-related Macular Degeneration (AMD) Clinic celebrated its five-year anniversary with patients, local Macular Society representatives and leaders from across ophthalmology, optometry and the health service at Amersham Hospital this month. By setting up and delivering a service where patients receive their treatment in the most efficient and safe manner, the AMD clinic has ensured that patients in Buckinghamshire with wet AMD have the best chance of keeping their eyesight, maintaining independence and leading full lives.

The Trust held two services to mark Remembrance Day on 11 November, one at Wycombe Hospital which was also livestreamed and the other at Stoke Mandeville Hospital. Both services were led by chaplaincy colleagues and included the sounding of the last post, the laying of wreaths and two minute silences. Colleagues with armed forces medals were invited to wear them to work with pride on the day. Lest we forget.

**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.

September 2021

Category	Role	Nomination	Nominated by
Collaborate	Marlow RRIC Intermediate Care	I work in the next office to the RRIC team supporting them with any admin that is required. At the moment the team is struggling with staffing levels but they still need to provide support to patients in the community in a dedicated, uncomplaining manner. They have Collaborated with each other to ensure all patients on the caseload have experienced consistent and excellent care. This has also been proven by the calls I have taken from the patients or family signing the praises of the team as a whole or individuals. I am amazed at times that they are still smiling despite the pressures they are all under at the moment. I see/hear first-hand the care and compassion they have for all the patients & families they see even those that prove to be more challenging. As a team they come together and support each other in difficult times whether that is because of the death of the patient or the challenging behaviour of the patient. I am proud to work alongside such individual but always professional and dedicated colleagues.	Staff member
Aspire	Maureen Miller NIPE midwife	Rothschild ward would simply grind to a halt if it were not for Maureen, particularly at the weekends. Maureen is our NIPE midwife. All babies require a NIPE (newborn check) before 72 hours. This in the week, is mainly performed by the paediatricians assigned to the ward that day, but at the weekend only we only have one paediatrician to cover everything on our ward. Maureen comes in on both days at the weekend and works her way through, our often long list of babies. She often stays well past when she should to get them all done. Mums & babies can not go home until this is done, and without Maureen performing the NIPE's we would have many unhappy families desperate to get their newborn home and we would be even more bed blocked! On top of the weekends, she has her own NIPE clinic to run in the week, and she will often stay on the ward to finish off what the paediatricians have not been able to do. She has come in on her annual leave to help the ward too. Rothschild ward simply could not cope with out Maureen going that extra mile and we all really appreciate what she does.	Staff member
Respect	Sally Sharpe Infant Feeding Coordinator	I would like to nominate Sally. She provided breastfeeding support to me and my son a couple of months ago which was invaluable. I was really struggling with breastfeeding and it was something important to me that I wanted to be able to do as I had struggled the first time around with my eldest son. She gave me support over the phone and saw me twice in person. She listened to me and gave helpful advice but most importantly made me feel listened to and supported. I never felt rushed and she gave me lots of her time whilst she observed our latch and helped me make small adjustments. She also diagnosed his tongue tie and then supported us after the tongue tie division. We are now nearly 6 months into our breastfeeding journey which we would not have achieved without Sally's help, support and kindness. I really appreciated her person-centred approach and the time she gave me.	Patient
Enable	Tiago Maia HCA St David's Ward	Tiago is very proactive and is all the time teaching the patient how to take responsibility for their care since they have a Spinal Injury and need to understand the changes in their body. Tiago is also the staff member that is always trying to share all the knowledge that he has with junior staff members.	Patient

## Appendix 2 – Executive Management Committee and Transformation Board

### Executive Management Committee 21 September to 09 November 2021

The 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 second half of this year the committee has also become the programme management office for the Trust Improvement Plan. 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 21 September 2021.

#### **Quality and Performance**

Cancer services performance  
Integrated performance report  
Assurance of external review register  
Overall elective recovery  
Recovery Programme report  
Recovery programme regulator update  
Recovery programme management proposal  
Mortality report  
Urgent care performance framework  
Winter capacity  
Winter plan and proposed H2 support  
Critical care expansion schemes  
Urgent Treatment Centre (UTC) model  
UTC Pathway Memorandum of Understanding (MoU)  
ICS Elective Care Board update  
Clinical harm review update  
Brunel Medical School update  
Blood Tubes update  
New NHSE/I guidance received  
Research and Innovation Committee meeting minutes  
Maternity incentive scheme (CNST)  
Mortuary Assurance  
Redrooms proposal  
Maternity safety report  
Safe staffing report  
Intrapartum care at Wycombe Birth Centre  
Tackling health inequalities  
Innovation Update – autonomous telemedicine  
Significant Incidents report including maternity  
Emergency Department quality report  
Non-specific symptoms pathway review  
Harms oversight process  
Weekly Infection Prevention Control report

#### **People**

CARE awards  
Workforce  
Vaccination Programme update  
Recruitment update  
Culture and behaviours  
Midwifery retention support funding MoU  
Workforce Race Equality Standard (WRES) and  
Workforce Disability Equality Standard (WDES) action  
plans  
Recruitment to consultant posts  
NHSE/I Volunteering Services Fund MoU  
Temporary staffing  
Outline proposal to bid for further international nurse  
funding 2022/23  
Excluded practitioners

#### **Money**

COVID-19 cost tracking  
ERF cost tracking  
COVID-19 and ERF expenditure requests  
Finance report  
H2 financial plan  
Capital Plan Progress – Estates and Digital  
Capital – Delegated Approval Limits  
Contract management including PFI and procurement  
Auditor's annual report

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

Critical services priorities  
Coroner service contract  
Outpatients telephony update  
Digital strategy update  
Communications approach  
Community Diagnostic Hubs update  
Developing Care Closer to Home – Community Hubs  
pilot  
Patient transport contract  
Abbott Laboratories managed service contract  
Data Protection and Security Toolkit update  
Wycombe and Amersham Energy Infrastructure project  
CT scanner maintenance support contract  
Head of midwifery staffing update report

#### **Governance**

Caldicott & Information Governance Committee  
minutes

CQC improvement plan

Lapsed Policies/Policies due to lapse

The following policies were approved:

- BHT Pol 149 - Safeguarding Children Policy v4.1
- BHT Pol 071 - Self Administration of Medicines Policy (Annex 7) v4.3
- BHT Policy 282 - Surveillance & Audit Policy for Infection Prevention and Control v1.0
- BHT Policy 283 - Infection Prevention & Control Policy v1.0
- BHT Policy 284 - Infection Control in the Built Environment
- BHT Policy 162 - Mandatory & Statutory Training Policy
- BHT Policy 248 - Commercial Research Policy
- BHT Policy 130 - Information Risk Policy
- BHT Pol 124 - Point of Care Testing Policy v7.0
- BHT Pol 071 - Medical Gas Policy (Annex 18) with Procedure A & Procedure B v1.4
- BHT Pol 071 - Intrathecal Chemotherapy Policy (Annex 11b) v13.1

Transformation Board 07 October to 04 November 2021

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:

Transformation and efficiency update

Asset management

High level milestones

NSIC transformation deep dive

Hospital redevelopment programme

Navenio portering system

Inequalities in maternity

Start Well update

Medicines transformation deep dive

Digital funding applications

Quality Improvement projects on a page:

- Developing a kinder workplace
- EY review pathway
- Improve healthcare transition
- Mapping discharge of medical patient
- Medicine Management Matron

Portfolio updates:

- Urgent and emergency care
- Planned care
- Community care
- Women Children and Sexual Health
- Diagnostics
- NSIC transformation
- Property and Commercial
- People
- IT and Digital
- Nursing
- Improving the health of the community
- Finance and improvement

**Meeting:** Trust Board Meeting in Public

**24 November 2020**

<b>Agenda item</b>	Mid year Freedom to Speak Up report which includes Q1 & Q2
<b>Board Lead</b>	Bridget O'Kelly – Chief People Officer
<b>Type name of Author</b>	Tracey Underhill Lead FTSUG
<b>Attachments</b>	Nil
<b>Purpose</b>	Assurance
<b>Previously considered</b>	Strategic Workforce Committee 08.11.2021

### Executive Summary

The key headlines are:

- From mid May to 30<sup>th</sup> September, our four new Outreach Freedom to Speak Up Guardians (OFTSUGs) which equate to 1 w.t.e have achieved an incredible **1,136 colleague contacts across the Trust with the service achieving 1,600 in total**. These contacts are raising awareness and promotional activity – these figures do not include October Speaking Up Month activities.
- Improved methods of capturing the information on ethnicity of those accessing the Freedom to Speak Up Service (FTSU) continue to show good representation of the workforce profile in Q2 – see *section 4.1*
- Research commissioned by the National Guardian Office (NGO), that BHT participated in last year which was undertaken by Roger Kline and also Ghiyas Somra of BRAP an equalities charity. This has resulted in a new report, Difference Matters – see *section 2.7* for key findings of notable interest.
- Themes from concerns this first half of the year highlight the need for ongoing tolerance, kindness, understanding and compassion to each other as colleagues. The work of Professor Michael West OBE was highlighted through his blog for October Speaking Up Month as guest blogger for the NGO – see summary for a key link to his specific blog on how *Compassionate Leadership Enables Speaking Up*

<b>Decision</b>	The Trust Board is asked to receive this report for the purposes of assurance and information.		
<b>Relevant Strategic Priority</b>			
<b>Outstanding Care</b> <input checked="" type="checkbox"/>	<b>Healthy Communities</b> <input type="checkbox"/>	<b>Great Place to Work</b> <input checked="" type="checkbox"/>	<b>Net Zero</b> <input type="checkbox"/>
<b>Implications / Impact</b>			
<b>Patient Safety</b>	A positive speaking up culture is key to patient safety		
<b>Risk: link to Board Assurance Framework (BAF)/Risk Register</b>	1.1 Inadequate staff resource to deliver outstanding quality care (insufficient levels of qualified, experienced staff and training opportunities) Retention		

	<p>4.1 Pandemic-related negative impact on morale, wellbeing and retention</p> <p>4.3 Variations in organisational culture and behaviours</p> <p>4.8 The organisation is not always inclusive and does not always treat people equally</p>
<b>Financial</b>	<p>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</p>
<b>Compliance</b> Select an item. Select CQC standard from list.	<p>NHS Contract, CQC Well led, NHS Constitution and National Guardian Office Board Guidance, Annual Trust and Quality Report</p>
<b>Partnership: consultation / communication</b>	<p>Concerns raised can highlight equality related issues.</p> <p>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.</p>
<b>Equality</b>	<p>A positive Speaking Up culture is essential to enabling organisational awareness of where BAF 4.8 risks (see opposite) are high.</p>
<b>Quality Impact Assessment [QIA] completion required?</b>	<p>N/A</p>

## Freedom To Speak Up – Mid Year Report to include Q2 for 2021 to 2022

### 1.0 Purpose

To provide the key headlines, progress and a summary of activity for the Freedom to Speak Up Service.

### 2.0 National Update

**2.1** The recruitment process to replace Dr Henrietta Hughes, previously the National Freedom to Speak Up Guardian continues. Her replacement is anticipated early in the new year.

**2.2** The NGO Annual Report 2020 – 2021, published in July, showed total numbers of concerns raised nationally amounted to 20,388 to FTSUGS across England. The highest number to date. This equated to a 26% increase on the previous year. The majority (95.9 per cent or 19,560) of cases were raised with Freedom to Speak Up Guardians in NHS Trusts.

**2.3** Of note, Q3 showed a record number of cases in any one quarter previously reported nationally with 5,334 being recorded. This is strongly associated with the pandemic. Locally our Q3 is usually also our highest number of cases which follows the national pattern.

**2.4** Interestingly, 18% of cases last year included elements of Patient safety / Quality of care which was down by 5% on the previous year 2019 – 2020. Numbers of cases containing elements of bullying and harassment remained the category with the highest number of concerns both nationally and locally, representing 30% of the overall cases. However, this too is slightly down on the previous year, as were the numbers of cases showing detriment as a result of Speaking Up. This could signal some positive progress although until current year data is published, we won't know.

**2.5** The report shows that Freedom to Speak Up Guardians are an important additional route through which workers may speak up. There is now a network of over 700 Freedom to Speak Up Guardians supporting workers in organisations in primary and secondary care, independent health care providers, clinical commissioning groups, hospices and national bodies.

**2.7** *Difference Matters: Freedom to Speak Up and Race Equality, Kline & Somra.2021.* Important research commissioned last year by the NGO and undertaken by Roger Kline OBE and Ghiyas Somra of BRAP an equalities charity, asked for NHS Trusts to volunteer to participate. BHT welcomed this opportunity and volunteered. The report was published just this month. This piece of work helps fill gaps in empirical research. Whilst it recognises it's own limitations; it is much needed research looking to better understand people's experiences of accessing Freedom to Speak Up Guardians and whether the ethnicity of a FTSUG can have an impact on their decision to speak up and the support they feel they receive. This research also touched on some of the barriers that might be the same across other protective groups.

However, based on the responses obtained, findings showed BAME colleagues were six times more likely than white respondents to say they were more likely to raise a concern with a Freedom to Speak Up Guardian of the same ethnicity as themselves. The commonest reason provided was their perception that a BAME FTSUG will have a better understanding of bias and discrimination. However, the rating of experience of FTSUGS was broadly similar for both White and BAME groups of colleagues which is some positive news.

**2.8** The most recent national NGO Speaking Up Review looking at Speaking Up culture and arrangements undertaken by the NGO (previously known and reported as Case Reviews) was published on 21<sup>st</sup> October. 2021 This was Blackpool Teaching Hospitals see link [National Guardian's Office](#) . A brief summary of the review, findings and learning has been requested at a CEO Leadership Briefing.

**3.0 Local Update**

**3.1** This mid year report provides an opportunity to celebrate the early but significant impact that the expansion of the FTSUG team has achieved. The most significant local news is the demonstrable positive impact that the Outreach FTSUGs and our new outreach model is making.

- Four Outreach FTSUGs have been in post since May and June – all have undertaken both national and local training resulting in successful registration.
- From mid May to 30<sup>th</sup> September ( part Q1 and Q2 ) The four new outreach FTSUGs have achieved an incredible **1,136 colleague contacts across the Trust**. These are contacts that equate to promotion of their role and our service and raising awareness. *(These figures do not include any of the contacts for October Speaking Up month which will be reported as part of Q3)*. See Table 1 below showing an encouraging steady increase since their appointment:-
- Of these contacts **more than 550 have been across our Community settings**. This is a significant improvement in outreach and accessibility for those in the community.
- Overall, on the basis of 2 WTE the FTSU service has achieved a total of:- more than **1,600 colleague contacts** across the Trust for Q1 and Q2.

**Table 1 Number of promotional / raising awareness contacts made by the Outreach FTSUGs showing monthly growth.**

Month	NO of OFTSUG contacts
May (2 weeks) and June	178
July	172
August	322
September	464
<b>Total</b>	<b>1,136</b>

- The overall impact and benefits of enabling a resource to provide a much more extensive face to face outreach should not be underestimated in relation to:-
  - the benefits to levels of raised awareness of the role and the service
  - the building of more local relationships
  - having a named local person, a known face designated for colleagues to contact
  - increasing and enabling better accessibility and diversity.
  - being able to respond and act earlier to help prevent and reduce concerns growing.

- October of Speaking Up month has been very successful and will be reported on more fully in the Q3 report to the EMC and SWC. This year the national campaign, which we are asked to support was all about the introduction of the new national training for all NHS colleagues to support the understanding of the importance of Speaking Up across our organisations to patient and staff safety. It very much supports the messages we have been giving locally since the introduction of the FTSU service at BHT around seeing the raising of concerns as positive. They are gifts for the cycle of improvement.

Developed by HEE with the NGO the training is called, **“Speak Up, Follow Up and Listen Up**. The first module is for all colleagues, the second is for all managers and the third, “Follow Up” is for all senior leaders and executive members of the Trust Boards but the latter is not yet released. Whilst the NGO had recommended that this training is treated in the same way as for statutory and mandatory, this was taken through our usual Trust procedures to our Mandatory and Statutory training (MAST) committee, to seek approval for it to be added. It was greatly encouraging to receive unanimous support from all clinical representation including medics and senior nursing staff and therapists to support this training on a two yearly repeat basis.

- The expansion of our team enabled the expansion of our October Speaking Up Programme this year with a considerable range of no less than 34 activities delivered in the month. Locally, as well as delivering the national agenda we have tried to build a programme that touches on behaviours and impact. There have been sessions exploring:
  - the importance of Psychological Safety, supported by our CEO and Dr Clare Daniels our Chief Psychologist,
  - Speaking Up and Black History month, with our Chief People Officer resulted in a collaborative session exploring the challenges, with powerful input and experiences from Molly Chibvuri our matron for ICU,
  - Patient Safety and Being the Best We Can Be explored with our Chief Nurse how the impact of a poor Speaking Up culture can impact on patient and staff safety.
  - Collaborative working with SCAS resulted in another visit from their Speakupulance and we ran a” Keep Ups for Speaking Up” competition for both our staff and the paramedics.
  - We held our first ever sport event in the programme with our “Shots Up” for Speaking Up and a really great and inclusive evening of fun basketball.
  - October the 20<sup>th</sup> saw us all in green (national colour for Speaking Up) with our Trustwide Wear Something Green Day
  - Dr Matthew Size, Consultant Anaesthetist, did a bespoke and really informative session on Speaking Up for excellence and talked about Appreciative Inquiry (AI)
  - Louise Evans global coach and facilitator – her film on 5 chairs, 5 choices owning our own behaviours and mastering our communication is a great film about a tool we can all use and this session was led by our lead FTSUG.
  - In addition, the team have been really busy out and about with stands, our selfie Speaking Up frame, they have been asking people to make pledges and of course taking lots of pictures.
  - As usual, we also have been busy mentioning the importance of completing the national staff survey, tweeting, posting to BHT Buzz and a variety of other social media platforms.

Activities have received really positive feedback and we have received a lot of requests for follow up with links, slides, references or resources mentioned etc so there has been good

engagement throughout the month. The National Guardian Office have also been following our activities on Twitter which is usual and positive.

#### 4.0 Case activity.

Quarter	2017/2018 Inaugural Year Cases	2018 / 2019 Cases	2019/2020 Cases	2020/2021 Cases (Covid)	2021/2022 Current Year Cases	Current Individuals
Q1 Cases	3 ( <i>Start-up quarter</i> )	20	26	32	25	29
Q2 Cases	10	16	19	23	27	34
Q3 Cases	20	22	35	35		
Q4 Cases	13	16	17	15		
<b>Year Totals</b>	<b>46</b>	<b>74</b>	<b>97</b>	<b>105</b>		

#### 4.1 Ethnicity

We have implemented a change to the process and since the beginning of Q2 we have moved to requesting people's self defined ethnicity at the point of them raising their concern. This is to help achieve the collection of this data. As with previous reporting, Q2 has shown a rich and diverse range of people "Speaking Up" but asking people to self define has provided an opportunity for understanding the detailed breadth of diversity e.g Afghan, Indian, Pakistan, African, Polish, Italian, South African. For the purpose and ease of reporting in this report, the groupings are:

**BAME** = 8 colleagues, (of which 3 self defined as British) ( Q2 = 23%)

**White Non British** = 6 Internationals of which 5 are European (Q2 = 18%)

**White British** 17 (Q2 = 50%)

**Not Stated** 3 (Q2 = 9%)

We are therefore able to demonstrate that the workforce profile of our colleagues accessing the Freedom to Speak Up Service in Q2 is well aligned and representative of our current workforce profile (*reference published WRES indicator information March 31<sup>st</sup> 2021*) The overall White British group is actually slightly under represented in those who accessed the FTSU service in Q2. Our published workforce profile figures follow:-

**White** 72%    **BAME** 23%    **Not Stated** 5%

#### 5.0 Key themes from concerns raised

- Localised poor culture which includes - barriers to Speaking Up, communication issues, poor behaviours, poor management, assumptions and ineffective decision making.
- Varying degrees of frustration from colleagues who are not feeling heard, which can often be due to a lack of feedback and follow through on actions that are sometimes

actually being undertaken. So a lot of this frustration could be prevented with improved communication and more management time.

- Bullying including upward bullying this quarter.
- People feeling specifically humiliated has been reported more so this quarter, which is also very impactful in it's effect and there is an increased level of frustration with people not being held to account for their poor behaviours often reported as unprofessional. This can impact on teams and can lead to wider dysfunction if not addressed.
- A lack of compassion, kindness and understanding colleague to colleague, management to team member and team member to management.
- Lack of respect and not feeling valued by colleagues, line management or the Organisation.
- Lack of genuine engagement of staff and seeking input into changes planned. Changes being decided with little or no staff and / clinical input where relevant.
- Confusion and ineffective management sometimes due to a lack of clarity in accountability, which has resulted from changes made at speed.
- Frustration at the lack of genuine and practical opportunity to take advantage of the vast opportunity of developmental opportunities the Trust offers due to demand pressures.

During this quarter there appears to be an increase in the proportion of concerns around interpersonal behaviours and communication issues as well as levels of frustration and tension amongst staff and managers.

It is not surprising to see this, in light of the ongoing impact of COVID, both at an individual, team and organisational level. With the increased pressures currently facing BHT as well as the NHS system, we move forward to address waiting times and winter pressures whilst still in uncertain times with COVID.

Whilst we all recognise that workforce tolerance and resilience is undeniably impacted across the NHS, locally, there is a key message of this mid year report, based on the concerns raised this quarter through the FTSU service. Colleagues are all at different stages of processing the impact of what they have seen and dealt with through COVID and this includes themselves personally, their families, friends and those who have lost loved ones. This will not be a quick process and for many it won't happen until years to come. However, despite the challenges the tiredness and the service pressures, those who raise concerns remain committed providers and supporters of delivering the best quality healthcare to our patients at BHT which has also been a very positive theme. Indeed, colleagues raise their concerns mostly to help drive improvement in care for our patients and staff

## **6.0 Summary**

This report demonstrates the early benefits being realised from the commitment of the Trust to expand the FTSU team with outreach showing significant achievements.

The early signs are showing there is value in this model but ongoing monitoring will be undertaken.

We have had a successful October Speaking Up month

Perhaps consideration could be given to utilising the launch of our new corporate strategy to re energise meaningful clear messages around our need to show ongoing compassion, kindness and respect to each other, to reach our common goals.

An appropriate blog from Professor Michael West OBE, one of the many high profile guest bloggers for the NGO during October Speaking Up Month captures some key points in his powerful words,

“Compassionate Leadership Enables Speaking Up” You are invited to read his words via this link:  
[Compassionate Leadership Enables Speaking Up Professor Michael West OBE](#)

**Meeting:** Trust Board Meeting in Public

**24 November 2021**

<b>Agenda item</b>	Recovery Update
<b>Board Lead</b>	Gavin Macdonald, Chief Operating Officer
<b>Type name of Author</b>	Isobel Day, Director of Business Recovery Matan Czaczkes, Deputy Director of Business Recovery
<b>Attachments</b>	November Recovery Programme Update report v1.0
<b>Purpose</b>	Assurance
<b>Previously considered</b>	F&BP October 2021

### Executive Summary

The purpose of this paper is to provide an update on progress on the recovery programme and recovering of the trust position. This will be the last separate operational recovery monthly report as the trust transitions to fortnightly hold trust improvement programme reporting.

Key conclusions from the report as follows:

**Progress on 104+ and diagnostics:** progress has continued on improving the 104+ numbers and the diagnostic performance, though the pace of improvement has slowed compared to last month. Performance is still within trajectory.

**UEC Performance challenging:** UEC performance continues to be challenged and despite clear improvement plans, the trust is struggling to achieve the required performance. However, this should be seen in the context of wider performance pressures within the region - the trust is currently the fifth highest performer for all type for hour wait targets

**Independent sector utilisation:** Independent sector contract utilisation is being tracked with a view to maximise usage. Just under 10% of contract values being tracked have been used to date.

**Recovery programme progress:** highlight reports for each of the elements of the operational recovery programme are provided. Though theatre productivity and the surge/bed modelling work streams are marked as green, endoscopy remains flagged as a red due to capacity issues. The remaining work streams are amber signalling progress but continue challenges.

**New trust improvement programme being developed:** further to engagement with NHSE/I the trust is launching an organisation wide improvement programme. The operational recovery programme will be one part of this alongside wider corporate and governance elements. Early proposals around governance structures are set out.

Recovery was considered at the Finance and Business Performance Committee on 16 November 2021 where the Committee requested further work to integrate the IPR and recovery papers noting that an improvement plan was in place for this purpose. The risks associated with the achievement of cancer targets and recovering services in light of the high cancellation rates were also noted.

### Decision

The Board is requested to review the proposed update, provide comment and approve the integration of monthly operational recovery

reporting into the proposed fortnightly trust wide improvement programme report.

**Relevant Strategic Priority**

**Outstanding Care**     **Healthy Communities**     **Great Place to Work**     **Net Zero**

**Implications / Impact**

<b>Patient Safety</b>	Patient quality and safety governance improvements suggested
<b>Risk: link to Board Assurance Framework (BAF)/Risk Register</b>	Update on BAF and Risk Register provided
<b>Financial</b>	Financial analysis of pre and post covid status provided
<b>Compliance CQC Standards Good Governance</b>	This paper sets out the performance information required for oversight from Board as well as ongoing governance proposals for future review
<b>Partnership: consultation / communication</b>	Links with ICS and Regional support offers
<b>Equality</b>	Impact in terms of recovering services equitably and ensuring equitable access
<b>Quality Impact Assessment [QIA] completion required?</b>	Yes, once plans approved

# Buckinghamshire Healthcare NHS Trust

## Recovery Programme Update

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# Recovery programme to date

## How the Trust is approaching operational recovery

To support improvement in operational performance following the COVID pandemic the Trust put in place a recovery programme architecture and the resources required to support operational and clinical management to deliver the Trusts Elective, Diagnostic and UEC recovery objectives.

Following a review meeting with NHSE/I in early October the recovery programme has been reviewed and expanded and a Integrated improvement plan has been developed

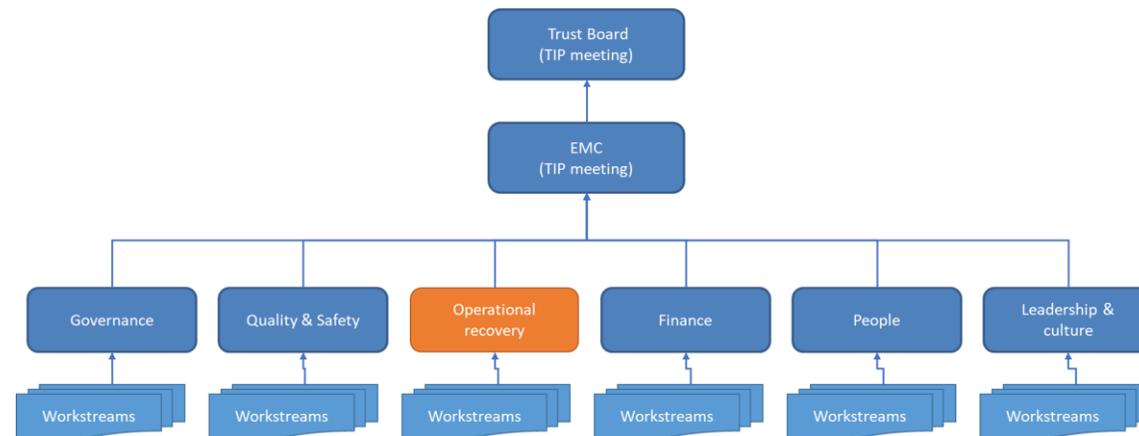
To support delivery of the Improvement Programme the Trust is being supported by system and regional colleagues to ensure delivery of its objectives. The support package includes:

- Board Leadership Capacity and Capability review
- Board development programme
- Implement a revised trust quality governance architecture
- Data driven workforce planning
- Leadership coaching and mentoring
- Participate in FMLM programme for MDs
- Continued support from the TVCA quality improvement manager and Clinical Director, to optimise the cancer pathways and ensuring the vague symptoms pathways are now effective.
- Continued support from ECIST and specifically ECIST clinical director
- Targeted investment Fund bids prioritising additional theatre and endoscopy capacity
- Unified Technology Fund bids to support digital infrastructure and process management

## Focus for this paper

The Integrated Improvement Plan brings together improvement and sustainability plans from operational divisions, workforce, finance, quality, performance and transformation. The plans are individually and collectively aligned to the trust clinical strategy and seek to support the requirements of the operational planning guidance

The chart below shows the scope of the programme:



This paper provides an update on the operational delivery elements of the recovery programme and details the governance arrangements that are being implemented for the Integrated Improvement Plan.

Reporting against the Integrated Improvement Plan Metrics will commence from the next cycle of reporting .

# Recovery performance update



Buckinghamshire Healthcare  
NHS Trust

# Elective current activity and regional context

One driver of lower day case activity rates is explained through the successful transfer of pathways from day case to outpatients

In line with the operational planning guidance the Trust is focussed on delivering levels of elective activity to achieve the required performance improvements. Increasing activity back to 19/20 levels acts barometer for progress of recovery since the impact of the Covid pandemic.

Comparison against regional colleagues allows the Trust to benchmark its performance to other comparable providers. In previous months the Trust underperformed against the regional average; in October the Trust delivered 90% of elective care compared to the same period in 2019/20, this is above the regional average. The variation in day case rates relates to the transfer of activity to outpatient procedures compared to 2019/20.

The table compares BHT elective activity against the average of the other trusts in the region. The latest data available is for the four weeks ending 25 October and looks at performance compared to 19/20 activity in the same time period. Where BHT has outperformed it's peers the figure has been highlighted in green.

. Full details for wider provider details, including previous week analysis, is available on request.

	Daycases	Ordinary electives	First Outpatients	Follow-up Outpatients
Provider Name	as a % of same weeks in 2019	as a % of same weeks in 2019	as a % of same weeks in 2019	as a % of same weeks in 2019
<b>Average</b>	88%	86%	95%	98%
<b>Buckinghamshire Healthcare NHS Trust</b>	80%	90%	90%	93%
Oxford University Hospitals NHS Foundation Trust	85%	77%	87%	100%
Royal Berkshire NHS Foundation Trust	88%	107%	114%	104%
Frimley Health NHS Foundation Trust	88%	95%	96%	109%
Hampshire Hospitals NHS Foundation Trust	96%	108%	85%	98%
Isle of Wight NHS Trust	106%	87%	90%	86%
Portsmouth Hospitals NHS Trust	90%	101%	94%	96%
University Hospital Southampton NHS Foundation Trust	89%	93%	100%	85%
Dartford and Gravesham NHS Trust	97%	63%	91%	105%
East Kent Hospitals University NHS Foundation Trust	92%	85%	89%	94%
Maidstone and Tunbridge Wells NHS Trust	85%	83%	111%	92%
Medway NHS Foundation Trust	80%	77%	121%	120%
Ashford and St Peter's Hospitals NHS Foundation Trust	89%	73%	78%	100%
Royal Surrey County Hospital NHS Foundation Trust	67%	71%	76%	72%
Surrey and Sussex Healthcare NHS Trust	76%	101%	105%	102%
East Sussex Healthcare NHS Trust	100%	73%	101%	96%
Queen Victoria Hospital NHS Foundation Trust	81%	82%	91%	98%
Brighton & Sussex University Hospitals NHS Trust	94%	86%	92%	112%

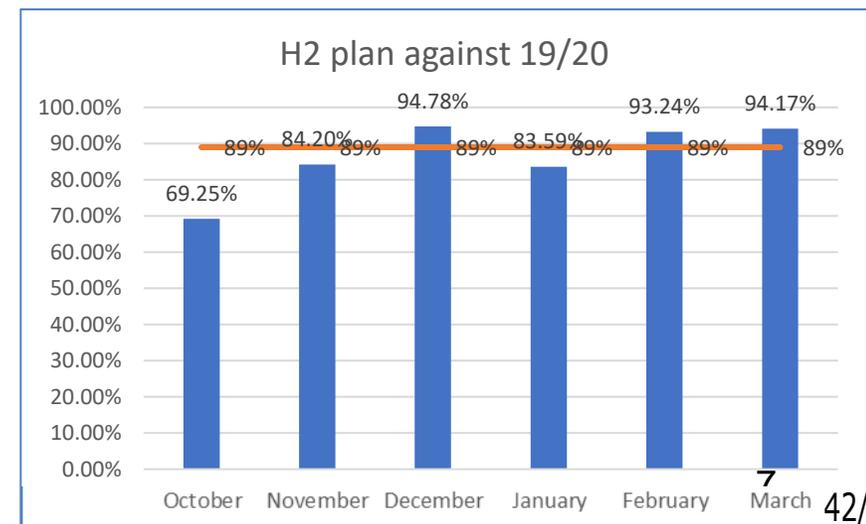
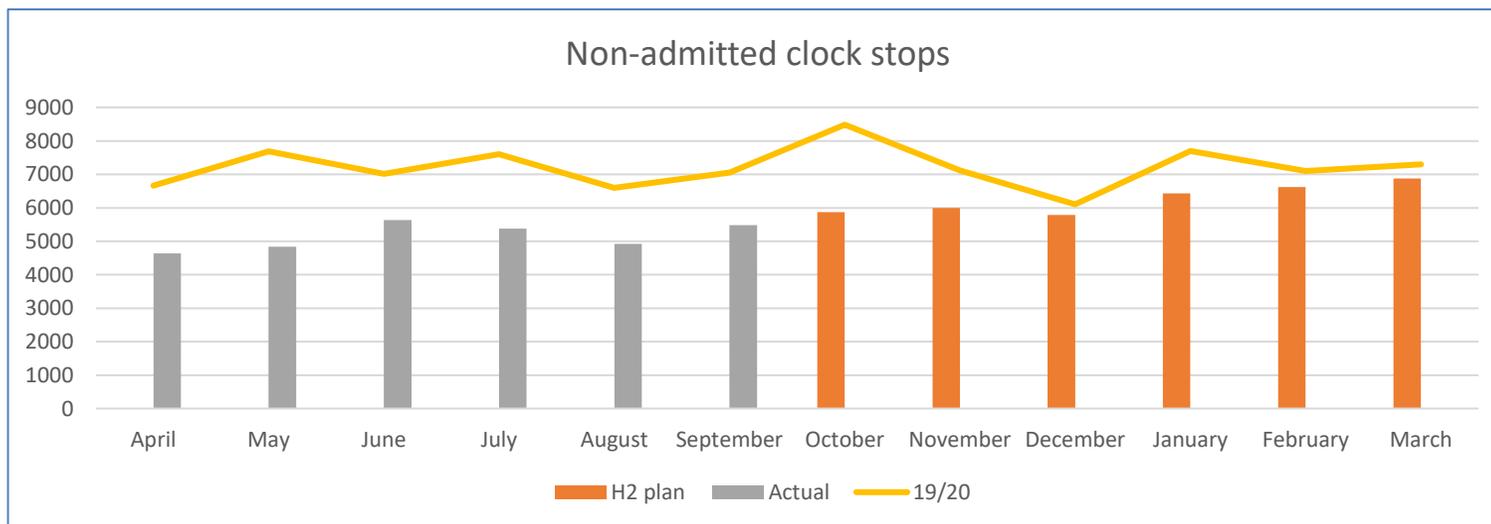
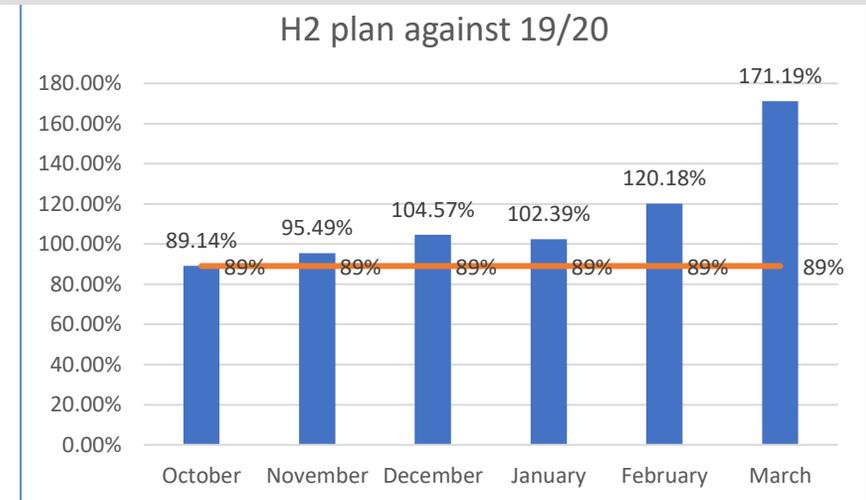
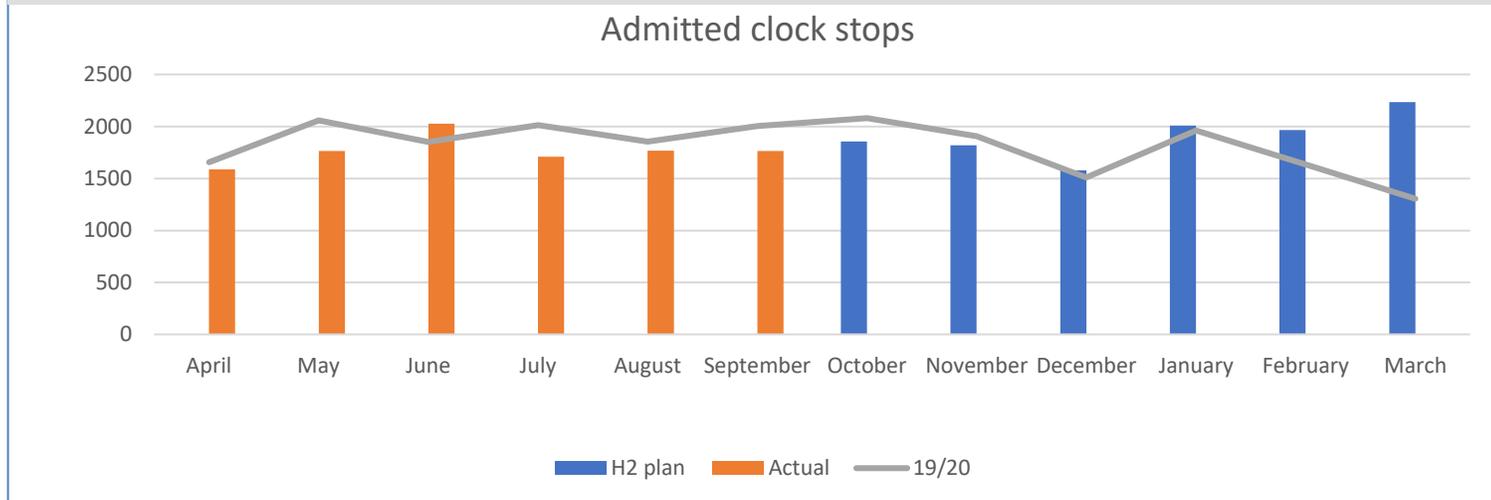
# Diagnostic current activity comparison regionally

The table below compares BHT diagnostic activity against the average of the other trusts in the region. Where BHT has outperformed it's peers the figure has been highlighted in green.

	CT Scans	MRI Scans	Colonoscopies	Flexible-sigmoidoscopies	Gastroscopies	Cystoscopies	Cardiology - Echocardiography	Non-obstetric Ultrasound	DEXA Scan_Total tests
Provider Name	as a % of same weeks in 2019	as a % of same weeks in 2019	as a % of same weeks in 2019	as a % of same weeks in 2019	as a % of same weeks in 2019	as a % of same weeks in 2019	as a % of same weeks in 2019	as a % of same weeks in 2019	as a % of same weeks in 2019
<b>Average</b>	107%	99%	227%	182%	169%	259%	88%	98%	84%
Buckinghamshire Healthcare NHS Trust	113%	118%	200%	56%	155%	207%	92%	85%	100%
Oxford University Hospitals NHS Foundation Trust	109%	102%	44%	31%	41%	111%	100%	102%	88%
Royal Berkshire NHS Foundation Trust	102%	96%	1%	1%	1%	192%	68%	109%	1%
Frimley Health NHS Foundation Trust	101%	95%	158%	151%	188%	132%	75%	96%	102%
Hampshire Hospitals NHS Foundation Trust	131%	82%	131%	67%	106%	57%	31%	95%	89%
Isle of Wight NHS Trust	137%	115%	104%	130%	81%	6%	149%	110%	n/a
Portsmouth Hospitals NHS Trust	90%	88%	264%	28%	95%	71%	89%	100%	78%
University Hospital Southampton NHS Foundation Trust	122%	115%	160%	44%	132%	871%	138%	104%	107%
Dartford and Gravesham NHS Trust	118%	112%	1938%	2000%	1418%	n/a	77%	110%	131%
East Kent Hospitals University NHS Foundation Trust	96%	59%	130%	130%	106%	106%	58%	83%	58%
Maidstone and Tunbridge Wells NHS Trust	124%	100%	16%	22%	30%	5%	86%	102%	228%
Medway NHS Foundation Trust	13%	24%	9%	1%	4%	356%	16%	13%	20%
Ashford and St Peter's Hospitals NHS Foundation Trust	118%	105%	136%	62%	72%	74%	107%	97%	88%
Royal Surrey County Hospital NHS Foundation Trust	120%	130%	105%	52%	97%	133%	114%	129%	n/a
Surrey and Sussex Healthcare NHS Trust	64%	95%	171%	96%	130%	1582%	101%	100%	82%
East Sussex Healthcare NHS Trust	111%	117%	183%	137%	120%	73%	140%	99%	n/a
Queen Victoria Hospital NHS Foundation Trust	145%	140%	n/a	n/a	n/a	n/a	51%	126%	n/a
Brighton & Sussex University Hospitals NHS	103%	91%	101%	91%	97%	168%	94%	104%	0%

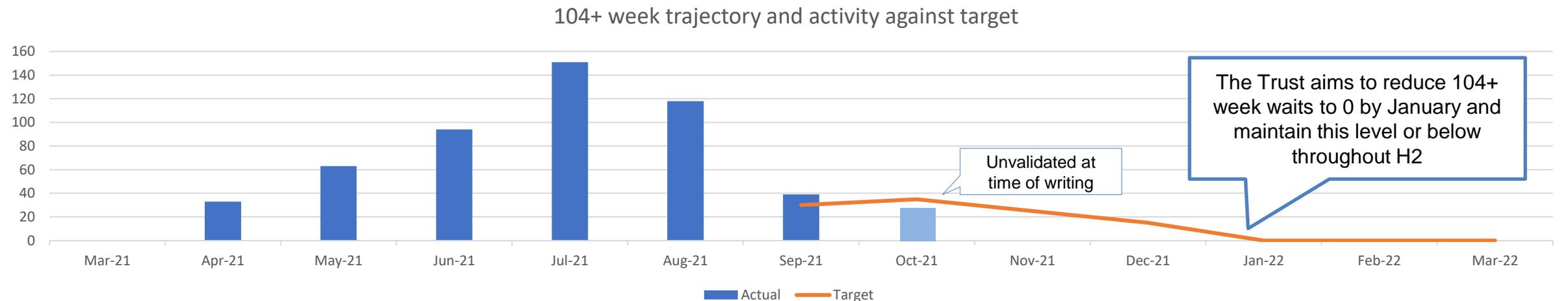
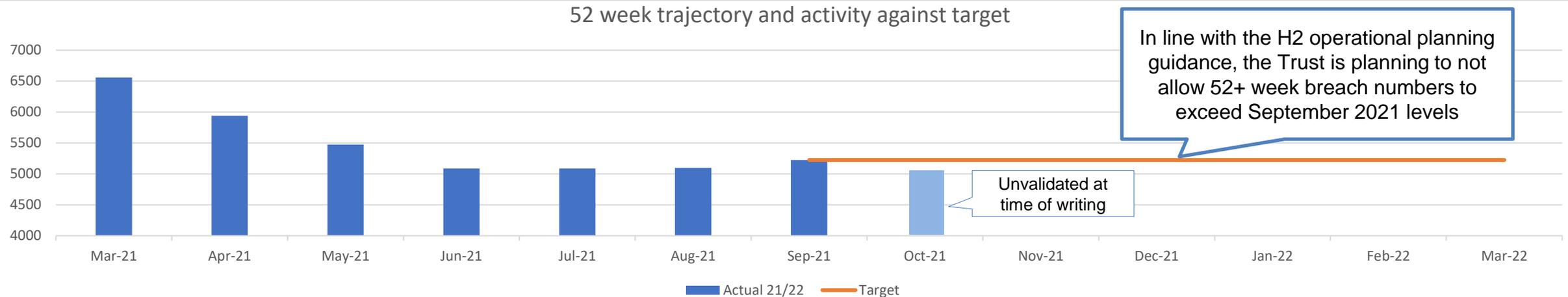
# Target elective trajectories

The charts below show the planned trajectory for clock stop number over H2. Clocks stops are the metrics by which NHSE/I have chosen to measure elective recovery. A validated RTT (clock stop) position for October was not available at time of writing but is expected imminently.



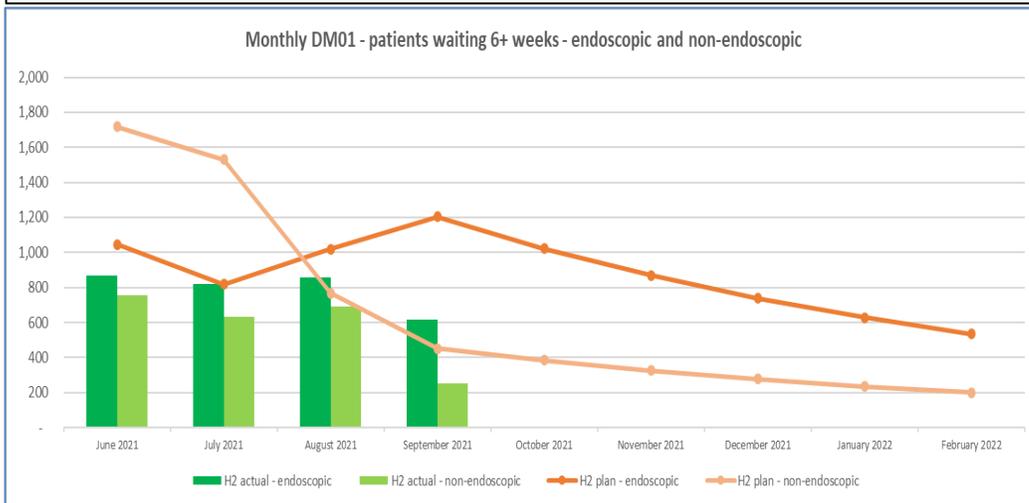
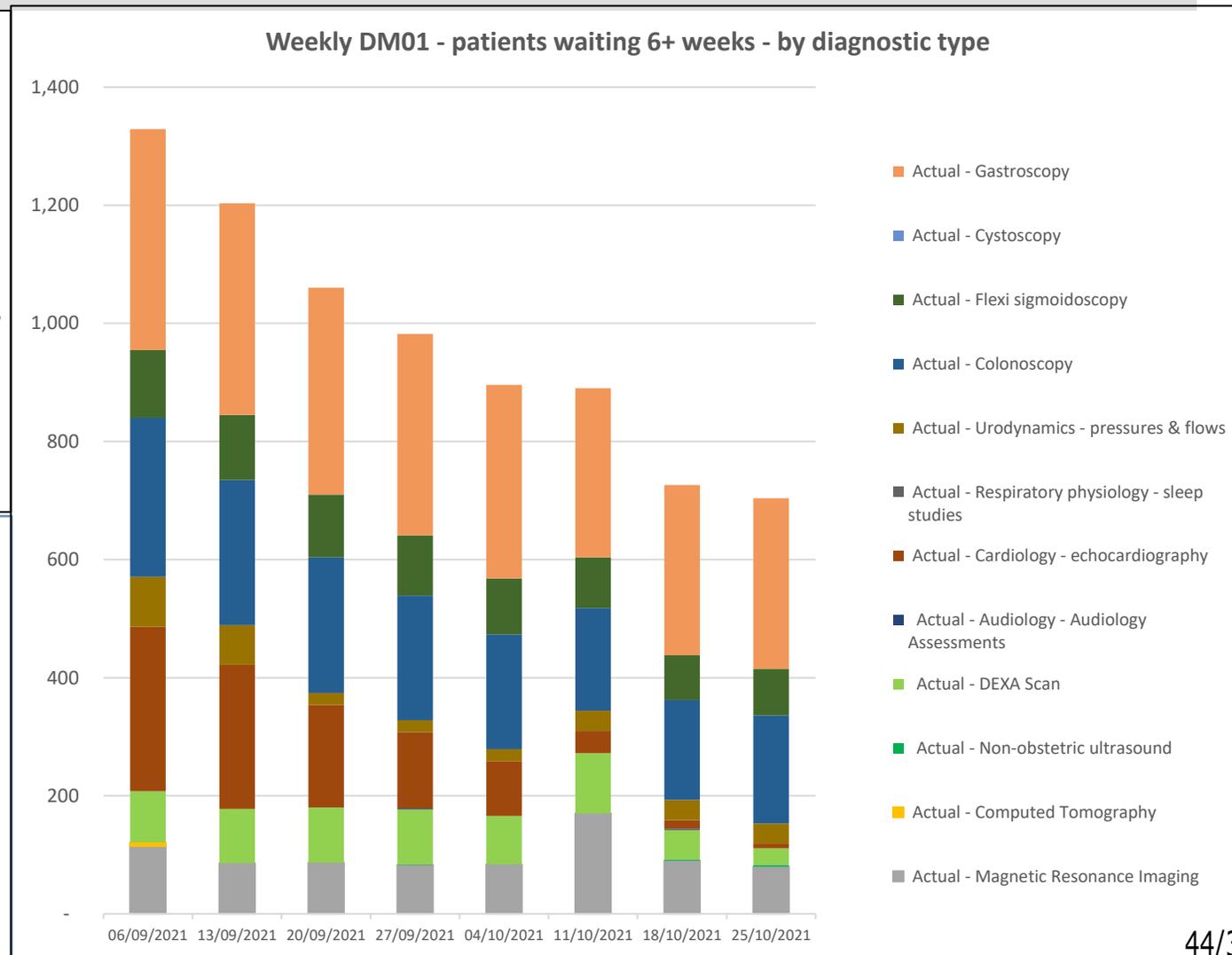
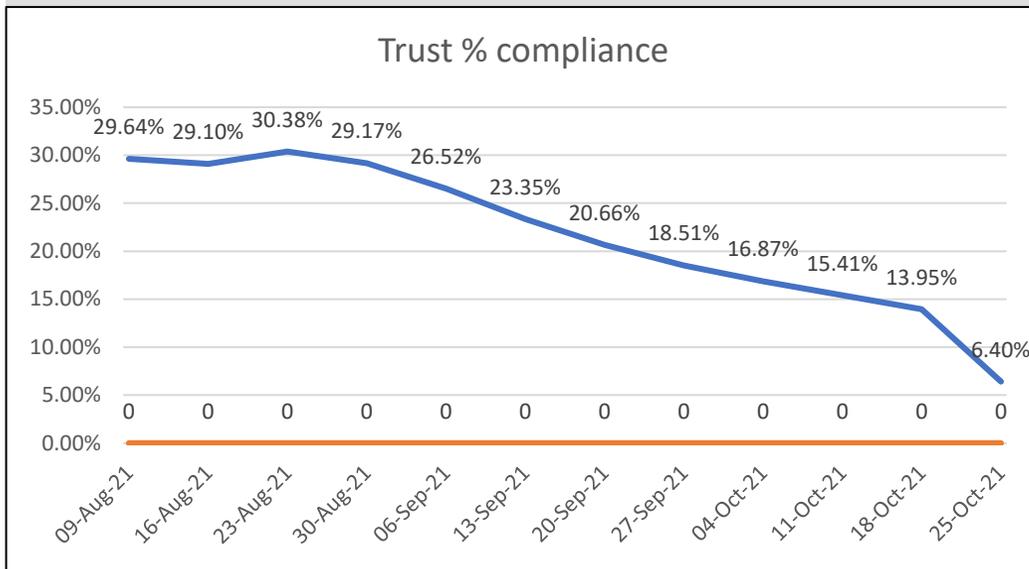
# Long wait trajectories and progress to plan

- The trust recovery and H2 activity plans support the trust to deliver a positive long wait trajectory as set out below.
- The Trust aims to reduce 104+ week waits to 0 by January and maintain this level or below, despite new patients being at risk of converting to 104+ waits every month
- In line with the H2 operational planning guidance, the Trust is planning to not allow 52+ week breach numbers to exceed September 2021 levels of 5150.
- The trust is currently slightly outperforming its planned 52 and 104 week trajectories



# Target diagnostic trajectories

The trust has committed to a diagnostic improvement trajectory (bottom left). Progress to this trajectory has been good in the last month, however progress has only been small in the last reported week



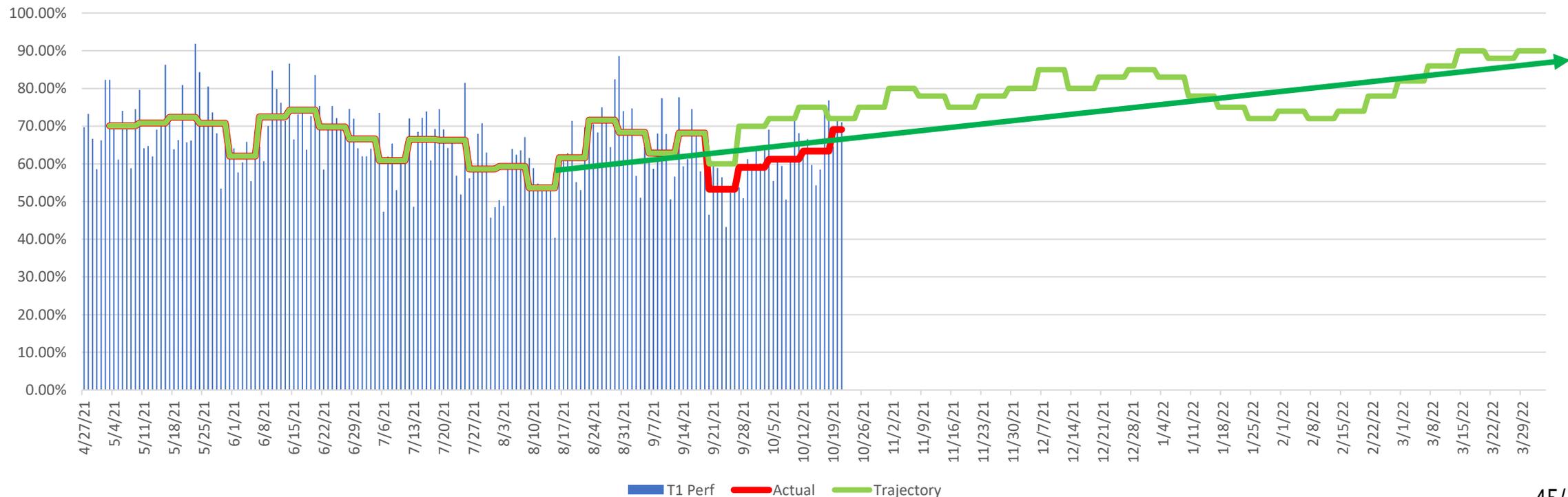
# Target UEC trajectories – 4 hour Target

Comparison against regional colleagues is important as it allows the trust to benchmark its performance to comparable providers. The trust is currently performing above the comparator average of the region in terms of all type 4 hour waits, though it is acknowledged that this performance falls short of the desired levels.

A weekly regional comparison of all type 4 hour target performance between November 1<sup>st</sup> and 25<sup>th</sup> of October puts ranks BHT as 5 out of 15, with an average across the 8 days of 72.5%

The UEC programme has set out trajectory to further improve the 4 hour ED target by the end of H2. as set out below

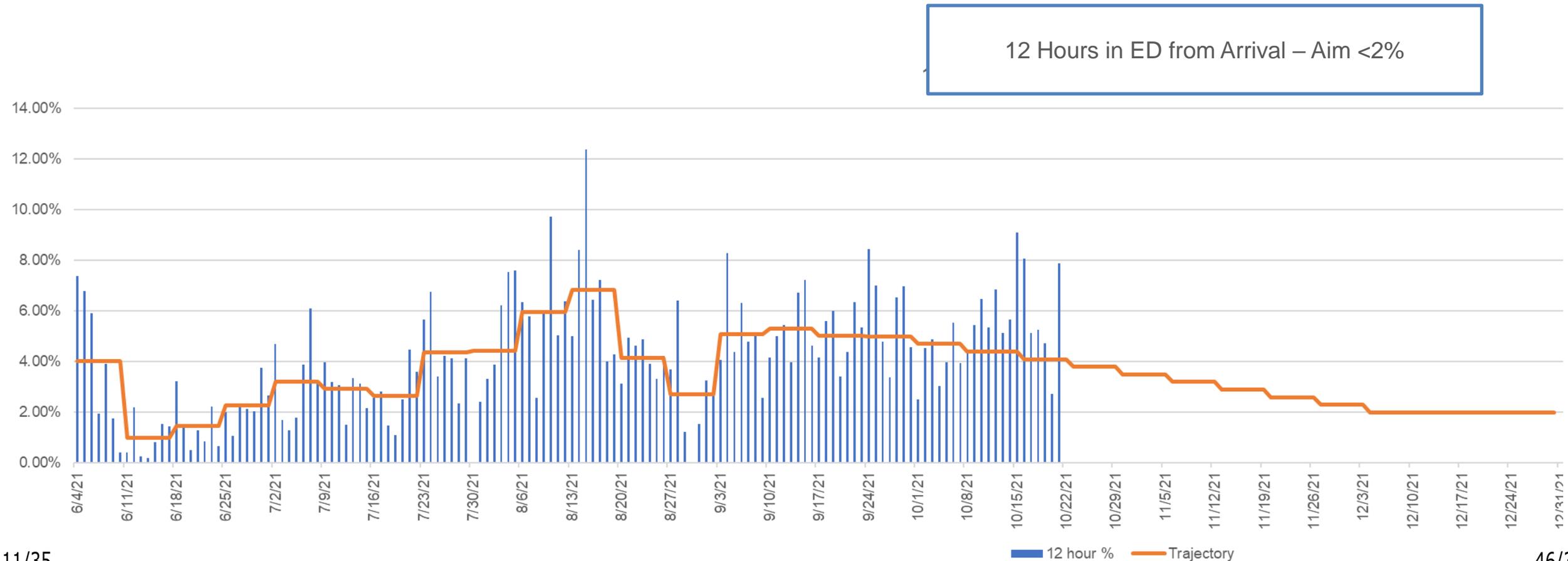
## Trust Type 1 Four Hour Standard Performance



# Target UEC trajectories – 12 hour waits

Through the UEC improvement plan the Trust aims to deliver the following performance trajectory for 12 hour waits in ED from arrival.

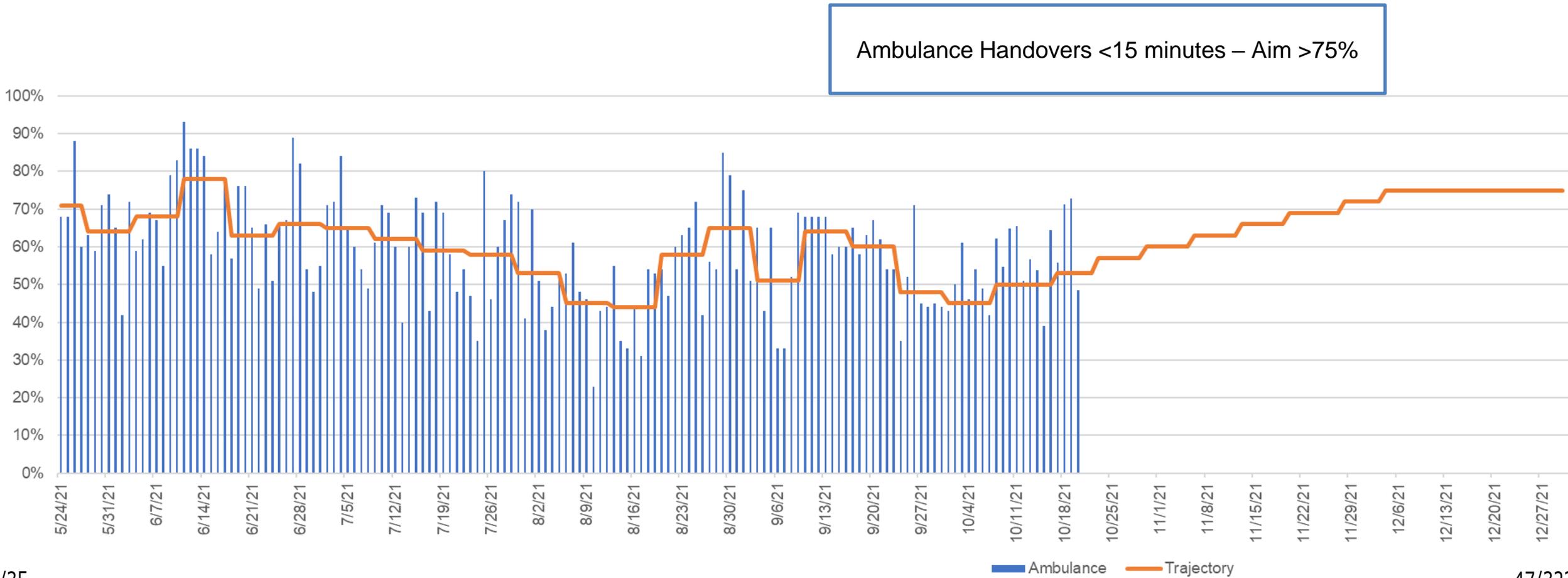
The planned trajectory is impacted by the same actions as in the 4 hour target slide.



# Target UEC trajectories – Ambulance handovers

By carrying out the action plans set out in the previous slides the Trust aims to deliver the following performance trajectory for the ambulance handovers less than 15 minutes.

The planned trajectory is impacted by the same actions as in the 4 hour target slide.



# Recovery programme update



Buckinghamshire Healthcare  
NHS Trust

<b>Executive summary</b>	<p>Following the Board-to-Board meeting with NHSE/I on 06/10/21 the recovery programme has been expanded to include overall Trust improvement requirements as well as continued delivery of operational recovery. An Integrated Improvement Plan to reflect the revised programme was submitted on 1 November 2021. Feedback on the plan is expected shortly.</p> <p>The Recovery Team have developed a single view 'cost of recovery' tracker for H2, which will inform the Trust financial plan, This tracker has now been handed over to finance colleagues.</p> <p>Pump prime ERF funding is being made available to ICSs, and the trust has put in a bid for approximately £11m of funding on this basis.</p>
<b>Progress since the previous meeting</b>	<ul style="list-style-type: none"> <li>Finalised and submitted a Trust wide Integrated Improvement Plan</li> <li>Begun to develop a Trust Improvement Program Governance Structure</li> <li>Submitted request for prime ERF funding to the value of approximately £11m of funding on this basis.</li> <li>Established UTC-like model now ready to launch on 24<sup>th</sup> Nov</li> <li>Developed a single view 'cost of recovery' tracker for H2 and handed over to finance colleagues</li> <li>Final review of and comment on theatre productivity analysis report</li> <li>Preparations begun to hand over operational recovery programme to new planned care SRO</li> <li>Produced monthly recovery programme update</li> <li>Commenced planning of mobilisation meetings for TIF schemes and updated ICS on priority funding schemes</li> </ul> <p><b>Key achievements in week:</b></p> <ul style="list-style-type: none"> <li>Developed a trust wide integrated improvement plan</li> <li>Submitted bid for approximately £11 million of ERF funding, supported by figures and activity</li> <li>Continued reduction in DM01 and 52-week compliance ahead of trajectory</li> <li>Arrived at agreed view of H2 'cost of recovery'</li> </ul>
<b>Actions planned up to the next meeting</b>	<ul style="list-style-type: none"> <li>Submit refreshed H2 operational planning activity numbers and narrative by 15<sup>th</sup> Nov</li> <li>Engage with outcome of TIF and ERF pump prime funding decisions due 9<sup>th</sup> November</li> <li>Progress Operational Improvement Capacity Programme jointly with PwC, the Executive Team and Trust Board</li> <li>Agree definitive mutual aid available from the ICS by 12<sup>th</sup> November</li> <li>Work with Executive Directors to agree and Improvement Plan workstream leads to embed new reporting programme</li> <li>Work with the Dir. of P&amp;P and the BI team to ensure automation of reporting of the Recovery Dashboard / metrics</li> <li>Launched theatre productivity analysis report</li> <li>Develop an approach across booking and scheduling that will address the processes, data, digitisation and workforce requirements.</li> </ul>
<b>Escalation / support required</b>	<ul style="list-style-type: none"> <li>BI support to automate reporting, alongside a proposed 'reporting amnesty' to provide performance colleagues sufficient time to automate processes.</li> </ul>

Workstream	Workstream RAG
Outpatient recovery	Amber
Theatre productivity	Green
Booking and scheduling	Amber
Additional capacity	Amber
Endoscopy	Red
Radiology productivity	Amber
Front door	Amber
Ambulation and acute / SDEC	Amber
Get me home	Amber
Bed and surge modelling	Green

Key Risks	Mitigating actions	Risk score
There is a potential risk regarding the ongoing management of the PMO due to current PMO capacity and competing commitments.	This will be further defined and mitigated through the Recovery PMO launch and communications plan.	Amber
There is a risk to Trust operational recovery if the workstreams do not achieve their interim actions and milestones, with metrics reflecting progress	This will be mitigated through the ongoing monitoring and management of workstream recovery metrics and workstream progress week on week.	Amber

<b>Workstream:</b> Theatre productivity	<b>Executive Sponsor:</b> Medical Director	<b>Workstream lead:</b> John Abbott	<b>Date completed:</b> 05/11/2021	<b>Overarching workstream delivery RAG</b>	Green
<b>Executive summary</b>	Work is ongoing to recover Theatre activity and performance to 19/20 levels at a minimum.				
<b>KPI / trend analysis and commentary</b> <i>(linked to the PMO dashboard metrics)</i>	<ul style="list-style-type: none"> <li>The team are starting to review late starts, early finishes and utilisation data, to be circulated with the surgical teams and explore opportunities to maximise utilisation.</li> </ul>				
<b>Progress since the previous meeting</b>	<ul style="list-style-type: none"> <li>Continued to explore opportunities to use the closed theatre at Wycombe</li> <li>Drafted final iteration of master scheduling template, booking template is now out to 12 weeks to support compliance with 95% booking standard</li> <li>Started planning for the Christmas period</li> <li>Started running weekend lists to work through the activity backlog, between 4-6 elective sessions per weekend throughout multiple specialties</li> <li>Held the “ideas week” with colleagues, with positive feedback to date</li> <li>Analytics team completed initial modelling</li> </ul>				
<b>Actions planned up to the next meeting</b>	<ul style="list-style-type: none"> <li>Update the action plan from “ideas week” and refine recovery trajectories accordingly</li> <li>Continue to refine process for booking patients at less than 2 weeks notice to use short notice capacity</li> <li>Explore options regarding the current operative day</li> <li>Based on modelling, analytics team will be identifying interventions to target evidenced productivity gaps</li> <li>Theatre workforce gaps to be identified for finance to cost, predicated on opening 30 additional theatre sessions per week</li> </ul>				
<b>Escalation / support required</b>	None at present.				

Initiative title	Initiative RAG
Waiting list validation governance	Green
Appropriate clock stops	Green
Alternate settings	Green
“Ideas week”	Green
6-4-2 structure	Green
Air extraction	Amber
Refined recovery trajectories	Amber

<b>* Delivery RAG definitions</b>
<b>Red:</b> off track / delayed with no mitigating actions identified or mitigating actions identified with limited success
<b>Amber:</b> partially off track or at risk of being off track with actions identified / underway to mitigate any delays or risks
<b>Green:</b> on track and delivering as planned

Key Risks	Mitigating actions	Risk score
Pre operative assessment capacity is a risk to 104 patients being booked and ultimately activity throughput	Interim operational management is now in place	Green
Identification of medically optimised patients and is a risk to patients being booked and ultimately activity throughput	The theatres workstream are out to recruitment for qualified nurses and HCAs to support booked admissions Additional locum slots in anaesthesia to conduct note reviews in the interim	Amber

Key workstream milestones (to April 2022)	Due date	Current status RAG
To hold a validated waiting list	[TBC – depending on the milestone owner]	Amber – not yet due
To plan and implement the outputs from the “ideas week”	w.c. 30/11/2021	Amber – not yet due
Booking of patients more than 3 weeks out	Ongoing	Amber
To hold a systematic review of the current 6-4-2 process including backward look and forward look – this happens weekly with the General Managers	Ongoing	Green
To bring the 11 <sup>th</sup> Theatre at Wycombe back online (post air extraction issues)	w.c. 30/11/2021	Amber – not yet due

<b>Workstream:</b> Outpatient recovery	<b>Executive Sponsor:</b> COO	<b>Workstream lead:</b> Tunde Adewopo	<b>Date completed:</b> 03/11/2021	<b>Overarching workstream delivery</b> RAG	Amber
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<b>Executive summary</b>	No update received.																									
<b>KPI / trend analysis and commentary</b> <i>(linked to the PMO dashboard metrics)</i>	<p><b>Out-Patient Appointment Slot Utilization History</b></p> <table border="1"> <thead> <tr> <th rowspan="2">SESSION NAME</th> <th colspan="2">202109</th> <th colspan="3">202110</th> <th colspan="2">Total</th> </tr> <tr> <th></th> <th>Avail New</th> <th>Avail FUP</th> <th></th> <th>Avail New</th> <th>Avail FUP</th> <th>Avail New</th> <th>Avail FUP</th> </tr> </thead> <tbody> <tr> <td>Total</td> <td>72%</td> <td>2911</td> <td>4820</td> <td>70%</td> <td>1407</td> <td>2499</td> <td>4318</td> <td>7319</td> </tr> </tbody> </table>	SESSION NAME	202109		202110			Total			Avail New	Avail FUP		Avail New	Avail FUP	Avail New	Avail FUP	Total	72%	2911	4820	70%	1407	2499	4318	7319
SESSION NAME	202109		202110			Total																				
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Total	72%	2911	4820	70%	1407	2499	4318	7319																		
<b>Progress since the previous meeting</b>	<ul style="list-style-type: none"> <li>No update received.</li> </ul>																									
<b>Actions planned up to the next meeting</b>	<ul style="list-style-type: none"> <li>Ongoing work with the BI team to develop dashboard metrics – built and now being validated and testing</li> <li>Implement performance standard for cashing up within 48 working hours from completion of the form (reporting is shared weekly at APMG, escalation daily within patient access).</li> <li>Follow up approval / implementation of new SOPs developed for cashing up.</li> <li>Recruiting temporary staffing to support call centres.</li> </ul>																									
<b>Escalation / support required</b>	<ul style="list-style-type: none"> <li>Insufficient informatics support means that defining measurable KPIs (beyond mandatory returns to NHSE) are difficult to define and measure.</li> <li>Service manager capacity – the workstream requires appropriate service manager capacity to input into the programme.</li> </ul>																									

Initiative title	Initiative RAG
Dashboard development	Amber
Analysis on non-cashed up clinics	Green
Waiting list validation governance	Amber
Clock stops	Amber
Short term call centre resource	Amber

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<b>Green:</b> on track and delivering as planned

Key Risks	Mitigating actions	Risk score
Momentum to keep teams motivated to deliver	Holding weekly specialty collaborative meetings to maintain momentum and ensure that staff are all informed of outpatient information feeds and requirements. Further work to be done to explore ring fencing of capacity to enable attendance at the meetings.	Amber
BI Support has been provided to assist with Dashboard	Recovery KPIs PC working with Dir. Transformation Strategic Information Management and Business Analytics and metrics are being defined and redesigned with the Recovery PMO and Director of Performance and Planning.	Amber
Risk to the cashing up element of outpatient recovery if the consultants are not completing ECO forms in a timely manner	Patient Access cashing up performing on target. Weekly sharing of data to operational and clinical leads including: escalation of incomplete forms at consultant level, league tables by specialty.	Red

Key workstream milestones (to April 2022)	Due date	Current status RAG
Review of current status of patients on hold to be validated (by the operational teams)	TBC – ongoing work	Amber
Metrics to be defined and dashboard developed	w.c. 29/11/2021	Red
Review of outpatient estate to run clinics (linked specifically to spinal activity rather than a wholesale review)	w.c. 25/10/2021	Amber

<b>Workstream:</b> Booking and scheduling	<b>Executive Sponsor:</b> Medical Director	<b>Workstream lead:</b> Tunde Adewopo	<b>Date completed:</b> 03/11/2021
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<b>Overarching workstream delivery</b> RAG	Amber
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<b>Executive summary</b>	PwC team (additional capacity) on schedule to mobilise from 28/10/2021, new POA pathways are being developed.
<b>KPI / trend analysis and commentary</b>	<ul style="list-style-type: none"> <li>Theatre booking density</li> <li>% of lists confirmed at 6 weeks – this will be monitored going forward</li> </ul>
<b>Progress since the previous meeting</b>	<ul style="list-style-type: none"> <li>Commencement of PwC staff training ongoing</li> <li>Ongoing check and challenge of risk matrix categorisation and medically optimised status and engaging with specialty operational managers and by consultant ongoing</li> <li>Started collating ideas from “ideas week” with regards to booking and scheduling completed</li> <li>Training staff (2 week programme including IT training and team orientation) with a view to fully mobilising the new team around 28<sup>th</sup> October 2021</li> <li>Workshop scheduled w.c. 18/10/2021 to discuss electronic booking, looking to map this into processes going forward.(completed and scoping issues to define the spec with BI for reporting )</li> <li>Meeting with the Theatres team to review and refresh the SOP for 6-4-2 to support booking density, list filling, etc. – SOP has been drafted.</li> <li>Share actions from Ideas week</li> <li>Work on POA department level SOP with the POA nursing leads, meeting to ok place – draft SOP in progress</li> </ul>
<b>Actions planned up to the next meeting</b>	<ul style="list-style-type: none"> <li>Commence training of staff to provide additional capacity</li> <li>Send letters to all patients between 26-90 weeks (admitted)</li> <li>Work on POA department level SOP with the POA nursing leads, meeting scheduled w.c. 18/10/2021</li> <li>Define POA processes with regards to patients waiting longer than 6 weeks to be medically optimised, revert back to Primary Care to manage.</li> <li>Meeting with the Theatres team to review and refresh the SOP for 6-4-2 to support booking density, list filling, etc.</li> <li>Write up actions from the “ideas week” with regards to booking and scheduling</li> <li>Share actions from Ideas week</li> </ul>
<b>Escalation / support required</b>	IT support in relation to printing booking letters and provision of smart cards to utilise Careflow effectively

Initiative title	Initiative RAG
Normalise clock stops	Amber
Capacity and demand modelling	Amber
Clinical feedback channels	Green
Review of current booking constraints	Amber
Temporary resource	Green
6-4-2 structure	Amber

<b>* Delivery RAG definitions</b>
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<b>Green:</b> on track and delivering as planned

Key Risks	Mitigating actions	Risk score
(Interdependent with Theatres workstream) identification of medically optimised patients and is a risk to patients being booked and ultimately activity throughput PwC ability to print booking letters / no smart cards provided at this stage. Theatre lists not confirmed at 8 weeks notice	The theatres workstream are out to recruitment for qualified nurses and HCAs to support booked admissions Additional locum slots in anaesthesia to conduct note reviews in the interim IT workarounds for printing in progress.	Amber

Key workstream milestones (to April 2022)	Due date	Current status RAG
Meeting with the Theatres team to review and refresh the SOP for 6-4-2 to support booking density, list filling, etc.	w.c. 18/10/2021	Green
Mobilisation of additional resource to support booking capacity	w.c. 25/10/2021	Green
Validation of the admitted waiting list	w.c. 29/11/2021	Amber
POA department level SOP signed off	w.c. 29/11/2021	Amber – not yet started
Circulate clinical communications regarding sending patients to POA when not medically optimised	w.c. 29/11/2021	Amber – not yet started
Confirm funding for the bid to support new digital pre operative assessment platform. This has gone through TIF process and the team are awaiting confirmation.	w.c. 04/10/2021	Amber
Review current workforce structure, identify capacity shortfall and confirm action plan	w.c. 01/11/2021	Amber – not yet started

**Workstream:**  
Radiology productivity

**Executive Sponsor:**  
Director of Strategy

**Workstream lead:**  
Andrew Wainwright

**Date completed:**  
03/11/2021

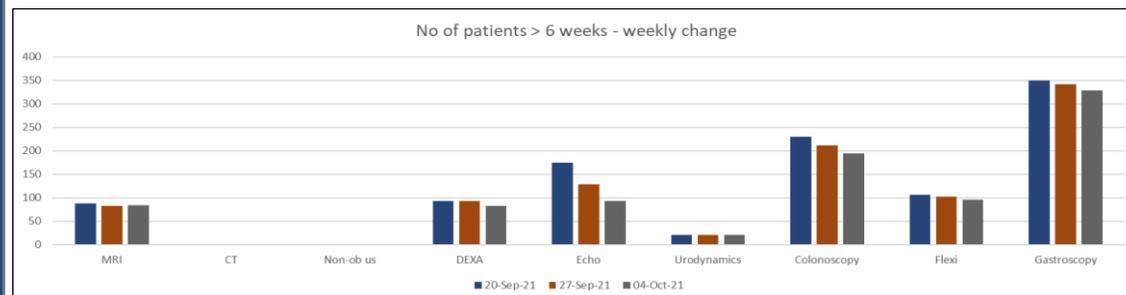
**Overarching workstream delivery**  
RAG

Amber

**Executive summary**

Work is ongoing to recover diagnostic activity and performance to 19/20 levels at a minimum.

**KPI / trend analysis and commentary**  
*(linked to the PMO dashboard metrics)*



**Progress since the previous meeting**

- Made good progress on clearance of the ECHO and urodynamics backlog in line with trajectory (with Parmi and W&C)
- Community Diagnostic Hub at Amersham has gone live, currently exploring staffing approach
- New MRI scanner has arrived on site and in situ, this is being ramped up ready for applications training
- Made good progress in exploring further MRI capacity, by extending the daily opening hours to 14 on the Wycombe mobile, with more work being done to look at booking patterns to generate more capacity, the team are still exploring MRI capacity external to the Trust
- Made good progress in exploring further DEXA capacity, there is a plan in place to increase DEXA capacity within the Trust, however we have just had one of our 3 DEXA Radiographers resign.

**Actions planned up to the next meeting**

- Explore further external opportunities MRI capacity across the County

**Escalation / support required**

- Financial support requested with regards to MRI capacity. Financial pressures expected in order to facilitate increased capacity.

Initiative title	Initiative RAG
Additional MRI slots	Red
DEXA scans capacity	Amber
Cardiac CT scan demand investigation	Red
Additional workforce	Amber-red

**\* Delivery RAG definitions**

- Red:** off track / delayed with no mitigating actions identified or mitigating actions identified with limited success
- Amber:** partially off track or at risk of being off track with actions identified / underway to mitigate any delays or risks
- Green:** on track and delivering as planned

Key Risks	Mitigating actions	Risk score
Bringing in and onboarding overseas radiographers has been a slow process due to overseas contracting requirements and administration.	This is being mitigated by anticipating demand to ensure sufficient staff are brought in, the team are currently recruiting 15 additional members of clinical staff, 9 of which have been delayed and will start in November and December.	Amber
There is a risk to the MRI scanner due to aged estate and a the replacement roof	Funding has been agreed to fix the roof, the team are planning to mobilise the roof repair, and there is a plan in place to ensure this is done prior to the NHSe scanner being installed.	Amber

Key workstream milestones (to April 2022)	Due date	Current status RAG
To develop the Diagnostics Board which encompasses radiology, pathology and endoscopy. Potential to bring this into Rad&Path Transformation Board.	TBC	Amber
Overseas radiographers start in post	w.c. 29/11/2021	Green
Cannon MRI scanner go live	w.c. 29/11/2021	Green
NHSe replacement scanner works	w.c. 03/01/2022	Green

Workstream: Cancer Performance	Executive Sponsor: COO Cancer Performance	Workstream lead:	Date completed: [03/11/21]	Overarching workstream delivery RAG	Amber	
<b>Executive summary</b>	The NHS Constitution outlines what patients can expect and their rights when they are referred on a cancer diagnosis and treatment pathway. Cancer waiting times (CWT) measure BHT's performance against these national NHS Constitution Standards, as well as a number of other metrics. These measures monitor the timely delivery of services to patients. Successful Cancer Performance is an objective that should be accountable and visible to each and every touchpoint within the organisation.				<b>Initiative title</b>	<b>Initiative RAG</b>
<b>KPI / trend analysis and commentary</b> <i>(linked to the PMO dashboard metrics)</i>	Please refer to national CWT guidance for further individual breakdown of operational standards. <ul style="list-style-type: none"> <li>2WW – 93%</li> <li>31-Day – 96%</li> <li>62-Day – 85%</li> <li>28-Day FDS – 75%</li> </ul>	Updates from September monthly data: <ul style="list-style-type: none"> <li>2WW position - 96.1%</li> <li>62-Day position – 64.6%</li> <li>31-Day position – 90.2%</li> <li>28-Day FDS position – 75.0%</li> </ul>		Capacity identification and utilisation processes	Amber	
<b>Progress since the previous meeting</b>	<ul style="list-style-type: none"> <li>Ongoing monitoring of the trajectory and potential outsourcing opportunities to tackle the Histopathology backlog. Made contact with an outsourcing company and the team are currently working through service queries. A twice weekly meeting with Pathology is now mobilised to tackle: (1) any deferrals from MDT due to pathology not being ready and (2) to work on the main pathology backlog.</li> <li>Successfully interviewed for 1.0 WTE position in 2WW office, further 0.4 WTE position to be recruited via TRAC</li> <li>Second round Interviews for the RDS transformation role to be undertaken in the next 2 weeks.</li> </ul>				Weekly escalation meeting with Pathology (escalation via APMG)	Green
<b>Actions planned up to the next meeting</b>	<ul style="list-style-type: none"> <li>Continue to escalate / utilise capacity across service areas via weekly PTL meetings / escalation via APMG – weekly activity</li> <li>24-48 hours escalation procedure in place for service response (escalation SM&gt;GM&gt;DD).</li> <li>Further interview for 0.4WTE position in the 2WW office.</li> <li>Recruitment of MDT Co-ordinator (1.0 WTE) to take place within the next week, and FDS tracker (1.0 WTE FTC).</li> </ul>				Recruitment drive in 2WW office	Green
<b>Escalation / support required</b>	<ul style="list-style-type: none"> <li>Support / Accountability from General Managers from services that underpin the cancer pathway – escalated to the GMs via APMG. No action required from EMC at present.</li> </ul>				Recruitment drive MDT/Tracking staff	Amber
				NHSE/TVCA Key programmes roll out	Amber	
				<b>* Delivery RAG definitions</b>		
				Red: off track / delayed with no mitigating actions identified or mitigating actions identified with limited success		
				Amber: partially off track or at risk of being off track with actions identified / underway to mitigate any delays or risks		
				Green: on track and delivering as planned		

Key Risks	Mitigating actions	Risk score
<ul style="list-style-type: none"> <li>If TAT's/capacity continues to be a problem area this will impact 2WW, FDS, 31-day and 62-day performance.</li> <li>Volume of referrals/breaches in October presents risk of failing both 2WW and FDS targets for October</li> </ul>	Accountability and commitment from service areas, funding for additional staff (Pathology consultant), recruitment drive within Radiology (6 tad	Amber

Key workstream milestones (to April 2022)	Due date	Current status RAG
Rapid Diagnostic Services (RDS) roll out	30/09/2021	Red
Remote monitoring/Risk Stratified Pathways roll out	31/03/2021	Amber
Sustainable Operational Cancer Performance	Ongoing	Amber

<b>Workstream: Endoscopy</b>	<b>Executive Sponsor: Medical Director</b>	<b>Workstream lead: Parmi Walia</b>	<b>Date completed: 07/10/2021</b>
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<b>Overarching workstream delivery RAG</b>	<b>Amber</b>
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<b>Executive summary</b>	Work is ongoing to recover Endoscopy activity and performance to 19/20 levels at a minimum.
<b>KPI / trend analysis and commentary</b> <i>(linked to the PMO dashboard metrics)</i>	<ul style="list-style-type: none"> <li>Endoscopy team have agreed with Dir of P&amp;P that they will use the m1-6 average activity levels as a baseline. To be monitored going forward.</li> <li>Despite decontamination issues in September 2021, the team have met their baseline.</li> </ul>
<b>Progress since the previous meeting</b>	<ul style="list-style-type: none"> <li>Dir P&amp;P has met with the ops/clinical team re IS – assurance on governance framework required by SDU – Dir P&amp;P to feedback</li> <li>Started the data cleansing exercise regarding comparison of patients and endoscopy points – this will be a longer term piece of work.</li> <li>Meeting with BI team to discuss access to data and available data to monitor</li> <li>Initial vanguard site visit happened – await FIT sign off before clinical engagement with the company</li> <li>PwC bookers started</li> <li>Decontamination de brief meeting held</li> </ul>
<b>Actions planned up to the next meeting</b>	<ul style="list-style-type: none"> <li>Once data access is granted (potentially not within the next week): <ul style="list-style-type: none"> <li>Verify the Endoscopy metrics monitoring on a weekly basis (supplied by the Director of P&amp;P).</li> <li>Gain assurance regarding clinical governance of patients that will be treated via mutual aid.</li> </ul> </li> <li>Confirm any physical space for booking team, submitting form to the Space Committee prior to confirming physical area. Estate (space) lead is aware of the requirements, awaiting formal panel representation and approval.</li> <li>Explore nurse endoscopists rates with HoN and NHSP</li> <li>Initial kick off meeting set up with Vanguard Company scheduled for 11/11.</li> </ul>
<b>Escalation / support required</b>	<ul style="list-style-type: none"> <li>Access to data – improvement lead requires access to data</li> <li>Physical space for the Endoscopy booking team – support required in identifying and confirming physical space for the booking team, this will underpin Endoscopy booking, scheduling and productivity going forward.</li> </ul>

<b>Initiative title</b>	<b>Initiative RAG</b>
BOB mutual aid	Amber
Endoscopy nursing business case	Green
Governance nurse at HW	Amber
Booking resource and processes	Red
Review of current booking constraints	Red
Temporary resource	Green
Refined recovery trajectories	Amber

<b>* Delivery RAG definitions</b>
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<b>Amber:</b> partially off track or at risk of being off track with actions identified / underway to mitigate any delays or risks
<b>Green:</b> on track and delivering as planned

<b>Key Risks</b>	<b>Mitigating actions</b>	<b>Risk score</b>
There is a risk that existing staff may resign due to the outcome of the 7-day working consultation and how this impacts their working life in practice. This may result in a lack of nursing capacity to support recovery of Endoscopy services and as a result – new consultants cannot be offered substantive weekday lists without additional list capacity. This may limit the amount of additional activity the service can undertake impacting recovery.	HoN of Endoscopy to engage with the nursing teams regarding 7 day working and the governance nursing role.	Red
There is a risk that there is not sufficient resource across the clinical, operational and management teams to deliver the initiatives within the recovery plan, limiting its impact.	Outsource work through mutual aid where possible / the understanding that any gains in capacity inhouse can only commence when resourced appropriately and agreed at an SDU level	Amber

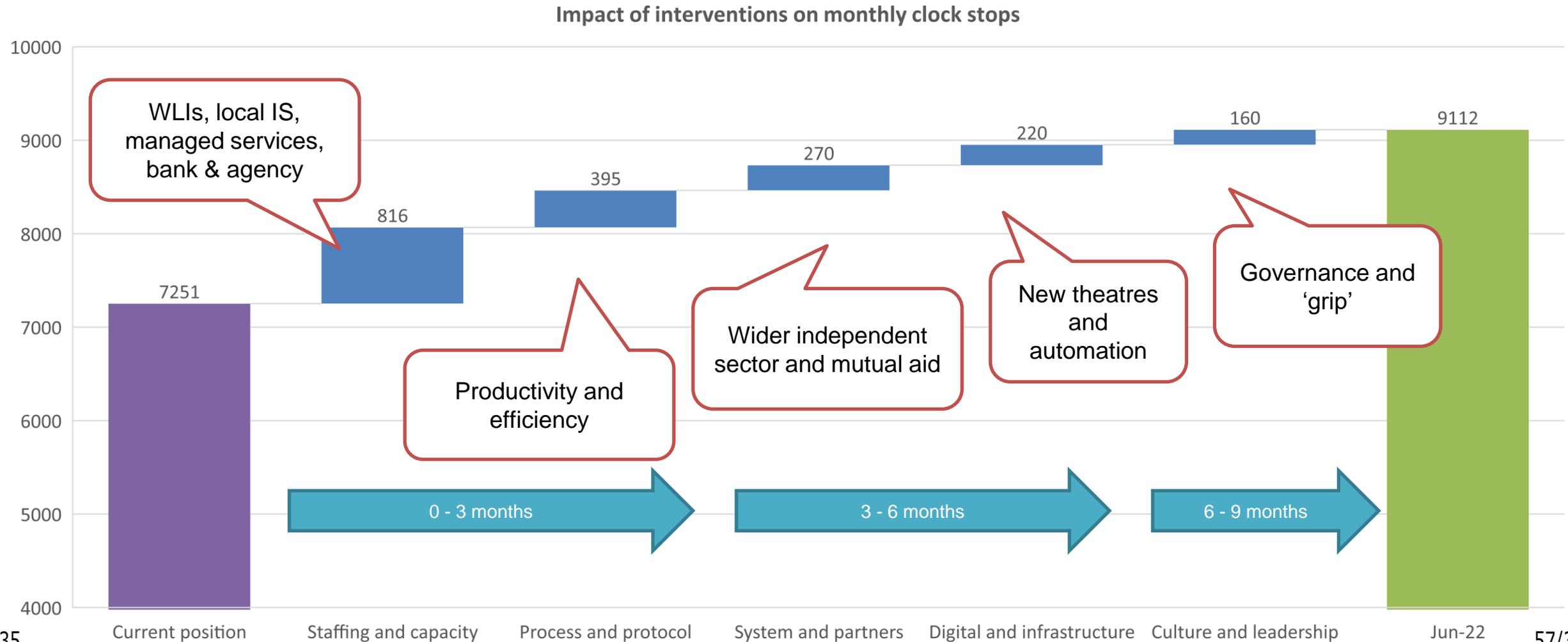
<b>Key workstream milestones (to April 2022)</b>	<b>Due date</b>	<b>Current status RAG</b>
Electronic booking in place – this is being championed by the CMO, December 2021 is an indicative timeframe	w.c. 20/12/2021	Red
The Endoscopy booking team having a booking office that is co-located with (or with easy access to) Endoscopy	w.c. 29/11/2021	Amber
Resolution of governance nursing role / job	w.c. 29/11/2021	Amber

Workstream: Additional capacity		Executive Sponsor: CFO		Workstream lead: Wendy Pocknell		Date completed: 04/11/2021		Overarching workstream delivery RAG		Amber	
Executive summary		Work is ongoing to optimise the agreements regarding independent sector, mutual aid, etc. RBFT confirmed 200 T&O theatre slots (H&K). Medifer and gut care contracts are progressing. In addition 600 out of county IS Endoscopy pieces. Format and process for tracking of activity utilisation in IS and mutual aid agreed.									
Progress since the previous meeting		<ul style="list-style-type: none"> <li>Work is underway to ensure that independent sector activity recorded on midway (the teams are currently working through location codes with regards to building clinics)</li> <li>RBFT offered 200 Orthopaedic slots as mutual aid – considering inclusion and exclusions</li> <li>Berkshire Independent offered 600 endoscopy slots – undergoing governance checks</li> <li>Gutcare insourcing underway in Endoscopy</li> <li>18 week support work underway in Ophthalmology and ENT</li> <li>Medefer due to start 1<sup>st</sup> December 21 with virtual consultations for Dermatology, Rheumatology and Gastroenterology</li> <li>Discussions underway with Circle and Spire as part of CCG contracting</li> <li>Additional booking support directed to help with IS administration</li> <li>Offer of support for further T&amp;O from OUH</li> <li>Manager appointed to expedite patient flow between BHT and IS providers</li> </ul>									
Actions planned up to the next meeting		<ul style="list-style-type: none"> <li>Begin regular reporting and tracking of activity</li> <li>Ensure independent sector contracts are signed and mobilised</li> <li>Agree specialities and numbers with all IS providers</li> <li>Continue to liaise with CCG colleagues to explore further opportunities to use independent sector</li> <li>Ensure all activity recorded on BHT PAS system</li> </ul>									
Escalation / support required		<ul style="list-style-type: none"> <li>Not able to routinely report level of activity, cost and alignment with ERF due to BI capacity constraints</li> <li>To note: Mutual aid on offer currently limited due to provider trusts concern around local performance levels – requires system intervention. Current size of support on offer not proportionate to the profile of this piece of work</li> <li>BI team to resolve integration issues</li> </ul>									
Key Risks						Mitigating actions				Risk score	
There may be a lack of truly available local independent sector capacity, particularly capacity by specialty demand.						Working with the CCGs to look at demand and capacity at specialty level to assess level of true capacity.				Red	
Independent sector contracts have a low conversion factor. This is often due to patients choice, typically because independent sector providers not being in close proximity to BHT patients who are unwilling to travel.						This remains a limiting factor, when the list of procedures was prepared, this was split into cohorts and used postcodes to best mitigate the travel time and look to reduce patient choice declines.				Amber	
There may be a lack of truly available mutual aid capacity, particularly capacity by specialty demand.						Working with BOB providers and sharing demand at specialty level to assess level of true capacity.				Red	
Risk that BHT are left with the financial responsibility from inter-provider transfers						Reduce the number of mid pathway patients transfer where possible Agree funding with ICS to cover BHT costs				Amber	
Key workstream milestones (to April 2022)								Due date		Current status RAG	
Additional contracts being signed								w.c. 11/10/2021		Amber	
Sharing the next cohort of patients with the independent sector								w.c. 18/10/2021		Amber – not yet due	
Agreeing any further use of currently underutilised independent sector capacity in line with commissioned activity								w.c. 18/10/2021		Amber – not yet due	
* Delivery RAG definitions											
Red: off track / delayed with no mitigating actions identified or mitigating actions identified with limited success											
Amber: partially off track or at risk of being off track with actions identified / underway to mitigate any delays or risks											
Green: on track and delivering as planned											

# Summary of elective actions and impacts

The chart below sets out at a high level the key interventions which the trust will carry out in the next 0-9 months in order to recover its elective position. Interventions are grouped by broad category with callouts to provide examples of the content. The following slides set out the content in detail.

Impact of the interventions is set out in terms clock stops in line with the H2 operating guidance. It is expected that the interventions will also have impact across a range of KPIs including RTT, DM01 and clinical harms reduction.



Workstream: Get me home		Executive Sponsor: Chief Nurse	Workstream lead: Nicola Newstone	Date completed: 04/11/2021	Overarching workstream delivery RAG	
						Amber
<b>Executive summary</b>		Transforming the discharge pathways in Buckinghamshire to enable timely discharge of patients from hospital to the most appropriate location and with the required support to achieve the optimum long term outcome for patients. The Get me Home Workstream is focussing on three key areas: Developing a system wide Home First service, development of an integrated discharge hub and improved informatics, with the ultimate aim of a digital solution to enable instant information sharing and real time capacity management to improve flow.				
		To note: this recovery workstream is a subset of a wider UEC recovery programme and accountable to the ICP Delivery Board.				
<b>KPI / trend analysis and commentary</b> <i>(linked to the PMO dashboard metrics)</i>		There has been an improvement in MOFD during October but the position remains over plan and very challenged. A surge escalation plan has been approved and recruitment to therapy and case management posts is underway alongside the commissioning of longer term home care contracts from 1 <sup>st</sup> November. The development of discharge hub beds is being taken forward with two care homes as pilots at pace with an onsite therapy and social worker presence to better support flow through these beds. The risks in home care capacity and recruitment challenges are recorded in the risk log.				
<b>Progress since the previous meeting</b>		<ul style="list-style-type: none"> <li>Integrated hub business case finalised</li> <li>Home First and D2A Dom Care pathway integrated on 04/10/2021. Recruitment and dom care capacity increase underway.</li> <li>Demand and Capacity work with Clarity due for completion 12<sup>th</sup> November. This has been complex due to data quality in Buckinghamshire</li> </ul>				
<b>Actions planned up to the next meeting</b>		<ul style="list-style-type: none"> <li>Integrated hub business case to take forward to ICP Delivery Board. Was on agenda for October Board but meeting was cancelled.</li> <li>Early demand findings from Demand and Capacity work widely shared in advance of finalised paper to enable input.</li> <li>Bid to unified tech fund regarding digitisation of the discharge pathway</li> </ul>				
<b>Escalation / support required</b>		<ul style="list-style-type: none"> <li>No issues to escalate</li> </ul>				
<b>Key RISKS</b>		<b>Mitigating actions</b>			<b>Risk score</b>	
IF there is no long term funding stream agreed for out of hospital discharge capacity then there will not be the ability to proceed with the new models of care.		<ul style="list-style-type: none"> <li>Identified cost pressure based on current usage and projected usage</li> <li>Modelling of required capacity</li> <li>Transformation pieces prioritised to shape capacity (i.e. Pathway 1)</li> </ul>			Red	
Currently there is no integrated digital solution for community discharge capacity. This means that the system has no live view of discharge capacity available. The capacity is managed via multi spreadsheets which leaves scope for human error, delays in understanding capacity and is very time consuming.		<ul style="list-style-type: none"> <li>BHT MOFD list has been moved to a digital platform which has improved visibility and reporting.</li> <li>Digital project support has been allocated by BC and ICP Digital task and finish group established within Get Me Home Workstream. High level ambitions identified.</li> </ul>			Amber	
If sufficient home care capacity is not provided, then there will be inadequate provision of care to patients going through the Home First pathway which will prevent the MOFD from being reduced		<ul style="list-style-type: none"> <li>Engage national provider</li> <li>Engagement with local markets to facilitate partnership working</li> <li>Maximise utilisation of current capacity with therapy and case management</li> </ul>			Amber	
<b>Key workstream milestones (to April 2022)</b>					<b>Due date</b>	<b>Current status RAG</b>
Completion of the demand and capacity modelling for business case					w.c. 29/11/2021	Amber
Implementation of Home First model					01/03/202	Amber
Implementation of Integrated Discharge Hub					01/03/2022	Amber
Recruitment of additional therapy case manager and home first service lead posts					w.c. 15/11/2021	Red
						58/322

**\* Delivery RAG definitions**  
**Red:** off track / delayed with no mitigating actions identified or mitigating actions identified with limited success  
**Amber:** partially off track or at risk of being off track with actions identified / underway to mitigate any delays or risks  
**Green:** on track and delivering as planned

<b>Workstream:</b> Bed and Surge modelling	<b>Executive Sponsor:</b> COO urgent care	<b>Workstream lead:</b> Amanda Hallums	<b>Date completed:</b> 04/11/2021
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<b>Overarching workstream delivery RAG</b>	Green
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<b>Executive summary</b>	Work is ongoing to model and plan for COVID surge scenarios with as little disruption as possible to recovering services.
<b>KPI / trend analysis and commentary</b> <i>(linked to the PMO dashboard metrics)</i>	<ul style="list-style-type: none"> <li>Average bed occupancy at SMH continues around 99% at SMH with significant pressure in the Emergency Department. This is impacting the ability to meet 15 minute handover, 4 hour and 12 hour ED standards. This is being mitigated through close working with admission avoidance teams, admitting teams, length of stay reviews which now take place on the wards, engagement with system partners, discharge best practice, etc.</li> </ul>
<b>Progress since the previous meeting</b>	<ul style="list-style-type: none"> <li>Refreshed bed and surge modelling – this is undertaken on a daily basis based on the latest COVID admissions and paediatric admissions, as a result of this, it confirmed where the additional capacity will be</li> <li>Additional children’s escalation capacity moved to ward 9 from Friday 15<sup>th</sup> October</li> <li>Opening of the ward bays is incremental due to staffing , currently now increased from 2 - 3 bays (= 12 beds), appears to work well at this number.</li> <li>Working through the actions required to meet the flow and discharge elements within the NHSEI UEC recovery 10 point action plan.</li> <li>Additional bed capacity c 35 beds mapped out , significant risk to delivery due to interdependencies</li> </ul>
<b>Actions planned up to the next meeting</b>	<ul style="list-style-type: none"> <li>CCG to confirm start date for additional domiciliary care – still awaiting as at 4 November 2021, there is a significant issue regarding both availability and capacity of providers within the system.</li> <li>CCG confirmed 8000 hours of domicillary care funding approved from November 2021 – March 2022.</li> </ul>
<b>Escalation / support required</b>	<ul style="list-style-type: none"> <li>Support required in conversations with external stakeholders that provide onwards care (e.g. CCG, social services, domiciliary care) and admission avoidance capacity.</li> </ul>

Initiative title	Initiative RAG
Projected COVID modelling, including estimated risk on elective bed base.	Green
Additional bed capacity	Amber
Capacity identification and utilisation processes	Green
bed and surge modelling and planning to protect Elective bed base over Winter	Green

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<b>Green:</b> on track and delivering as planned

Key Risks	Mitigating actions	Risk score
Modelling has been conducted on a best case scenario - there is a risk to delivery is the worst case scenario occurs.	To date the modelling predictions have been very close to actuals.	Amber
There is a dependency on external stakeholders and capacity - including primary care, social care, nursing/ residential capacity, domiciliary care etc. System partners will form an integral part in maintaining flow within the hospital in a surge scenario.	This is an ongoing and increasing risk, to be mitigated through ongoing engagement with external stakeholders and system partners.	Red

Key workstream milestones (to April 2022)	Due date	Current status RAG
Children’s services move	w.c. 11/10/2021	Green – complete
Additional domiciliary care starts. Moved from Amber to Red on 14 <sup>th</sup> October due to potential issues regarding true capacity of domiciliary care providers within the system. Remains Red as at 4 November	w.c. 25/10/2021	Red
Deliver national standards: sustained decline in 12 hour breaches	w.c. 20/12/2021	Amber ? Red
Deliver national standards: sustained decline in 4 hour breaches	w.c. 20/12/2021	Amber? Red

<b>Workstream: Front door</b>	<b>Executive Sponsor: Chief Nurse</b>	<b>Workstream lead: Caroline Capell</b>	<b>Date completed: 29/10/2021</b>	<b>Overarching workstream delivery RAG</b>	<b>Amber</b>
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<b>Executive summary</b>	Progress on the development of the UTC Pathway at the Front Door of SMH including agreement of patient pathway and the patient flow within the Front Door. IT and Reporting being developed over coming weeks. Aim to start the model 24 <sup>th</sup> November 2021.
<b>KPI / trend analysis and commentary</b> <i>(linked to the PMO dashboard metrics)</i>	Performance at the Front Door of the Stoke Mandeville Emergency Dept has remained challenging throughout October with no significant improvement.
<b>Progress since the previous meeting</b>	<ul style="list-style-type: none"> <li>Clinical Pathways agreed for front door of SMH</li> <li>ED Team Away day took place to help develop cohesiveness across the team</li> <li>Project Plan, Risk Register and Issues Log in place and circulated for the UTC Pathway at Front Door Project.</li> </ul>
<b>Actions planned up to the next meeting</b>	<ul style="list-style-type: none"> <li>Continue mobilisation of UTC Pathway including IT and reporting</li> <li>Agree rescoping of workstream</li> <li>Commencing gap analysis of Clinical Review of Standards</li> <li>Deliver gaps in NHSE guidance for Ambulance handovers</li> </ul>
<b>Escalation / support required</b>	<b>No further support required at the moment.</b>

<b>Initiative title</b>	<b>Initiative RAG</b>
Front Door physical redesign at SMH Emergency Dept (go live date now agreed)	Green
Hospital Ambulance Liaison Administrator at RAT in SMH	Red
24/7 Direct bookings into ED	Red
Additional ED Nursing role	Amber
Additional GPs	Green
Establishment of a UTC at SMH	Green

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**Green:** on track and delivering as planned

<b>Key Risks</b>	<b>Mitigating actions</b>	<b>Risk score</b>
Trust Performance continues to remain challenging and inconsistent.	Now reporting splitting admitted and non-admitted breaches to ensure focus and improvement Director appointed with specific focus on ED and patient flow	Red
ED Improvements including reconfiguration of estates may disrupt progress in plan and reduce engagement and buy in from key stakeholders	Reconfiguration of estates planning and involving key stakeholders	Amber
Not meeting expectation of ED direct bookings 24/7 for all patient cohorts. Conflicting regional and local deadlines.	Clear expectations to be determined from national team and good clear plans in place for roll out	Amber
Approval of the funding for the new UTC model at the Front Door of the Emergency Dept at Stoke Mandeville Hospital.	Business Case approved and funded. Mobilisation now starting.	Amber

<b>Key workstream milestones (to April 2022)</b>	<b>Due date</b>	<b>Current status RAG</b>
Roll Out Plan for Consultant Connect (delayed – resource and capacity issues)	w.c. 15/11/2021	Red
UTC pathway at ED Front door	w.c. 22/11/2021	Amber
HALO starting at ED	w.c. 01/11/2021	Red
24/7 Direct bookings from 111 into ED go live	w.c. 22/11/2021	Red
Clinical review of standards (new national targets)	w.c. 20/12/2021	Green

<b>Workstream:</b> Same Day Emergency Care	<b>Executive Sponsor:</b> Chief Nurse	<b>Workstream lead:</b> Michael Maynard	<b>Date completed:</b> 29/10/2021
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<b>Overarching workstream delivery RAG</b>	Amber
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<b>Executive summary</b>	SDEC service moving from current location to an alternative location in order to accommodate winter surge planning. This is being reviewed to understand potential impact.  To note: this recovery workstream is a subset of a wider UEC recovery programme.
<b>KPI / trend analysis and commentary</b> <i>(linked to the PMO dashboard metrics)</i>	N/A – there are no KPIs required for the moving of the SDEC location
<b>Progress since the previous meeting</b>	<ul style="list-style-type: none"> <li>Project delayed as awaiting approval of Business Case for additional staff and gap analysis against national model.</li> <li>SDEC Unit has been moved due to winter pressures so review of scope taking place on what can be achieved.</li> <li>National SDEC Return completed</li> </ul>
<b>Actions planned up to the next meeting</b>	<ul style="list-style-type: none"> <li>Review of scope of project to move to achievable deliverables</li> </ul>
<b>Escalation / support required</b>	<ul style="list-style-type: none"> <li>The project is delayed as awaiting approval of Business Case – this has been escalated via Gold command.</li> <li>Support required from leadership and operational colleagues to minimise the disruption to staff during the SDEC move (e.g. staff working in the unit).</li> </ul>

Initiative title	Initiative RAG
SDEC Resource Business Case	Red
Recruitment of ACP staff to enable direct bookings	Green
Development of Direct booking capability (note that this is location dependent)	Amber
ED into SDEC pathway reconfigured (dependency with front door workstream)	Amber

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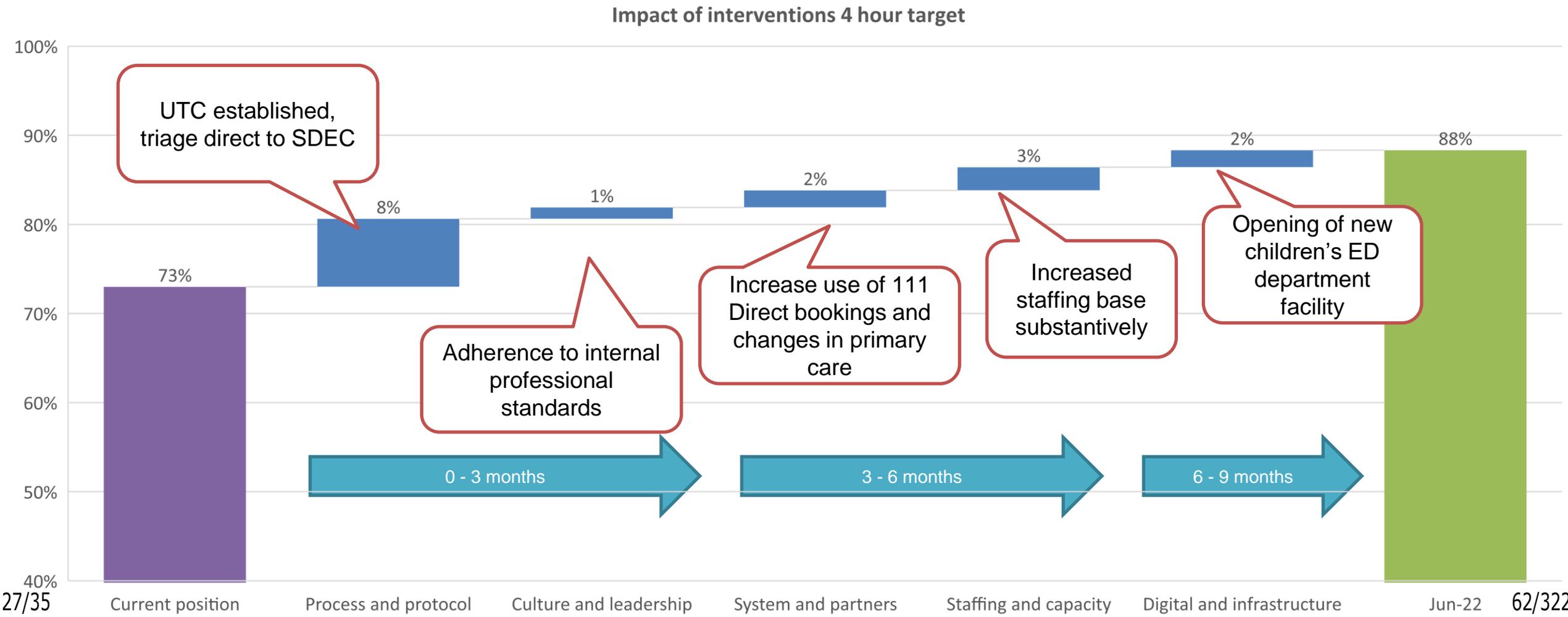
Key Risks	Mitigating actions	Risk score
If a suitable location (size) is not found this will impact the capacity of the department	Daily meetings are being held with key stakeholders to find the right location	Amber
The ability to implement alternative pathways may be limited in the new location e.g. SCAS into SDEC	Transformation meetings will continue (with partners) once a new location has been found	Amber
There is a risk the original trajectory to increase foot traffic into the department will not be met	Daily meetings are being held with key stakeholders to find the right location	Amber

Key workstream milestones (to April 2022)	Due date	Current status RAG
Feed into the national reporting of SDEC NHSE return	25/10/2021	Green
Clinical pathway alignment between Frailty SDEC and Adult SDEC	30/11/2021	Green
Additional resource starting to enable joint working and increase capacity	TBC	Green
Business case finalised and submitted for sign off	31/10/2021	Red
Direct Booking into SDEC (Dependant on additional resource starting)	30/11/2021	Amber
Plan and implement the merger of frailty and all other SDEC pathways, enabled by the additional ACP recruitment. Recruitment to be finalised by the end of October and interviews thereafter, date to be updated post interviews.	TBC	Amber

# Summary of UEC actions and impacts

The chart below sets out at a high level the key interventions which the trust will carry out in the next 0 - 9 months in order to recover its Urgent and Emergency care position. Interventions are grouped by broad category with callouts to provide examples of the content. The following slides set out the content in detail.

Impact of the interventions is set out in terms 4 hour target improvements in line with the H2 operating guidance it is expected that the interventions will also have impact across a range of KPIs including compliance with clinical review standards for UEC i.e. time to assessment, ambulance handover, compliance and reducing 12 hour LOS in ED



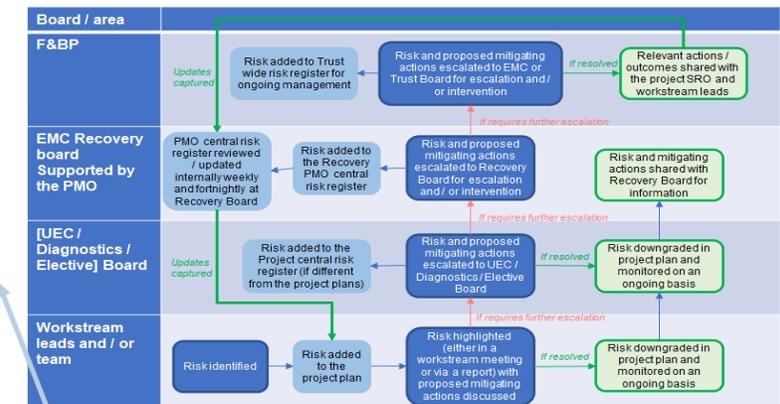
# Programme risks and management

Risks to the improvement programme are tracked with mitigating actions identified and followed up on. The table below sets out a subset of the key risks identified, both programme risks as well as quality/safety concerns, alongside owner and mitigation.

Alongside the programme risk register the trust also maintains a corporate risk register for managing quality and risk at the highest level. Details of this are set out in the quality sections.

Risk level	Risk	Risk detail	Impact (1-5)	Likelihood (1-5)	Score	Suggested owner	Suggested mitigating actions
Programme	Endoscopy capacity	Limited staffing capacity may mean difficulty to clear endoscopy long waits, which may in turn impact other pathways requiring this diagnostic intervention	4	5	20	DD for Medicine	(1) Provide targeted enabling workstream (workforce) support to be provided to the Endoscopy management team, potential solutions may include: (a) Exploring the idea of pooling staffing solutions e.g. reaching out to system colleagues, exploring single procurement options, working with teams to understand the skillset required to confirm if posts identified can be adjusted at all to aid recruitment, etc. (b) ensuring that BHTs locum and overtime rates are competitive
Programme	Clinical harms for P2s	Continued numbers for high clinical priority patients (P2) waiting over four weeks may represent a clinical risk if not booked or reviewed as not clinically urgent	4	4	16	Chief Nurse	(1) Scope additional capacity to support clinical waiting list validation (2) Continue harm review process to ensure patient pathways are continuously monitored and escalated as appropriate (3) Review booking prioritisation processes and ensure that the correct booking prioritisation is being applied (4) Ensure that the correct P category is assigned in accordance in national criteria
Programme	Staff availability	Ongoing difficulties finding appropriately skilled staff to recruit substantively or through bank and agency may limit services ability to actualise recovery plans	3	5	15	Workforce workstream	Ensure close alignment between the recovery delivery workstreams and workforce workstream, share delivery workstream plans as they become available.
Programme	Booking and prep team	Risk to sustainability of preoperative and booking administration team due to burnout	5	3	15	DD for specialist services	(1) Scope additional capacity to support to the booking and scheduling team (2) Conduct a review of processes and current workload to look to streamline efforts if at all possible
Programme	Long waits non-admitted converting to long wait admitted	Delays in outpatient appointments may mean that patients 'come on to' the admitted pathway already as long waiters	3	4	12	Outpatients workstream	Ensure that this is addressed in the Outpatient recovery workstream plan and provide support as required
Programme	D categorisation and single diagnostic PTL	No visibility of robust plans for full compliance with diagnostic categorisation may mean trust becomes non-compliant with national request. Single diagnostic PTL not complete, making it challenging to book in correct order	3	4	12	Diagnostics project	Ensure that this is addressed in the Diagnostic recovery workstream plan and provide support as required
Programme	Theatre availability	Limited theatre capacity at times when surgeons are scheduled to work risks slowing admitted recovery	3	4	12	Theatres workstream	Ensure that this is addressed in the Theatres recovery workstream plan and provide support as required
Programme	104+ from diagnostics	Patients on a diagnostic pathway converts to admitted pathway at a breach position	3	4	12	Diagnostics project	All patients on the diagnostic pathway that are nearing 6 breaches to be reviewed and a plan agreed, on an ongoing basis
Programme	104+ from patient choice	Patients cancel leaving insufficient time to rebook before a breach occurs	3	4	12	Booking and scheduling workstream	(1) Review reasons for cancellation (2) Review pre operative processes and explore opportunities to implement further measures to confirm that patients are attending e.g. Text reminders?
Programme	Recruitment impacting UEC performance	Risk of stalling improvement in UEC performance if unable to recruit sufficiently	3	4	12	Workforce workstream	(1) Provide targeted enabling workstream (workforce) support to be provided to the UEC management team, potential solutions may include: (a) Exploring the idea of pooling staffing solutions e.g. reaching out to system colleagues, exploring single procurement options, working with teams to understand the skillset required to confirm if posts identified can be adjusted at all to aid recruitment, etc. (b) ensuring that BHTs locum and overtime rates are competitive

As previously discussed, risks and issues are managed via a structured framework. This will be subject to review further to support from central and regional colleagues.



# Introduction on communications

Central to our recovery communication strategy will be ensuring colleagues feel involved in developing and delivering the recovery programme, regardless of role and seniority. It is also key that colleagues understand the extent of the current operational challenges and understand what their role is in order to improve the situation. This applies to both clinical and non-clinical colleagues, as we continue to reinforce the message that we are 'one team'.

We need to describe a clear roadmap so that everyone has a consistent and defined view of where we are heading and how we will know when we've arrived. As well as making colleagues feel informed and involved, this clarity can give people greater confidence to make decisions and perform their roles.

Effective communication can also align and guide teams on how to prioritise and distribute effort, understanding how a smaller project fits into the overall picture and why a specific deadline is important.

Celebrating success, both collectively and individually, will be important to ensure we maintain momentum and motivation as we travel on the recovery journey together.

We will build on existing communications channels whilst exploring opportunities for new ones. Whilst central communications channels will play an important role, senior leaders have a crucial role to play in embedding the programme, role modelling to their teams and providing visible leadership and support.

## Communication objective are to ensure colleagues ...

- are aware of our **current operational performance** and areas of **concern**
- understand **the objectives** of the recovery programme and how it is being **managed**
- feel **valued** and appreciated
- **know** they are listened to
- can **access** information they need in an easy and timely manner
- understand **how** changes affect them and our service users
- understand **why** decisions have been taken
- understand **the part** they have to play in delivering recovery
- are **proud** to work for BHT

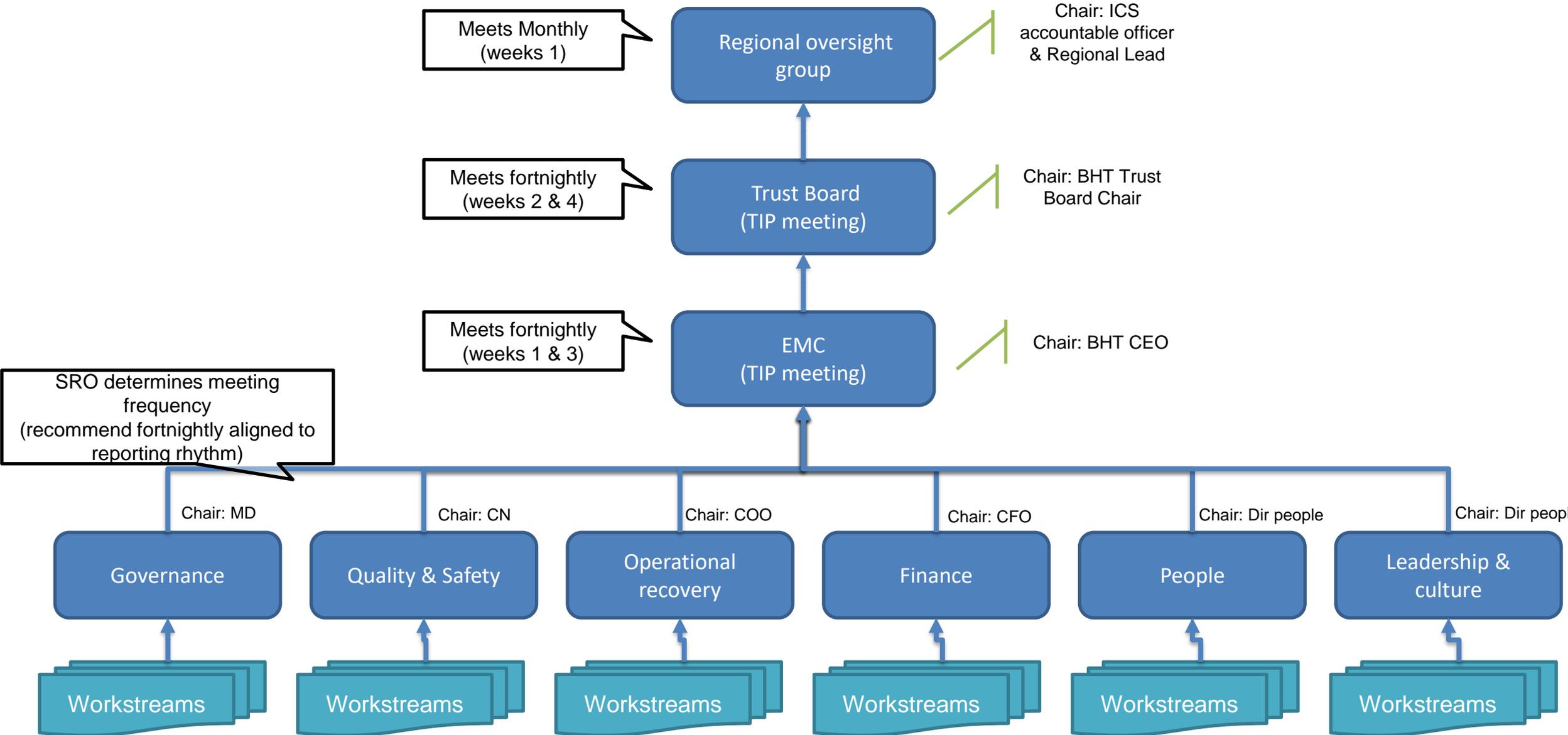
## A detailed communication plan is available on request



# Governance and next steps: Trust Improvement Programme

# BHT Trust Improvement Programme – board and groups

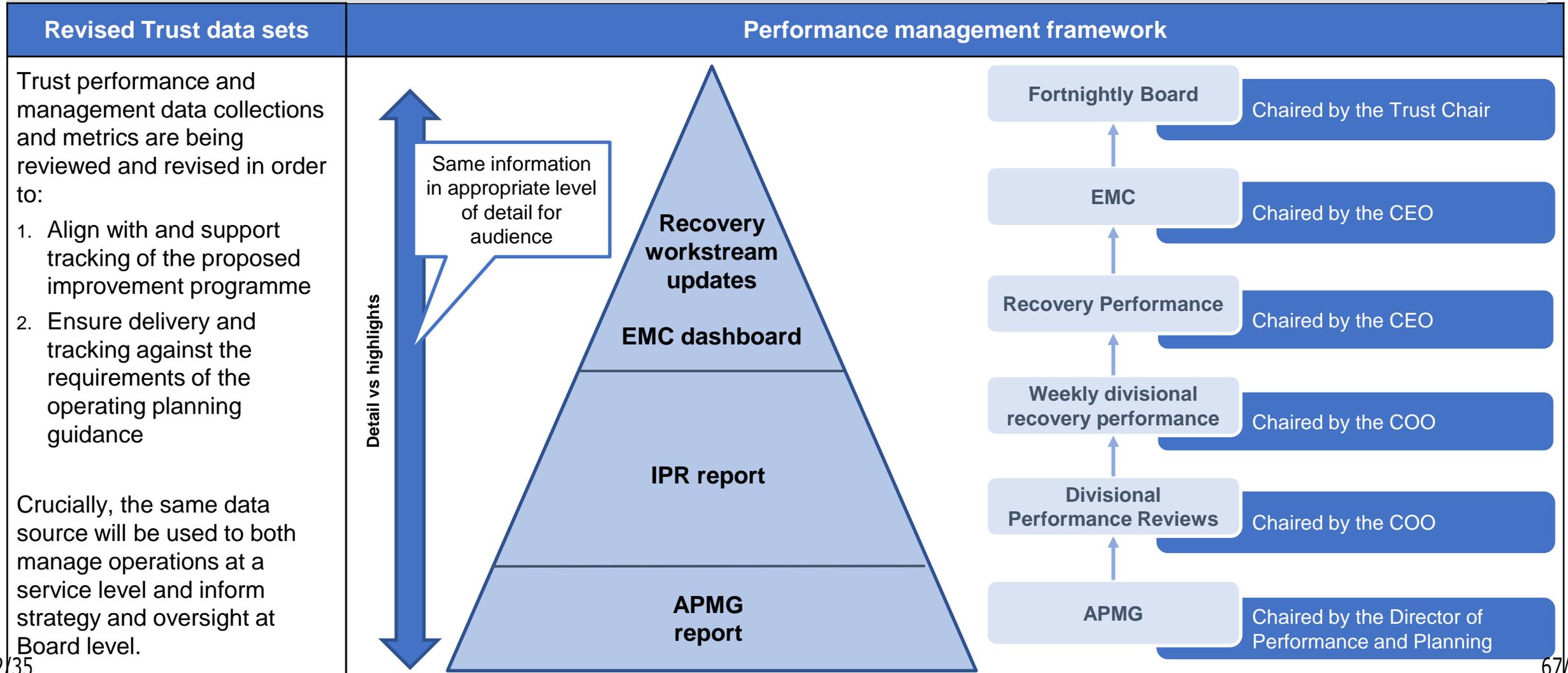
The Trust Improvement Programme brings together improvement plans from operational divisions, workforce, finance, quality, performance and transformation. A draft governance structure for the programme is shown below.



# Governance: Trust Improvement Programme

## Performance management framework

Underpinning the improvement programme is a comprehensive performance framework supported by managed performance information flows. This will allow the Trust to work with 'one version of the truth' while providing the right level of detail depending on context. The framework of performance meetings has been revised to provide good grip and control over performance improvement and early correction where issues arise. At the highest level, the full board will now meet twice monthly to review progress.



# Improvement plan – operational workstreams and outcomes

Project	Workstream	Key metrics	Aspirations / targets	Target date
Elective recovery	Outpatient transformation	<ul style="list-style-type: none"> <li>Number of non-admitted 52 week breaches</li> <li>Non-admitted clock stop levels</li> </ul>	<ul style="list-style-type: none"> <li>Below Sept level (3,731) by March 2022</li> <li>At least 89% of 19/20 levels from Dec 2021</li> </ul>	31/03/22
Elective recovery	Theatre productivity / planning	<ul style="list-style-type: none"> <li>Number of admitted 52 week breaches</li> <li>Admitted clock stop levels</li> <li>Compliance Waited Activity Unit peer group as per GIRFT</li> </ul>	<ul style="list-style-type: none"> <li>Less than Sept level (1,492) by March 2022</li> <li>At least 89% of 19/20 levels from Dec 2021</li> <li>In line with peer group by March 2023</li> </ul>	31/03/22
Elective & Diagnostic recovery	Booking and scheduling	<ul style="list-style-type: none"> <li>P2 patients waiting longer than 4 weeks</li> <li>Non-admitted patients booked</li> <li>Admitted patients booked at 6 weeks</li> </ul>	<ul style="list-style-type: none"> <li>&lt;205</li> <li>70%</li> <li>70%</li> </ul>	28/01/22
Elective & Diagnostic recovery	Independent Sector	<ul style="list-style-type: none"> <li>Independent Sector utilisation</li> </ul>	<ul style="list-style-type: none"> <li>At least 120% of 19/20 levels.</li> </ul>	28/01/22
Elective & Diagnostic recovery	Cancer	<ul style="list-style-type: none"> <li>Cancer Wait Times (CWT) performance - 62-day pathway standard.</li> </ul>	<ul style="list-style-type: none"> <li>85% compliance</li> </ul>	29/04/22
Diagnostic recovery	Endoscopy	<ul style="list-style-type: none"> <li>Endoscopic patients waiting more than 6 weeks</li> </ul>	<ul style="list-style-type: none"> <li>Less than 400</li> </ul>	28/03/22
Diagnostic recovery	Radiology productivity	<ul style="list-style-type: none"> <li>Non-endoscopic DM01 breaches</li> </ul>	<ul style="list-style-type: none"> <li>&lt;1%</li> </ul>	31/12/22
UEC recovery	Front door	<ul style="list-style-type: none"> <li>ED 4 hour breaches weekly average</li> <li>12 hour waits in ED</li> <li>Ambulance Handovers Within 15 Minutes</li> </ul>	<ul style="list-style-type: none"> <li>Less than 400</li> <li>Less than 2% of attendance</li> <li>&gt;75%</li> </ul>	31/03/22
UEC recovery	Ambulation and acute	<ul style="list-style-type: none"> <li>SDEC attendances (incl. trajectory)</li> <li>12 hour waits in ED</li> <li>Ambulance Handovers Within 15 Minutes</li> </ul>	<ul style="list-style-type: none"> <li>1,417</li> <li>Less than 2% of attendance</li> <li>&gt;75%</li> </ul>	31/03/22
UEC recovery	Get me home	<ul style="list-style-type: none"> <li>Total MOFD patients average daily per month over 48hrs</li> <li>21+ day LOS</li> </ul>	<ul style="list-style-type: none"> <li>&lt;35</li> <li>&lt;35</li> </ul>	31/03/22

# Improvement plan – corporate workstreams and outcomes

Area	Workstream	Key metrics	Aspirations / targets	Target date
Governance and management	Recruitment of new Chair	<ul style="list-style-type: none"> <li>Appointment of new Chair</li> </ul>	<ul style="list-style-type: none"> <li>Interviews 6 December, new chair appointed before the New Year</li> </ul>	01/01/22
Governance and management	Performance and reporting	<ul style="list-style-type: none"> <li>Embedded reporting framework</li> <li>Tracking and delivering H2 operational planning requirements</li> </ul>	<ul style="list-style-type: none"> <li>IPR report in place and delivered fortnightly</li> <li>H2 operational requirements met</li> </ul>	28/12/21 31/03/22
Governance and management	Programme management	<ul style="list-style-type: none"> <li>Milestone delivery</li> </ul>	<ul style="list-style-type: none"> <li>Delivered 90% of milestones on time</li> </ul>	01/07/22
Leadership & colleagues	Recruitment and Retention	<ul style="list-style-type: none"> <li>Nursing, midwifery and health visiting vacancy rate</li> </ul>	<ul style="list-style-type: none"> <li>8.8% by end of financial year</li> </ul>	31/03/22
Leadership & colleagues	Recruitment and Retention	<ul style="list-style-type: none"> <li>Turnover rate</li> </ul>	<ul style="list-style-type: none"> <li>13.5% or less by end of financial year</li> </ul>	31/03/22
Leadership & colleagues	Communications	<ul style="list-style-type: none"> <li>% of staff who respond to staff survey report that they are aware of the Improvement Programme</li> </ul>	<ul style="list-style-type: none"> <li>70%</li> </ul>	28/01/22
Quality & safety	Clinical risk oversight improvements	<ul style="list-style-type: none"> <li>Reported errors and DATIX numbers</li> <li>Patient harm identified</li> <li>NICE compliance</li> </ul>	<ul style="list-style-type: none"> <li>Increase from 20/21 baseline</li> <li>Decrease from 20/21 baseline</li> <li>Improved outcome of NICE audit of 20/21</li> </ul>	31/03/23
Quality & safety	Clinical harm management	<ul style="list-style-type: none"> <li>Morbidity and mortality rates</li> <li>Nosocomial infection rate for COVID-19</li> </ul>	<ul style="list-style-type: none"> <li>Reduction from 20/21 baseline</li> </ul>	31/03/23
Quality & safety	Patient experience improvements	<ul style="list-style-type: none"> <li>Patient satisfaction and staff experience survey results</li> </ul>	<ul style="list-style-type: none"> <li>Improvement from 20/21 baseline</li> </ul>	31/03/23
Quality & safety	Quality and safety improvements	<ul style="list-style-type: none"> <li>Avoidable harm and death associated with missed opportunities</li> </ul>	<ul style="list-style-type: none"> <li>Reduction from 20/21 baseline</li> </ul>	31/03/23
Finance	Non-pay operational efficiencies	<ul style="list-style-type: none"> <li>Delivered efficiencies</li> </ul>	<ul style="list-style-type: none"> <li>£1m</li> </ul>	31/03/23
Finance	Grip and control	<ul style="list-style-type: none"> <li>Temporary staffing approvals</li> </ul>	<ul style="list-style-type: none"> <li>Reduced compared to 21/22 levels</li> </ul>	31/03/23
Finance	LTFM	<ul style="list-style-type: none"> <li>System progress</li> </ul>	<ul style="list-style-type: none"> <li>Model completed</li> <li>Financial strategy agreed</li> </ul>	31/03/22

# Governance and board-level oversight

Reflecting the vital importance to the trust of delivering this integrated improvement plan, a decision has been taken to convene the full Trust Board at fortnightly intervals. The express purpose of this fortnightly board will be to review progress against the integrated improvement plan and its related metrics. The decision was taken to convene a full board, rather than subcommittee, in order to provide holistic oversight of what is a trust wide endeavour.

Acknowledging the complexity and scope of the integrated improvement plan, a companion tracking tool will be developed and used to inform, update and assure the board on progress. An early example of the elective care and urgent and emergency care plan trackers are copied out below

## Key new governance actions

- Full board to be convened fortnightly
- Focus of fortnightly meetings will be on tracking and assuring the delivery of the integrated improvement plan
- Full board will be convened, rather than subcommittees, to ensure holistic review
- Bespoke integrated improvement plan tracker will be used to provide clarity against the backdrop of a large and complex plan
- Brought forward timeframe for recruitment of a new Trust Chair

## Example Board-level plan trackers

ID	Type of Intervent	Area of Impact	Action / Solution headline	Action / Solution detail	Phase	Target end dt	Status	Expected impact (tick stops)	Lead Elective recovery KPI
1	Staffing and capacity	All planned care	Agency/bank utilisation	Work with HR to ensure full use of agency and bank capacity/staff to fill gaps in roles	0-3 months	31/01/2022	Ongoing	100.00	Clock stops compared to 19/20
2	Staffing and capacity	All planned care	Short-term recruitment	Begin recruitment to increase numbers of fixed term mixed workforce agreed using ERF funding	0-3 months	31/01/2022	In progress	100.00	Clock stops compared to 19/20
3	System and partners	Elective	Full utilisation of local IS	Track utilisation of IS contracts at service level and ensure full use month on month. Work with CCG colleagues to develop and fund longer term IS contractual	0-3 months	31/01/2022	In progress	150.00	Total 52-week breaches
4	Staffing and capacity	Elective	Pre-op 'buffer' for full list utilisation	Implement call centre and pre-op to contact patients to utilise short notice capacity and enable launch of Evolve software ready pool of short notice	0-3 months	31/01/2022	In progress	100.00	Clock stops compared to 19/20
5	Staffing and capacity	Elective	Locum pay rates review for WLU	Review locum pay rates and release additional short-term locum funding to implementation of NLA guidelines with support from Four eyes consultancy. Ensure compliance with productivity and efficiency opportunities identified by GIRFT and model hospital. E.g. moving to 3 sessions	0-3 months	31/01/2022	Done		Clock stops compared to 19/20
6	Process and protocol	Elective	Theatre productivity gains	Implement of weekly escalation meetings chaired by the COO or nominated deputy, these escalating to CEO weekly	0-3 months	31/01/2022	Ongoing	40.00	Clock stops compared to 19/20
7	Process and protocol	Outpatients	RAS and A&G demand management	Improve the % resolved at RAS includes via A&G. Target services with low resolution.	0-3 months	31/01/2022	Ongoing		RTT performance
8	Culture and leadership	All planned care	Weekly escalation meetings	Implement of weekly escalation meetings chaired by the COO or nominated deputy, these escalating to CEO weekly	0-3 months	31/01/2022	Ongoing	60.00	Total 52-week breaches
9	Process and protocol	Outpatients	Implement PFIU	Implement PFIU across all major non-emergency specialties support demand	0-3 months	31/01/2022	Ongoing		RTT performance
10	Process and protocol	Elective	Alternative setting surgery	Mitigate demand for operating theatres by agreeing which procedures can be done in alternative settings.	0-3 months	31/01/2022	In progress	40.00	Clock stops compared to 19/20
11	Process and protocol	Elective	Implement 'perfect week' training	Embed learnings from 'perfect week' into 'level six' practice	0-3 months	31/01/2022	In progress	40.00	RTT performance
12	Process and protocol	Elective	Increase booking density using 6-4-2 methodology	Agree a consistent structure for 6-4-2 meeting. Re-circulate Toll and what information each attendee is required to bring to each meeting. Embed changes into calendar the best use of current Theatre capacity is per Four Eyes. Methodology for	0-3 months	31/01/2022	In progress	95.00	Total 52-week breaches
13	Process and protocol	Revised theatre			0-3 months				
49	Staffing/ Capacity	ED		Review recruitment and retention premium for consultants and registrars - match local providers		05/07/2021	1	Mean time to see a clinician	<60 minutes
24	Staffing/ Capacity	ED		Extend Minor Injuries and GP streaming delivery times to meet demand (using bank and agency in first instance)		05/07/2021	1	Mean time to see a clinician	100%
46	Staffing/ Capacity	Flow		Begin recruitment to increase numbers of mixed workforce agreed at EMC - initially through bank/agency while permanent recruitment takes place		21/06/2021	1	Type 1 stays in ED on arrival < 12 hours	<60 minutes
31	Wider trust			Triage direct to SDEC		05/07/2021	1	Mean time to see a clinician	WDEF1
				Code sign a full ED standard operating procedure including: • How shifts is run • Roles and responsibilities (see above)					

(note: pictured is only a small illustrative extract of the trackers)

## Next month's report

From mid November 2021 the format of this report will change to incorporate the wider Trust Improvement Programme. Reporting will be fortnightly. The work stream and metric updates will encompass

- Governance
- Quality & Safety
- Finance
- People
- Culture & Leadership
- Operational Delivery

**Meeting:** Trust Board Meeting in Public

**24 November 2021**

<b>Agenda item</b>	EPRR Annual Assurance
<b>Board Lead</b>	Chief Operating Officer
<b>Type name of Author</b>	Emergency Planning
<b>Attachments</b>	BHT EPRR Board Report
<b>Purpose</b>	Assurance
<b>Previously considered</b>	F&BP 16.11.2021

### Executive Summary

Annually, the Trust audits itself and goes through a check-and-challenge process with NHS Buckinghamshire CCG and NHS England to ensure compliance with the NHS EPRR 'Core Standards', which reflect NHS statutory duties under the Civil Contingencies Act 2004.

The Trust's rating for 2021-22 is fully compliant with the Core Standards.

The attached documentation and evidence was scrutinised and approved by the CCG Resilience Manager and the Trust Emergency Planning leads, and accepted by NHS England EPRR Senior Manager.

The assurance process requires the approved documentation and confirmation of compliance status to be noted by the Trust's Executive Team and through the Public Board process.

The Finance and Business Performance Committee were assured by this report at the Committee meeting on 16 November 2021.

<b>Decision</b>	The Board is requested to take assurance from this report.
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### Relevant Strategic Priority

<b>Outstanding Care</b> <input checked="" type="checkbox"/>	<b>Healthy Communities</b> <input checked="" type="checkbox"/>	<b>Great Place to Work</b> <input type="checkbox"/>	<b>Net Zero</b> <input type="checkbox"/>
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### Implications / Impact

<b>Patient Safety</b>	No direct impact from this assurance process, full compliance with the assurance ensures BHT is working to the highest standard
<b>Risk: link to Board Assurance Framework (BAF)/ Risk Register</b>	No associated risks with this assurance process
<b>Financial</b>	No financial impact

<b>Compliance</b> Select an item. Select CQC standard from list.	Compliance with NHS England and NHS Improvement EPRR Annual Assurance process
<b>Partnership: consultation / communication</b>	All required consultation with internal partners, CCG, and NHS England to achieve approval
<b>Equality</b>	No direct impact from this assurance process, full compliance with the assurance ensures BHT is working to correct standards
<b>Quality Impact Assessment [QIA] completion required?</b>	No

# Emergency Preparedness, Resilience and Response (EPRR) Board report

## November 2021

### Background

The Trust has duties and responsibilities in Emergency Preparedness, Resilience and Response. This report provides an update on these requirements and activities in evidence of their completion and competence.

The Civil Contingencies Act (CCA) 2004 is a statutory document detailing the UK's response to civil emergencies. The Act sets out two categories of responders. Category 1 responders have a statutory requirement to fulfil the full remit of the Act, whilst Category 2 responders have a supporting obligation.

As an acute health care provider BHT, is a designated Category 1 responder with a duty to:

- Risk Assess (prioritisation and mitigation)
- Ensure plans are in place (covering the organisation and linking with multi-agency partners)
- Warn, inform, and advise (for patients and the public)
- Co-operate in resilience planning and preparations (working with the Thames Valley Local Resilience Forum)
- Engage in Business Continuity Management (within the organisation and linking with multi-agency partners)
- Sharing information (with partner organisations and the Thames Valley Local Resilience Forum)

### Assurance

Health organisations evidence their compliance with the CCA via the 'NHS EPRR Core Standards' which are created by NHS England as a set of criteria to follow and audit against. This report covers our compliance with governance, assurance, and systems working in more detailed sections below.

For 2021/22: **The Trust will be be Fully Compliant with the standards.**

### Governance

To ensure full compliance as a Category 1 responder, the Trust has several key items in place:

- A designated Accountable Emergency Officer (AEO), a role fulfilled by the Chief Operating Officer
- The AEO chairs the Trust Resilience Committee. This committee meets every two months and includes attendance from across all the Divisions including senior managers and clinicians
- The Trust employs a full time Emergency Planning Officer and part time Emergency Planning Support Officer
- Overseen by, and reporting to, the Resilience Committee are the key workstreams. These each have a project group for each specific area in which BHT is required to have plans. These include:
  - Command and Control,

- Major/Mass Casualties,
- Contaminated casualties (Hazmat/CBRN),
- Severe Weather,
- Mass Fatalities,
- Pandemic Influenza,
- Evacuation,
- Lockdown,
- Business Continuity

The Trust runs a raft of training for key staff ranging from Strategic and Tactical Leadership training for all on call Gold and Silver commanders, allied training to key staff groups and specific training for example to clinical and receptionist staff within the emergency department. Much of the training is mandatory for key staff groups and includes a basic EPRR e-learning module for **all** staff.

### **External/Internal Assurance:**

To comply with the CCA 2004 the Trust is also required to host tabletop exercises, and a live exercise every three years. Periods in which a real incident is managed also suffices for the standard.

Regular table top exercises allow for scenarios and plans to be tested and ensures adequate opportunities for all Gold and Silver Commanders and other key staff to attend.

All Gold and Silver Commanders are required to participate in a table top exercise every two years, and names are allocated on a rotational basis to attend.

Table top exercises run/BHT participation in include:

- 1) Regional Exercise Novus Coronet (Pandemic Influenza)
- 2) Trust wide Covid-19 table top exercise (Pandemic Influenza)
- 3) Oxygen Supply Loss exercise (Covid-19)
- 4) Women's & Children Division Covid-19 Surge/Wave 2 table top exercise
- 5) Regional Burns Exercise Comet (Burns surge & Escalation)
- 6) Trust IT Cyber Security attack table top exercise
- 7) OUH Major Incident ED table top exercise (BHT EPO supported)
- 8) Regional Exercise TalkTalk (Major Incident cascade)
- 9) Maternity Infant abduction departmental simulation
- 10) Major Incident on-call bleeps and nurse bleep holder Communications cascade exercise test

A Trust wide table top exercise for a Major Incident involving Mass Casualties and potentially HazMat contaminated casualties is being planned. As part of this exercise, the Trust's Emotional Wellbeing Response will also be tested.

Compliance against live exercise requirements can be achieved in the event of any live incidents' where plans have been invoked. The Trust has experienced Business Continuity issues including:

- Covid-19 pandemic response
- Critical Incident declared due to damaged infrastructure
- Critical Incidents declared due to capacity and flow
- Bleep system faults and system upgrades
- Significant snowfall affecting travel

- Significant heat events

The above required the Incident Response policy and business continuity plans to also be invoked.

The Trust Fire Safety Officer also runs regular 'live' fire evacuation drills within the clinical areas and reports back regular on learnings to the Trust Resilience Committee.

## **Risk Assessments**

To be compliant with the CCA the Trust is required to undertake risk assessments. This is documented on the Trust EPRR risk register and forms a standing agenda item at the Resilience Committee and each of the workstream groups. The Risk register is also formally reviewed monthly by the Trust Governance Manager at the Risk and Compliance Governance meetings which the Trusts EPO attends. Any high-level risks are included on the Corporate risk register.

## **Whole Systems**

The Trust cooperates in resilience with the following in place:

- Attendance at the Local Resilience Forum (LRF) Resilience Group chaired by the Local Authority. This group has representation from all emergency services, health, local authorities, utilities companies and voluntary sector. It meets on a regular basis to share information, review regional risks, progress actions and mitigations, and share learning from incidents and training. It encourages joint working between whole system partners.
- Attendance at the Local Health Resilience Partnership (LHRP) Executive Group: This is a strategic group with representation from all health partners including NHS England, UK Health Security Agency, CCG and Ambulance Service. The Acute providers are represented by their AEO. It provides a strategic plan for Health against the core standards and required actions, and links into the National NHS England Resilience Team.
- Attendance at the LHRP business group: This is the tactical (working) group at which the provider and CCG EPOs attend. The role of the group is to ensure completion of the Strategic objectives and to raise any issues or risks to the LHRP.

## **NHSEI EPRR Annual Assurance process:**

NHSEI publishes NHS core standards for Emergency Preparedness, Resilience and Response arrangements. These are the standards which NHS organisations and providers of NHS funded care must meet. The Accountable Emergency Officer in each organisation is responsible for making sure these standards are met. Trusts are required to provide formal assurance to NHS England on a yearly basis, which takes the form of a compliance matrix against which The Trust assesses itself. This RAG rating once approved at the Trust Resilience Committee is signed off by the AEO and is submitted to the CCG AEO and Resilience lead. The Trust is required to attend a 'confirm and challenge' meeting with the CCG where the details of the ratings and compliance is discussed and agreed. Formal submission of this rating along with an overall compliance rating plus an action plan for any amber or red rated areas is submitted via the CCG to NHS England.

## 2021/2022 Assurance

NHSEI have published the EPRR Core Standards for 2021/2022. Upon review, there are **not expected** to be any issues relating to the Core Standard requirements for this period for the Trust. Submission of the Annual Assurance Process to NHSEI will be completed within the timescales requested following approval from the Trust AEO, having completed our check and challenge discussions with the CCG and having this accepted by NHSE EPRR.

The Trust reports full compliance with the standards.

Quarterly assurance and discussion meetings also continue between BHT EPRR and CCG EPRR. In addition to this, the EPRR teams at the CCG, BC and BHT have a weekly standing teleconference discussing mutual planning concerns and support.

**NHS England South EPRR Assurance compliance ratings** - To support a standardised approach to assessing an organisation's overall preparedness rating NHS England have set the following criteria:

Compliance Level	Evaluation and Testing Conclusion
Full	Arrangements are in place that appropriately addresses all the core standards that the organisation is expected to achieve. The Board has agreed with this position statement.
Substantial	Arrangements are in place however they do not appropriately address one to five of the core standards that the organisation is expected to achieve. A work plan is in place that the Board has agreed.
Partial	Arrangements are in place, however they do not appropriately address six to ten of the core standards that the organisation is expected to achieve. A work plan is in place that the Board has agreed.
Non-compliant	Arrangements in place do not appropriately address 11 or more core standards that the organisation is expected to achieve. A work plan has been agreed by the Board and will be monitored on a quarterly basis in order to demonstrate future compliance.

## Conclusion

Overall, the Trust is in a good position in terms of its EPRR obligations. It has been noted that as a Trust we do have a high level of 'buy in' and co-operation from senior managers, Executives and clinicians in terms of planning, training and exercising.

**Meeting:** Trust Board Meeting in Public

**24 November 2021**

<b>Agenda item</b>	Domestic Violence and Abuse Annual Report 2021
<b>Board Lead</b>	Neil Macdonald, Chief Executive Officer
<b>Type name of Author</b>	Dr Jane O'Grady, Director of Public Health for Buckinghamshire
<b>Attachments</b>	Bucks Council Director of Public Health Annual Report 2021
<b>Purpose</b>	Information
<b>Previously considered</b>	n/a

### Executive Summary

This report covers key areas related to domestic violence and abuse including how to recognise the signs, where to get help, who may be at greatest risk and when. It also includes information on those interventions that contribute to reducing the risk and harm of domestic abuse and the need for further work on this.

The report is informed by a needs assessment undertaken by Buckinghamshire Council, views from victims and service users, frontline professionals and organisations within Buckinghamshire. The report makes recommendations based on the local situation for a range of partners within the County to implement.

<b>Decision</b>	The Board is requested to note this report.
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### Relevant Strategic Priority

<b>Outstanding Care</b> <input checked="" type="checkbox"/>	<b>Healthy Communities</b> <input checked="" type="checkbox"/>	<b>Great Place to Work</b> <input type="checkbox"/>	<b>Net Zero</b> <input type="checkbox"/>
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### Implications / Impact

<b>Patient Safety</b>	One in 20 adults are estimated to experience domestic abuse every year with the prevalence highlighted by the pandemic.
<b>Risk: link to Board Assurance Framework (BAF)/Risk Register</b>	BAF 4.2 – Changes in the ICS and in Buckinghamshire; 'Integration and Innovation: working together to improve health and social care for all'.
<b>Financial</b>	Not applicable
<b>Compliance CQC Standards Safeguarding</b>	The information contained within this report will support the Trust in safeguarding our patients and the local community.
<b>Partnership: consultation / communication</b>	Ending domestic abuse requires a coordinated response from system partners. The report will be presented by

	the Director of Public Health for Buckinghamshire.
<b>Equality</b>	It is recognised that domestic abuse can happen to anyone at any age, across all gender identities and ethnic groups.
<b>Quality Impact Assessment [QIA] completion required?</b>	n/a

**See separate report.**



# DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT 2021

## Domestic Violence and Abuse



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## Acknowledgements

Thanks to all who participated in the domestic violence and abuse needs assessment and in compiling this report, especially those who allowed us to reflect their views and personal stories. Also particular thanks to Lucy Cunningham who led on pulling together all the information for this report.

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### Contributing stakeholders:

Adam Johnson  
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Claire Hawkes  
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Jenny Chapman  
Karen Ross  
Lisa Latchford  
Louise Hurst  
Lucy Cunningham  
Mollie Raine  
Sanita Kalyan  
Sue Hinks  
Teresa Martin  
Tiffany Burch

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Thank you to the survivors and service users who shared their experiences.



If you think you or someone you know may be experiencing domestic abuse, go to [reducingtherisk.org.uk/Buckinghamshire](https://reducingtherisk.org.uk/Buckinghamshire) for support and advice.

# 1. INTRODUCTION

**This year my Director of Public Health Annual Report focuses on domestic violence and abuse.**

One in 20 adults are estimated to experience domestic abuse every year equating to almost 21,000 people a year in Buckinghamshire or 57 people every day. Women are more commonly victims of domestic abuse than men but it can happen to anyone, at any age, across all gender identities, ethnic groups and walks of life.

Domestic abuse is a crime often hidden from view, at home and out of sight. It often goes unreported, as victims and witnesses such as children in the family may not report abuse for many different reasons. Surveys suggest fewer than one in five women experiencing domestic abuse report it to police. On average it takes three years for victims of domestic abuse to access support services.

Domestic abuse has a profound impact on victims and survivors, their family and wider society. Domestic abuse causes poor physical and mental health both in the short and long term, and in some extreme cases death. There are also serious consequences for children in the household witnessing domestic abuse with impacts on their mental and physical health, safety and educational attainment. Domestic abuse also contributes significantly to homelessness and increases the risk of poverty for victims and their children. The Home Office estimates that the economic and social costs of domestic abuse are over £66 billion in England and Wales.

The prevalence of domestic abuse was vividly highlighted during the Covid-19 pandemic. During and following the first lockdown, data up to January 2021 showed a 15% increase in domestic abuse crimes reported to police for Buckinghamshire with a 13% increase in known victims and perpetrators. Service data showed an increase in demand for domestic abuse support services.

Ending domestic abuse is everyone's business and requires a co-ordinated response from national government, local partners and the public.

This report is informed by a needs assessment undertaken by Buckinghamshire Council, views from victims and service users, frontline professionals and organisations in Buckinghamshire. It covers key areas including how to recognise signs of domestic abuse and where to get help, who may be at greater risk of experiencing abuse and when, including research on the warning signs leading up to domestic homicides. It also covers what is known about interventions that contribute to reducing the risk and harms of domestic abuse and the need for more work to focus on preventing perpetrators from committing domestic abuse. The Domestic Abuse Bill 2021 was recently passed in April and will also inform local actions. My report makes recommendations based on our local situation for a range of partners in Buckinghamshire to implement.

Finally I would like to thank all those who participated in the needs assessment and in compiling this report, especially those who allowed us to reflect their views and personal stories. I hope that the coming years will see us make very significant progress in reducing domestic abuse in Buckinghamshire and offering effective support to all those affected.

**Dr Jane O'Grady**  
**June 2021**

## 2. WHAT IS DOMESTIC ABUSE AND HOW CAN WE RECOGNISE IT?

### What is Domestic Abuse?

The Domestic Abuse Bill (2021) sets out a new statutory definition of domestic abuse that covers both the nature of the relationship and the range of behaviours that are considered abusive.<sup>1</sup>

It says that **behaviour is abusive** if it consists of any of the following:

1. Physical or sexual abuse.
2. Violent or threatening behaviour.
3. Controlling or coercive behaviour.
4. Economic abuse.
5. Psychological, emotional or other abuse.

The behaviour can consist of a single incident or ongoing behaviour.

Domestic abuse can take place in different types of relationships, it can be between family members, ex-partners and people not living together. The definition refers to people aged 16 or over, but the Bill says that children can still be victims. If the abuser directs his/her behaviour at a child in order to be abusive to another adult, this is domestic abuse (see appendix for full definition).



For women, coercive control has been shown to be the most common, and the most dangerous context of abuse.

There were 24,856 offences of coercive control recorded by the police in the year ending March 2020 in England and Wales.<sup>2</sup> It is defined as "*...assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim*". This can also include stalking, which is a pattern of persistent and unwanted attention. For women, coercive control has been shown to be the most dangerous context of abuse.<sup>3</sup>

“ In middle class suburbia, there's a culture of things being hidden. It's humiliating to admit you're going through something like this. ”

- Victim of domestic abuse, Buckinghamshire

## How can we recognise signs of domestic abuse?



Recognising domestic abuse is the first step to taking action.

Recognising domestic abuse is the first step to taking action. Some victims as well as their friends, family and colleagues may not recognise or acknowledge the abuse. There are resources available to help us all recognise domestic abuse,<sup>4</sup> and to respond effectively as a positive bystander so that we can assist victims safely.<sup>5</sup>

Signs that someone may be a victim of domestic abuse include:

- Being withdrawn.
- Becoming isolated from family and friends.
- Having bruises, burns or bite marks.
- Having finances controlled.
- Not being allowed to leave the house, or stopped from going to college or work.
- Having internet, social media or other communications monitored.
- Being repeatedly belittled, put down or told they are worthless.
- Being told that abuse is their fault, or that they are overreacting.

Children may respond to experiencing and/or witnessing abuse in different ways. Signs in children include:

- Being anxious, depressed or withdrawn, easily startled.
- Having difficulty sleeping, having nightmares or flashbacks.
- Complaining of physical symptoms such as tummy aches.
- Bed wetting.
- Developing behavioural problems e.g. temper tantrums and problems in school, behaving as though they are much younger than they are, becoming aggressive.
- Having a lowered sense of self-worth.
- Older children playing truant, using alcohol or drugs, or self-harming.
- Developing an eating disorder.
- Feeling angry, guilty, insecure, alone, frightened, powerless or confused.
- Having ambivalent feelings towards both the abuser and the non-abusing parent.

“ It took me a long time to realise there was a problem and therefore to seek help. I felt that it wasn't bad enough to be abuse because he wasn't hitting me. ”

- Victim of domestic abuse, Buckinghamshire

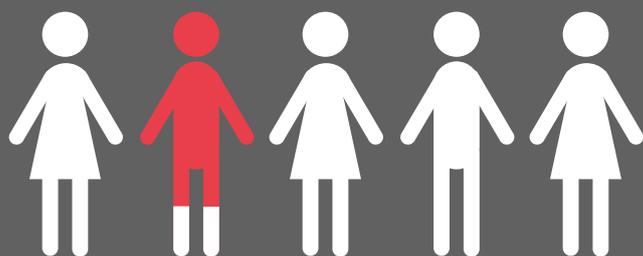
### 3. HOW COMMON IS DOMESTIC ABUSE?

#### Victims

Data on domestic abuse comes from several sources. The Crime Survey for England and Wales and national police data on recorded crime are analysed and published by the Office for National Statistics. Local data from Thames Valley Police is available to inform what is happening in Buckinghamshire.

We can also use national and local data on use of domestic abuse services to determine who is using services.

The current data have limitations. Domestic abuse often goes unreported and, when it is reported, there can be a lack of detail about the type of abuse suffered and the characteristics of people involved e.g. ethnicity. For example, fewer than one in five women (17%) who had experienced partner abuse in the year to March 2018 reported the abuse to the police.<sup>6</sup>



Fewer than one in five women (17%) who had experienced partner abuse in the year to March 2018 reported the abuse to the police.

For the year to March 2020 in England and Wales<sup>7</sup> we know that:

- One in 20 adults aged 16 to 74 years reported experiencing domestic abuse in the year to March 2020 (ONS).
- There were approximately 1.28 million recorded domestic abuse-related incidents and crimes.
- Twice as many women experienced some form of domestic abuse as men.
- Women aged 16 to 19 years were more likely to report being a victim of domestic abuse than women in all other age groups. 14% of women in this age group said that they had experienced any domestic abuse.
- For men, the age group most likely to report being a victim of domestic abuse was also 16 to 19 years old. 5% of men of this age said that they had experienced any domestic abuse.
- People with a disability were more likely to experience domestic abuse than people without a disability.

- Unemployed people were more likely to have experienced domestic abuse than those who were employed or economically inactive.
- People living in a single-parent household were more likely to experience domestic abuse.
- People in the Mixed ethnic group were more likely to experience domestic abuse compared to other ethnicity categories (Asian/Asian British, Black/Black British, White and Other).
- Women in the lowest household income bracket are four times more likely to report being victims of domestic abuse.<sup>8</sup>
- There were 357 domestic homicides between 2017 and 2019.<sup>9</sup> Men committed 86% of all domestic homicides. The victim was female in 77% of domestic homicides cases. The suspect was male in 96% of female homicides and 53% of male homicides.

We also know from research in England and Wales that:

- Women experience more of certain types of abuse: more repeated physical violence, more severe violence, more sexual violence, more coercive control, more injuries and more fear of their partner compared to men.<sup>10</sup>
- 91% of domestic violent crimes causing injuries are against women.<sup>11</sup>
- 83% of victims experiencing more than ten violent crimes are women.<sup>11</sup>



Domestic abuse affects an estimated 21,000 adults in Buckinghamshire each year, or 57 people every day.

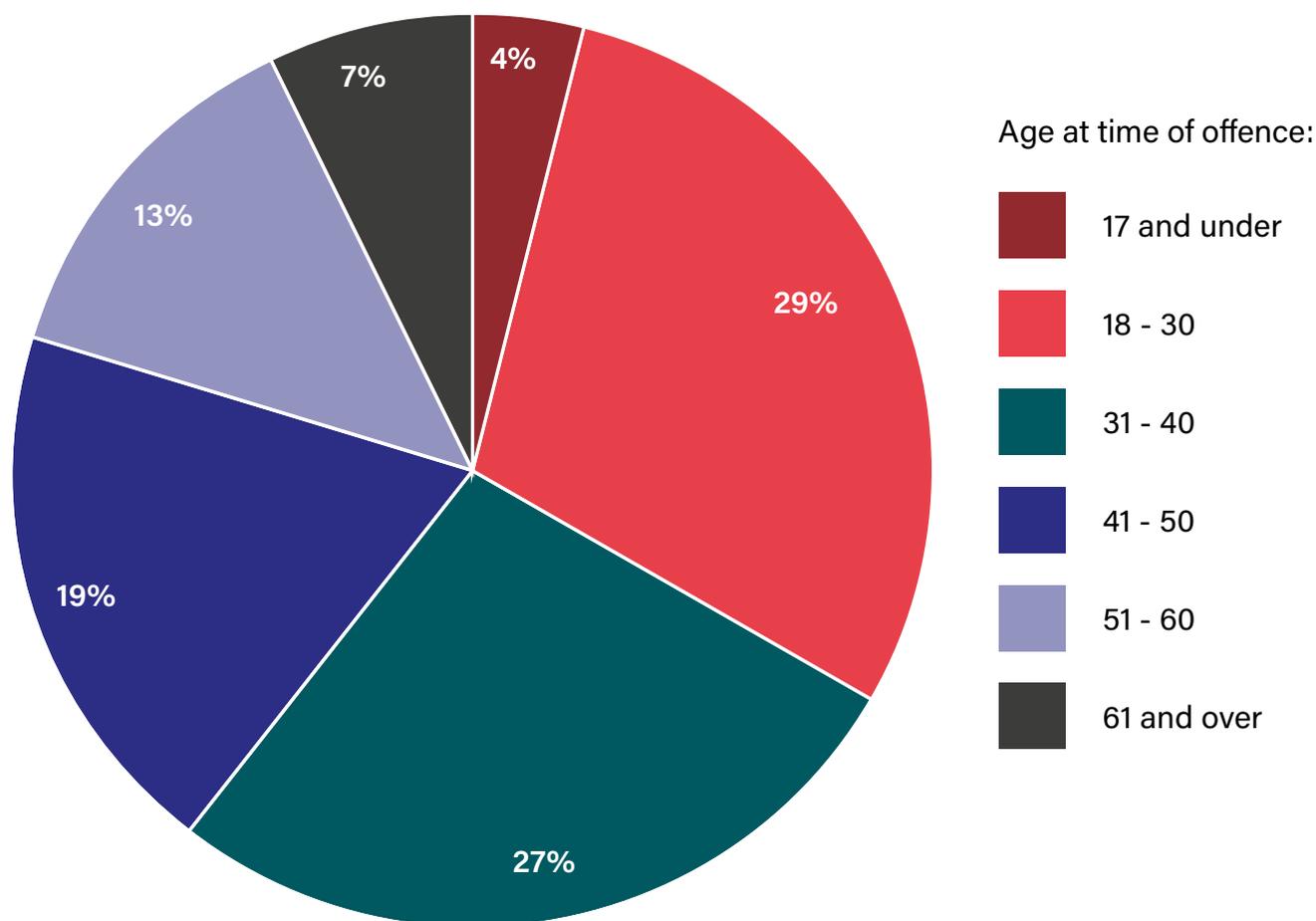
Domestic abuse data for Buckinghamshire tell us the following:

- Domestic abuse affects an estimated 21,000 adults in Buckinghamshire each year, or 57 people every day.
- Police data for Buckinghamshire from 2020 to 2021 showed that:
  - Only around 4,000 victims of abuse were recorded. This reflects a known pattern of under-reporting of domestic abuse for all victims.
  - More victims are female (71%) than male.
  - Over half of victims (56%) are aged between 18 and 40 years of age.
- Between 2011 and 2020, there were 15 domestic homicides in Buckinghamshire and 39 across the Thames Valley area.

It's more difficult to tell people that you're a victim of abuse if you're male - it's too shameful and embarrassing.

- Victim of domestic abuse, Buckinghamshire

Age of victim at time of abuse. Buckinghamshire data as recorded by Thames Valley Police, April 2020 to Jan 2021



A local needs assessment (2019) found that domestic abuse services in Buckinghamshire compare well to gold standard guidance from the National Institute for Health and Social Care Excellence (NICE).<sup>12</sup> For example, the county has the recommended number of independent domestic violence advisers (IDVAs) for its population size. Local domestic abuse service data add to our knowledge of domestic abuse.<sup>a</sup> Understanding who is (and who isn't) using services can inform service planning, commissioning, and delivery.

Data collection in these services can be challenging and sensitive, and therefore service data are often incomplete. However, comparing the data we have with national estimates suggests that some groups may be under-represented in service users. These groups include, but may not be limited to: men, older people, ethnic minorities, disabled people and people who are lesbian, gay, bisexual, transgender, or have another definition of their gender and sexuality (LGBT+). This under-representation may reflect the fact that not all victims want to seek help, and/or that services are not meeting the needs of these groups.

<sup>a</sup> *Women's Aid Bucks provides domestic abuse services in Buckinghamshire, including independent domestic violence advice (IDVA), outreach services and refuge space.*

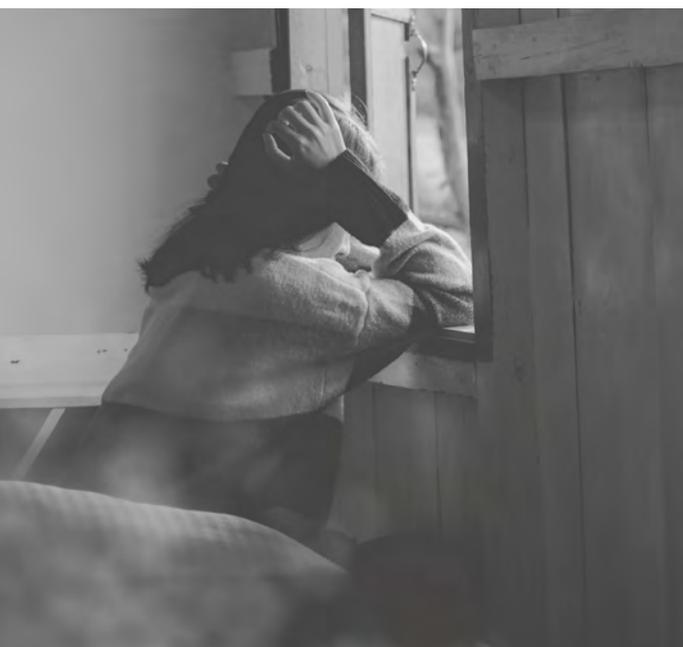
## Perpetrators



Less is known about the people who carry out domestic abuse than their victims.

Less is known about the people who carry out domestic abuse than their victims. It is vital that we understand more about perpetrators if we are to understand how to prevent abuse and change their behaviour.

Whilst data are limited,<sup>13</sup> one report suggested that there are around 400,000 perpetrators in England and Wales causing high and medium levels of harm.<sup>14</sup> Perpetrators are more often a partner or ex-partner rather than a family member.<sup>15</sup> They are more likely to be male. Male perpetrators are more likely to seriously injure or kill their victim; of the 357 domestic homicides committed in England and Wales between 2017 and 2019, 86% were committed by men.<sup>16</sup>



3,212 perpetrators committed 4,431 domestic abuse crimes.

From Thames Valley Police data for Buckinghamshire (10 months to January 2021), we know that:

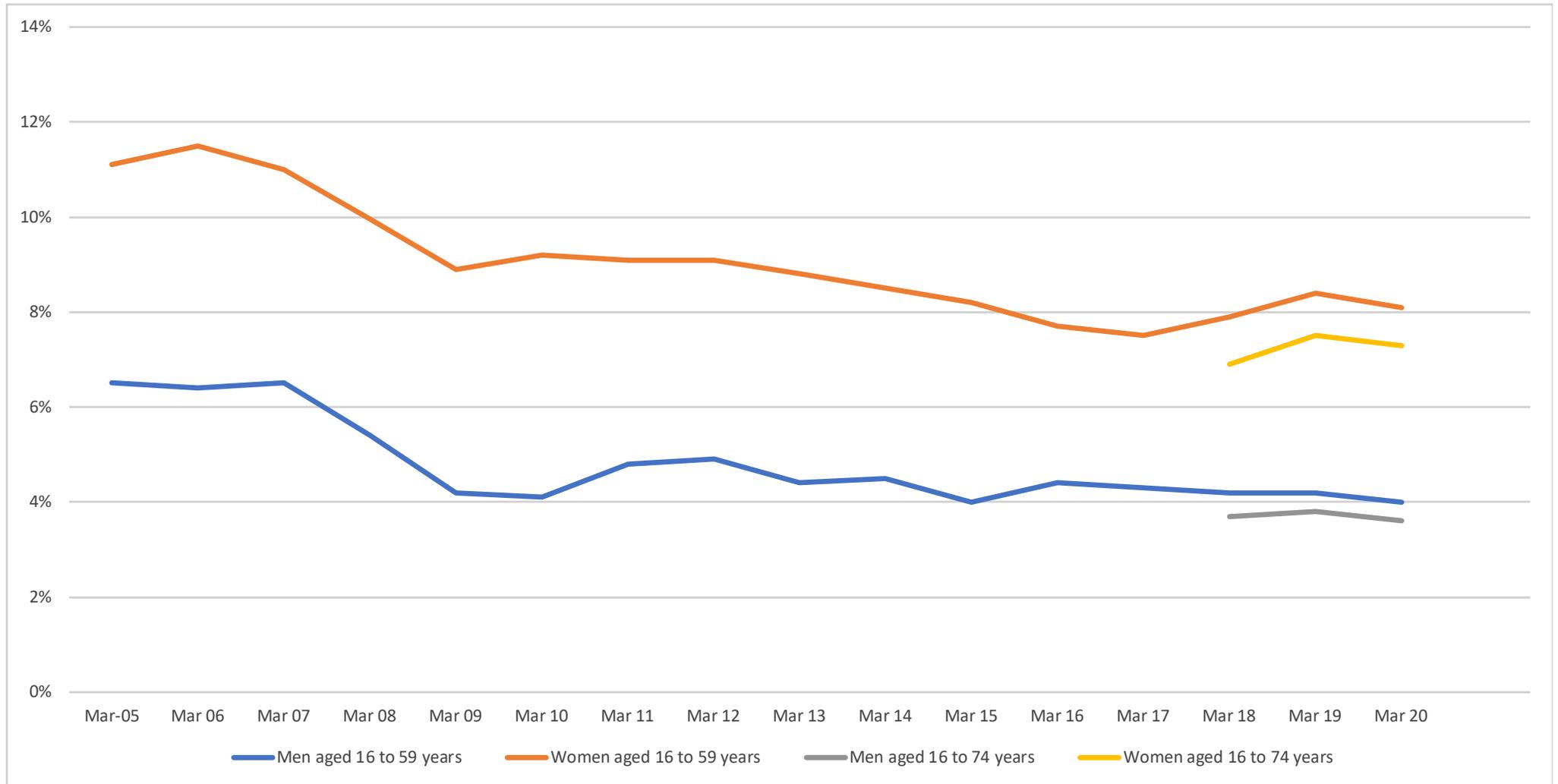
- There were 3,212 perpetrators who committed 4,431 domestic abuse crimes (Thames Valley Police data for Buckinghamshire, April 2020 - January 2021).
- 72% of perpetrators of known gender were male.
- 64% of perpetrators of known age were 40 years old or under.

Perpetrators can be children as well as adults. Research and local professionals tell us that teen-to-parent and teen-to-teen domestic abuse occurs locally.

## Trends over time

Crime Survey for England and Wales data show fewer people experiencing domestic abuse over time, from 2005 to 2020.

**Percentage of adults reporting domestic abuse in the annual Crime Survey, England and Wales, 2005 to 2020.<sup>17</sup>**



Despite the gradually decreasing rates of domestic abuse reported in surveys, there was a 9% increase in domestic abuse-related incidents and crimes reported to police from 2019 to 2020 in England and Wales. This may relate to changes in police recording or may reflect a true increase in reporting to the police.



Domestic abuse-related incidents and crimes accounted for 15% of all crime in Buckinghamshire from 2019 to 2020.

In Buckinghamshire, these crimes accounted for 15% of all recorded crime from 2019 to 2020, 14% of all crime from 2018 to 2019, and 11% of all crime from 2017 to 2018.

The Covid-19 pandemic saw a significant increase in reported domestic abuse. During the first lockdown (March to June 2020), police data showed a 7% increase<sup>b</sup> in domestic abuse related offences.<sup>18</sup> In the 10 months from April 2020, contacts to the National Domestic Abuse charity Refuge<sup>19</sup> rose by 61% and contacts to the charity Respect which supports male victims of domestic abuse rose by 70%.<sup>20</sup> Calls to the National Stalking Helpline in the year from March 2020 increased by almost 10%.<sup>21</sup> The lockdown resulted in victims being confined at home with perpetrators. School closures may have increased exposure of children to household violence. In-person contact with health and social services reduced. And home visits which may have identified and intervened in risky situations were reduced. Victims reported that the abuse worsened during the pandemic, especially if they lived with their abuser.<sup>22</sup>

<sup>b</sup> As the number of offences flagged as domestic abuse-related has been increasing in recent years, it is not possible to determine what impact the coronavirus pandemic may have had on the increases in 2020.



The Covid-19 pandemic saw a significant increase in reported domestic abuse.

Victims reported that the abuse worsened during the pandemic, especially if they lived with their abuser.

In Buckinghamshire, reports of domestic abuse and use of domestic abuse services have increased since the start of the pandemic. The table shows increases in police and service use data.

<b>POLICE DATA</b>	<b>Before Covid-19 April 2019 to Jan 2020</b>	<b>After Covid-19 April 2020 to Jan 2021</b>	<b>Percentage change</b>
<b>Reported domestic abuse crimes</b>	3849	4431	15% ↑
<b>Numbers of victims</b>	2924	3291	13% ↑
<b>Numbers of perpetrators</b>	2839	3212	13% ↑
<b>Domestic-related stalking crimes*</b>	54*	415*	669% ↑*
<i>*Large increase is due to changes in recording practises by the Home Office in April 2020.</i>			
<b>SERVICE DATA</b>	<b>Before Covid-19 April to Sept 2019</b>	<b>After Covid-19 April to Sept 2020</b>	<b>Percentage change</b>
<b>Victims supported by IDVAs<sup>c</sup></b>	601	1062	77% ↑

<sup>c</sup> This includes victims supported within a police station and/or within Women's Aid IDVA services in Buckinghamshire.

# I never expected domestic abuse would happen to me

"I always thought that domestic violence and abuse was something that happened to other people. But it happened to me. This is my story from ten years ago.

"He will be nameless. We met online, but we had mutual acquaintances in common, so I felt okay about meeting him. We first met in a quiet local pub - he wasn't really my type, and I only agreed to a second date to not hurt his feelings. However after meeting more, I felt that we had a connection. We ended up moving in together quite quickly and that's when my life began to change.

"From the start he was 'love bombing' me, a tactic that abusers sometimes use to get you on side - sending texts saying that he really liked me, and thought I was amazing. He was also controlling and overbearing - my phone would ring and he would be hovering, wanting to hear what I was saying. He would question me - what did they want, why had or hadn't I spoken about him? Then there were questions about why people weren't ringing or texting me. I felt that I couldn't do anything right.

"Things reached a head when I stayed away overnight for a work trip. He accused me of making it up - I was going away because I was having an affair (I wasn't). He cornered me in our bedroom, pushing me against the wall, yelling and screaming at me. In his mind, he was right - I couldn't say anything to stop him. I'm not proud of it, but I slapped him. Silence. Nothing happened. I got my bags and I left. For the next 36 hours I had text after text saying things like the police would arrest me, he was sorry, please come back, I love you, I need you, why aren't you telling me the truth, don't you dare come back, your stuff is in bin bags at the front door.

"You might wonder, why I didn't ring someone and tell them? What do you say? Who do you tell? Abusers pull you away from your friends and family. Contact becomes limited, and often you can't see people without the abuser being present. Unless you've been in this position, you can't imagine how lost and alone you feel. Reaching out to talk to someone, becomes the most impossible thing you can do.

"Christmas came. I was trapped in a flat, with a man I was petrified of. We rowed, and by 4am, he had ripped out clumps of my hair, tried to strangle me, kicked me in the ribs, given me a black eye, and ripped an earring out my ear. He proposed at some point that night. I said yes because I didn't know what else to say. It was terrifying. I couldn't even cry. I just felt numb.

"It was another three weeks before I left, and I can't tell you what happened. I don't let myself think about it. But I did leave. And I didn't go back."

- Anonymous resident, Buckinghamshire

## 4. WHO IS AT GREATER RISK OF SUFFERING DOMESTIC ABUSE?

Some people are more likely to be victims of domestic abuse. Tools such as the DASH risk checklist (Domestic Abuse, Stalking and Harassment and Honour Based Violence) help trained health and social care professionals and the police to assess the risk level (standard, medium or high) of domestic abuse victims.<sup>23</sup> The checklist identifies vulnerabilities such as mental ill health, financial dependency and disability. High and medium risk victims receive support from independent domestic violence advisors (IDVA), and may be referred to a multi-agency risk assessment conference (MARAC).

However, a lack of complete data on victims limits our understanding of the full picture of who is at greater risk of domestic abuse. Much of our data come from surveys or services. A lack of data may reflect reluctance to provide information, poor data collection, or barriers to accessing services, either because services are not inclusive or are not perceived to be.

### Disability



Around 14% of disabled adults experienced domestic abuse, compared with 5% of adults without disabilities from 2018 to 2019 (in England and Wales).

Around 14% of disabled<sup>d</sup> adults experienced domestic abuse, compared with 5% of adults without disabilities from 2018 to 2019 (in England and Wales).<sup>24</sup> Disabled men are twice as likely to experience domestic abuse compared to non-disabled men (8% and 4% respectively);<sup>25</sup> disabled women are more than twice as likely compared to non-disabled women (17% and 7%). National and local data suggest that either disability is not recorded by services, or that disabled victims are not accessing them.

“ Having a physical disability meant that it was difficult for me to get advice or support outside home. ”

- Victim of domestic abuse, Buckinghamshire

### Learning disability

National data suggest that one in five (19%) people with a learning disability experienced any domestic abuse in the last year (2019 to 2020).<sup>26</sup>

<sup>d</sup> *Being disabled refers to a person self-reporting a long-standing illness, condition or impairment, which causes difficulty with day-to-day activities.*

## Mental ill health

Domestic abuse and mental ill-health are commonly associated. Recent research suggests that women with mental health problems are three times more likely to experience domestic abuse, and women experiencing domestic abuse are three times more likely to develop mental health problems.<sup>27</sup>

## Older people

Older people are affected by domestic abuse. Police data for Buckinghamshire from 2019 to 2020 showed that 9% of victims of known age were 61 years or older. However this age group only made up 4.5% of IDVA service users in the same year. Older people may be more vulnerable to coercive control (including economic abuse) given their dependence on family and carers as they age.<sup>28</sup> They may be unwilling or unable to disclose, recognise or leave abusive relationships due to age-related conditions such as dementia. Such situations are both a safeguarding and a domestic abuse concern.

## Ethnicity

Ethnicity is not well recorded in relation to domestic abuse. Recent police data show that in Buckinghamshire, in 70% of cases the victim's ethnicity was not recorded. Domestic abuse is also commonly under-reported in ethnic minorities. Although domestic abuse is experienced by people from all ethnic origins, cultural values and norms will affect people's perceptions of and responses to domestic abuse. For people from some ethnic minority backgrounds, these may include fear (of not being believed, of being exposed, of the criminal justice system), victim-blaming culture, and failure to recognise abuse. Honour and shame are highly important concepts in certain cultures, and the consequences of dishonouring family or community by disclosing abuse are significant.

I will live with the abuse rather than get divorced.  
Divorce in my culture means my life is over.

- Quote from Thames Valley BAMER Project Report



Honour and shame are highly important concepts in certain cultures, and the consequences of dishonouring family or community by disclosing abuse are significant.

The Thames Valley Black, Asian, minority ethnic and refugee (BAMER) Project Report identified barriers faced by women from ethnic minorities who experience abuse. For example a victim needing a family member to interpret at appointments is denied privacy to discuss abuse with the health or social care professional.<sup>29</sup>



English isn't my first language so I use language translation apps when I meet with different workers - it's not perfect but it works.



- Victim of domestic abuse, Buckinghamshire

## Gypsy, Roma and Traveller communities

There are limited data around domestic abuse in the Gypsy, Roma and Traveller communities. However, as in other communities, community members and workers have noted domestic abuse as a serious and long-standing problem.<sup>30</sup> The domestic abuse charity One Voice 4 Travellers estimated as many as three in four women from these communities experience domestic abuse at some point in their lives.<sup>31</sup>

## Sexual orientation and gender identity

National statistics do not report domestic abuse by sexual orientation or gender identity. However, studies suggest that between 25 and 40% of lesbian, gay and bisexual people report one or more domestic abuse incidents in their lifetime. This rises to between 28% and 80% for trans people.<sup>32</sup> An NSPCC survey in UK schools suggested that 44% of teenagers with same-sex partners had experienced some form of physical partner violence, increased from 20% for those in heterosexual relationships.<sup>33</sup>

Domestic abuse victims with lesbian, gay, bisexual, transgender, or another definition of their gender and sexuality identity (LGBT+) are known to present with higher levels of risk and complex needs compared to non-LGBT+ people, such as mental health problems, self-harm and drug and alcohol misuse.<sup>34</sup>



LGBT+ victims may face threats of 'outing' about sexual orientation and gender identity.

They also face unique issues such as being victim to threats of 'outing' about sexual orientation and gender identity, and 'identity abuse' which may include withholding of medication or clothing relating to their identity.<sup>35</sup>



Most of my friends and family didn't know I was gay so I didn't want to drop a double bomb-shell on them by telling them I was also being abused by my partner.



- Victim of domestic abuse, Buckinghamshire

## 5. WHAT ARE THE RISK FACTORS FOR BECOMING A PERPETRATOR?

Certain factors are associated with increased risk of perpetrating domestic abuse. They may not cause the abuse to happen, but they contribute. Risk factors can be cumulative, and combine to increase the risk of committing domestic abuse.<sup>36</sup>

Greater risk is associated with low self-esteem, hostility towards women, and/or the need for dominance and control. A history of depression and suicide attempts have also been linked to increased risk of becoming a perpetrator. Where economic stress, marital conflict and/or jealousy occurs, domestic abuse is more likely. Additionally, evidence suggests that communities with lower social cohesion, lower bystander intervention, and lower social capital have higher rates of intimate partner violence.

In contrast, protective factors can reduce the influence of risk factors. Good physical and mental health and a sense of wellbeing are protective against perpetrating abuse.

Good physical and mental health and a sense of wellbeing are protective against perpetrating abuse.

Having a stable home and family life are also protective. Communities with greater social cohesion, good access to healthcare and knowledge and training of bystander interventions have reduced risk of domestic abuse. Social norms that discourage violence and support gender equality, and public policy that aims to level up health inequalities are also protective.<sup>37</sup>

To illustrate the interplay between risk and protective factors, a recent study with domestic abuse practitioners showed common risk and protective factors associated with becoming a perpetrator.<sup>38</sup> For example, normalising abusive behaviour was a risk factor. Protective factors included having meaningful support networks. Understanding these multilevel factors can help identify various opportunities for prevention. For example, improving access to stable housing, and promoting bystander interventions to reduce the risk of domestic abuse.

It was useful - I learnt how to put myself in my partner's shoes and to see things from her perspective.

I wouldn't have done this unless I'd been forced to. There should be more help and advice like this to help men before they get into a criminal situation like I did.

- Perpetrators of domestic abuse in Buckinghamshire reflecting on their attendance at a positive relationships programme

## 6. WHEN IS SOMEONE MORE AT RISK OF DOMESTIC ABUSE?

There are certain times when abuse may be more severe or more frequent.

### Pregnancy and postnatal period

International estimates suggest that between four and nine of every 100 pregnant women are abused during pregnancy or soon after birth.<sup>39</sup>



Pregnancy is associated with an increased risk of domestic abuse.

Pregnancy is associated with an increased risk of domestic abuse and also changes to the pattern of abuse.<sup>40</sup> The time of greatest risk is thought to be the postnatal period. Estimates suggest that between 290 and 650 Buckinghamshire women may be affected by domestic abuse each year when pregnant or in the postnatal period. Midwives and Health Visitors are aware of the potential for domestic abuse and screen patients carefully, seeking specialist help as appropriate. Local domestic abuse services support pregnant and postnatal women.

### Drug and alcohol use

Drug and alcohol use can decrease inhibitions, act as a catalyst, and may lead to violence to solve conflicts in intimate partner relationships.<sup>41</sup> In the Crime Survey for England and Wales (2018) victims reported that the perpetrator was under the influence of alcohol in 17% of cases and drugs in 11% of cases. Victims were under the influence of alcohol (8%) and drugs (2%) less often at the time of abuse.<sup>42</sup> Recent police data for Buckinghamshire show that nine in ten perpetrators were not using alcohol at the time of the offence.

## Separating or fleeing from perpetrator



Leaving - and shortly after leaving - an abuser is a dangerous time for the victim.

Leaving an abuser is a dangerous time. The risk of further abuse can increase as and after the victim leaves. One study explored post-separation violence, and found three in four women suffered further abuse, and one in three women suffered continued post-separation violence.<sup>43</sup> Furthermore, 37 of the 91 women killed by a male partner in the UK in 2018, had either separated or were taking steps to separate from their partner. Eleven of the 37 women were killed in the first month of separation.<sup>44</sup>

### Football matches

Studies in England have shown significant increases in the number of domestic abuse cases recorded by the police when the men's national team are involved in significant football matches, both when they win, and even more so when they lose.<sup>45</sup> A recent study showed that England football success in international tournaments also increased the likelihood of alcohol-related violent behaviours in the home.<sup>46</sup> A London hospital reported a 200% referral increase to its domestic abuse support service during the 2014 men's football World Cup.<sup>47</sup> The Women's Aid campaign 'Football United Against Domestic Violence' aims to raise awareness of domestic abuse, and battle sexist attitudes that underpin abuse against women. Wycombe Wanderers are one of the football clubs that supports this campaign.<sup>48</sup>

## 7. WHAT ARE THE IMPACTS OF DOMESTIC ABUSE?

Experiencing and witnessing domestic abuse can have devastating impacts on victims, and their children, friends and wider family. There are also wider societal impacts. Tools such as the DASH risk checklist help trained health and social care professionals to identify the risk of harm victims may be facing.

### Victim's health



Harm as a result of domestic abuse can have lifelong impacts on physical, mental and sexual health.

Harm as a result of domestic abuse can have lifelong impacts on physical, mental and sexual health. The more severe the abuse, the greater the impact. In the worst cases, domestic abuse can result in homicide, including suicide as a result of domestic abuse.

One in five domestic abuse victims at high risk of serious harm or murder reported attending an accident and emergency department because of their injuries in the year before getting help. Abuse can also result on long term health problems.

A study interviewing women and girls over 15 years old found that those who had experienced physical or sexual violence by a partner were more likely to report overall poor health, chronic pain, memory loss, and problems walking and carrying out daily activities.<sup>49</sup>

Sexual violence can lead to infections, chronic pelvic pain, sexually transmitted infections, unintended and unwanted pregnancies, and abortions.<sup>50</sup>

Alcohol and drugs can be used by the victim as a way of coping or self-medicating, putting victims at risk of further ill health.<sup>51</sup> Their effects may also leave victims less capable of negotiating resolution and at risk of further violence.

Domestic abuse and mental ill health are commonly associated. A recent study found that half of women presenting to their GP with domestic abuse had already had some form of diagnosed mental illness.<sup>52</sup> Victims experience anxiety, depression, low self-esteem, inability to trust others, flashbacks, eating and sleeping disorders, and emotional detachment.<sup>53</sup> Considering or attempting suicide has been reported in 16% of victims, and self-harming in 13% of victims.<sup>54</sup> An estimated one in three women who attempt suicide in the UK have experienced domestic abuse.<sup>55</sup>

Domestic abuse affects all areas of life, as well as poor health.

## Housing and homelessness



Domestic abuse is a leading driver of homelessness. Latest national figures from 2020 show that domestic abuse was the second most common reason given for losing a home.

Domestic abuse is a leading driver of homelessness. Latest national figures from 2020 show that domestic abuse was the second most common reason given for losing a home (14.5% of cases).<sup>56</sup> The homeless charity Crisis estimates that almost one in five of homeless women (18%) are homeless due to domestic abuse.<sup>57</sup> Domestic abuse accounts for at least one in ten people who require local authority support for homelessness in England, Wales and Scotland.<sup>58</sup> Actual need may be higher; the survey showed that one in three respondents left their home because of the abuse or leaving a relationship.

## Finances

A recent survey of female survivors of domestic abuse found that one in three respondents said their access to money during the relationship was controlled by the perpetrator.<sup>59</sup> One in four respondents said that their partner did not let them have money for essentials during the relationship. A similar number reported that they used savings or children's money for essentials. Many (43.1%) reported being in debt because of the abuse, and over a quarter regularly lost sleep through worrying about debt.

The consequences of domestic abuse can increase the risk of poverty. One study found that women in poverty were more likely to have faced extensive violence and abuse (14%), compared to women not in poverty (6%).<sup>60</sup>

## Employment

Over half (56.1%) of respondents on the same survey who had left an abusive relationship felt that the abuse had impacted their ability to work. Just under half of all respondents felt the abuse had negatively impacted their long-term employment prospects/earnings.

## Children and young people



In the words of UNICEF, some of the biggest victims of domestic abuse are the smallest.

In the words of UNICEF, some of the biggest victims of domestic abuse are the smallest.<sup>61</sup> Domestic abuse has a negative impact on the mental, emotional and psychological health of children. Children can suffer social and educational developmental problems, and in some cases grow to accept abuse as normal behaviour. An estimated one in five children are exposed to domestic abuse in the UK,<sup>62</sup> with 130,000 children living in homes where there is a high risk of serious harm or murder due to domestic abuse.<sup>63</sup>

In Buckinghamshire, for the financial year 2020 to 2021, there were over 2,400 referrals for a social care assessment to children's social care where domestic violence was the primary concern. This represents a 31% increase on the previous year. This accounts for 23% of all children's social care referrals. Almost 700 children and young people where domestic violence was a concern were given children in need plans, child protection plans or became looked- after. Children starting a social care service from 2020 to 2021 – where domestic violence was the primary concern – accounted for 23% of all children's social care services received. 105 children who had domestic abuse mentioned as a factor in their assessment became looked after by the local authority from 2020 to 2021. This represents half of all children who became looked after in that year. These figures will underestimate domestic abuse suffered and witnessed by children in Buckinghamshire as not all cases will be referred to social care. Of the 116 children accommodated in Women's Aid Buckinghamshire refuges from 2019 to 2020, over half (66%) had directly witnessed domestic abuse, and 17 of the families were subject to a Child Protection Plan.

The full extent of harm will differ for each child depending on their circumstances and age. Around two in three (62%) children living with domestic abuse are thought to be directly harmed by the perpetrator; harm is also caused by witnessing abuse.<sup>64</sup> Wider effects such as having to move home and school to escape abuse can further harm children by increasing instability in their lives. A survey of women in English refuges showed that about two in three residents had children with them.<sup>65</sup>

## Growing up with domestic abuse is likely to be a traumatic and stressful negative experience.

Growing up with domestic abuse is likely to be a traumatic and stressful negative experience, and the impacts will vary between children. Children may demonstrate outward behaviours such as aggression, anti-social behaviour and risk taking;<sup>66</sup> others may have difficulty expressing their emotions. Children may also feel depressed, anxious, angry, guilty, confused, and helpless.<sup>67</sup>

The impacts can be long term. Studies suggest that exposure to domestic abuse in early life may increase the risk of:

- Alcohol use. Children witnessing violence are more likely to misuse alcohol later in life.<sup>68</sup>
- Becoming a victim or perpetrator of domestic abuse, although this association is complex.<sup>69,70</sup> For example, normalising experiences of abuse will make it difficult for children to establish and maintain healthy relationships, and may increase their risk of domestic abuse in the future.
- Antisocial and risk-taking behaviour, early pregnancy and homelessness. Experiencing any or a combination of these in adolescence increases vulnerability to sexual exploitation and criminal behaviour.<sup>71</sup>

“Feeling safe is even more important when you have your children to think about.”

- Victim of domestic abuse, Buckinghamshire

### Wider society

A Home Office report estimated the annual economic and social costs of domestic abuse, including domestic homicides, to be over £66 billion in England and Wales (year ending March 2017).<sup>72</sup> The largest costs as a consequence of domestic abuse were the physical and emotional harms (£47,287 million). The largest costs in response to domestic abuse were police costs (£1,257 million). The average total cost per victim was an estimated £34,010, made up of lower-costing crimes such as indecent exposure, to the highest-cost crime of domestic homicide.



Using Home Office costs with our local estimate of 21,000 victims, we estimate that the potential annual cost of the consequences of domestic abuse in Buckinghamshire is £687 million.

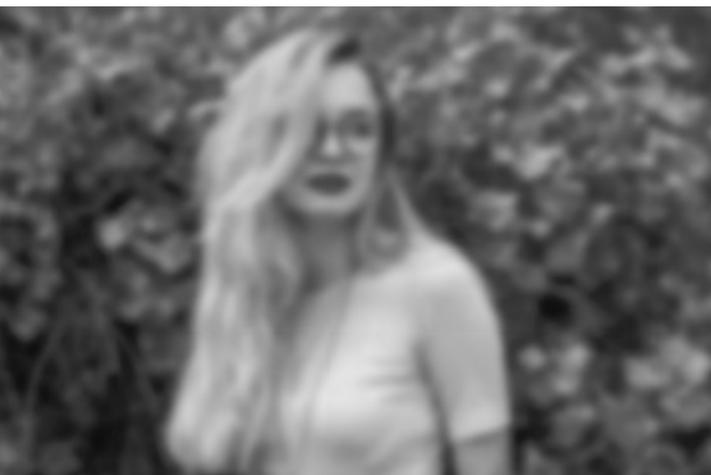
Using Home Office costs with our local estimate of 21,000 victims, we estimate that the potential annual cost of the consequences of domestic abuse in Buckinghamshire is £687 million. This is physical and emotional harm costs of £510 million, lost output costs of £152 million (time off work and reduced productivity), and health service costs of £25 million.

Using Home Office costs with our local estimate of about 4,000 victims known to the police in 2020 to 2021, we estimate that the potential annual cost of responding to domestic abuse in Buckinghamshire only for those we know about is £3.5 million, of which police costs account for £2.5 million. However, the health impact and costs would still accrue whether the victim reported the crime or not, so the local health costs will be an underestimate.

## Deaths from domestic abuse: domestic homicide reviews

A domestic homicide review must be carried out by local authorities in England and Wales following the death of an individual aged 16 or over, which has, or appears to have resulted from violence, abuse or neglect, and inflicted by someone personally connected to the victim.<sup>e</sup>

Each review provides a detailed account of events leading up to the homicide, the context, and what we can learn from the event. The most recent data from the Home Office (December 2016) show that over 400 reviews have been completed since domestic homicide reviews started in 2011.<sup>73</sup> As of July 2020, 39 domestic homicides have taken place in the Thames Valley region, and 15 in Buckinghamshire.



As of July 2020, 39 domestic homicides have taken place in the Thames Valley region, and 15 in Buckinghamshire.

### What can we learn from these deaths?

Published homicide data for England and Wales (from the Home Office report and another recent report), show that no two cases are the same.<sup>74</sup> However, there are certain key themes which have been identified. Data for England and Wales are used given the limited data available for local cases.

- Women are more likely to be victims than men. About eight in ten victims are female.
- Men are more likely to be perpetrators than women. About nine in ten perpetrators are male.
- Data on ethnicity of victims is often missing.
- Substance misuse can be a prominent feature in the lives of both victims and perpetrators.

<sup>e</sup> Perpetrator and victim related, or are/were in intimate partner relationship, or member of the same household.

- Victims and perpetrators are commonly known to services prior to the homicide. For example, just under half of cases were known to the police to be in an abusive relationship.
- Perpetrators of homicides follow a pattern of behaviour, including having previous controlling behaviour, and reacting violently to loss of control of the victim or relationship.<sup>75</sup>

Given that domestic homicide reviews aim to identify learning, service improvements and better prevention of domestic abuse and homicide, an anonymised and accessible national database of reports would help local authorities learn from other areas to help prevent these tragedies from happening.<sup>76</sup>

## Warning signs for intimate partner homicides

Between 2009 and 2018, a woman was killed every four days by her partner or ex-partner in the UK.<sup>77</sup>

Most victims of intimate partner homicides are women. A review of 372 intimate partner homicides of female victims, and patterns of behaviour in national domestic homicide review information identified **eight stages** that may predict homicide.<sup>78</sup> Controlling behaviour by the perpetrator was the best predictor of homicide, rather than a history of violence. This review has led to learning about how these homicides can be predicted, and therefore prevented.

All perpetrators who reached the last stage and committed homicide moved through each of the eight stages. However, many cases saw progression to stage five or six, followed by either regaining control and returning to stage three, or moving to another relationship.

1. **Pre-relationship history.** In almost all cases the perpetrator has a history of coercive control, stalking or domestic abuse.
2. **Early relationship.** The relationship moves at speed, such as moving in together and declaring love early on.
3. **Relationship.** There are controlling patterns in every case study, such as limiting the victim's movements, what she wears, or who she sees. The relationship may be dominated by coercive control, stalking, or domestic abuse. This stage ranged from 3 weeks to 50 years in the case studies.
4. **Trigger/s.** Risk rises due to possible loss of control by the perpetrator over the victim or the relationship. Usually this loss of control comes from separation initiated by the victim.
5. **Escalation.** The perpetrator tries to gain back control back. More frequent and severe controlling behaviours are seen, such as crying, violence, stalking, or suicide/murder threats.
6. **Change in thinking.** With the loss of control comes a decision by the perpetrator about how they deal with this loss. This may be to form a new relationship, to mend the current relationship, or to decide to kill someone.
7. **Planning.** The perpetrator plans the homicide. This could include buying weapons, digging a grave, researching methods online, planning and organising finances, or stalking to gather intelligence.
8. **Homicide.** Case studies included violent homicides where the level of violence used appears to have no direct relation to that within the relationship.

Over 125 domestic abuse organisations and professionals have been calling for a national response to perpetrators for some time, including a national perpetrator strategy. A positive step towards this came in the HM Treasury Budget 2021, which included funding across England and Wales for perpetrator behaviour change programmes that work with offenders to reduce the risk of abuse occurring.<sup>79</sup>

## To start with it was the occasional push or slap, but it got worse

"I met my ex-husband when I was 17. I moved in with his family six months later when I was pregnant. Everything went well for a while. However, one evening at the pub he suddenly told me we were going home – I thought it was a bit strange but agreed. On the way home he told me that he was angry with me as I was flirting with another man. I told him that I hadn't and he slapped me around the face. This was a bit of a shock but he apologised straight away and told me that he was sorry.

"Things went okay, we got married and my child was born. I quickly became pregnant again and although things did become a bit tense, I put this down to the pressures of suddenly having a family. My ex-husband would drink a bit. It seemed that if he had too much we would argue, he would say that I was lazy, and that I could not look after my children properly. The drinking was happening most evenings and so were the insults. Then it started to get physical.

"To start with it was the occasional push or slap, but it got worse. One particular evening, when the children were six and five, he came home from work early and shouted at me because the dinner was not ready when he had arrived. He told me that I was useless, slapped me across the face and then told me to get on with his dinner. When I took it through to him he started shouting at me – 'What the hell are you giving me, I don't like this..!' He grabbed the back of my neck, and pushed my face towards the food, shouting at me all the time, saying I was trying to poison him. Then he shoved his hand full of food in into my mouth and told me to eat it. He pushed me to the floor and started to punch and kick me.

"The children were screaming. He told me to shut them up or he would sort them out too. I managed to quieten them down by taking them upstairs. When I returned I apologised to him about the food and he told me to clear it up. He said that I was not fulfilling my duty as his wife properly. He then made me have sex with him and all the time he was telling me how useless I was and that I deserved everything I got.

"The next morning I decided that I could not do this anymore. I contacted my friend and she took me to her house. We spoke to housing and they gave me the number for Women's Aid, where there was space in a refuge for me and my children. I did not have much with me, just a few clothes and things for the children. When I got to the refuge I was shown to a room and was given some spare clothes and food. I did not have any money. My worker helped me to claim a crisis loan and sorted out getting my benefits. I did report what had happened to the police and my worker came with me to make a statement. The police were very helpful but unfortunately although they arrested him he denied everything. They were unable to proceed with any charges.

"When I was in the refuge I was helped with things like housing, and support for the children getting them in to school. I stayed in the refuge for six months and I was then offered a house from the Council. The staff at the refuge helped me to get things for the house and helped me move in. I contacted Women's Aid later as my ex-husband had applied for custody of the children. He was awarded contact only. I could not have coped without the help of Women's Aid and I am so grateful to them for helping me and the children. My ex-husband no longer sees the children as he moved out of the country."

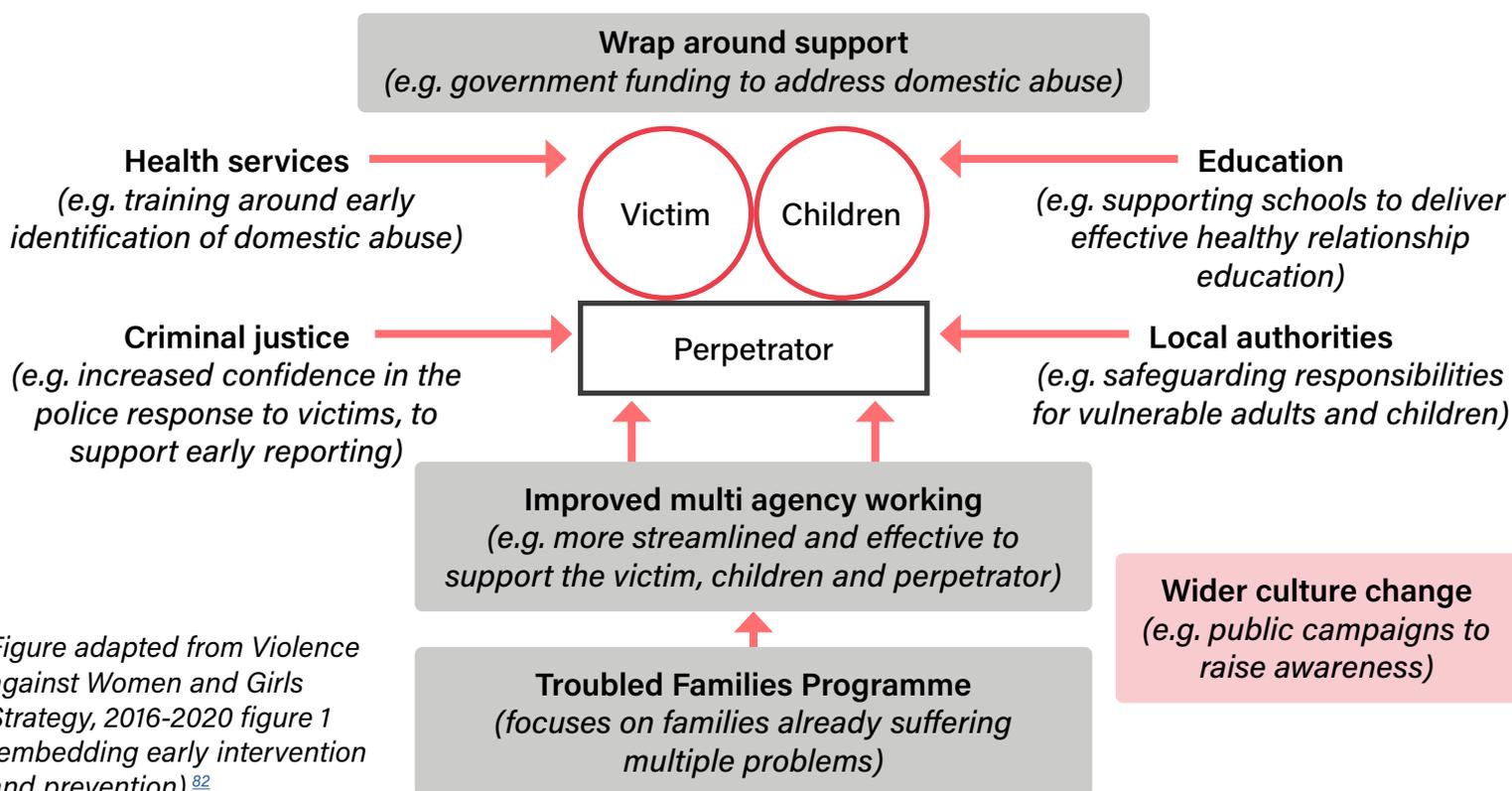
- Anonymous resident, Buckinghamshire

## 8. WHAT WORKS TO PREVENT DOMESTIC ABUSE?

Domestic abuse is a complex societal issue spanning many areas of life. Prevention and the response must be multifaceted.

Domestic abuse is a complex societal issue spanning many areas of life. Prevention and the response must be multifaceted. The National Institute for Health and Care Excellence (NICE) has published guidance on multi-agency working for domestic violence and abuse (2014) which includes 17 recommendations.<sup>80</sup> These include a local strategic partnership to prevent domestic abuse; the scope, shape and variety of local services; the quality of partnership working; and staff knowledge and skills in identifying and supporting victims of domestic abuse.

Embedding early intervention and prevention into a multiagency response to domestic abuse is highlighted in the government's Violence Against Women and Girls Strategy (2016 to 2020).<sup>81</sup> The response includes government-led initiatives as well as local authority multi-agency working, safeguarding, and commissioning. It highlights the multi-layered and co-ordinated health, social and criminal justice approaches required to tackle this issue and can be applied to all victims rather than only women and girls.



New and existing programmes should be monitored and reviewed to improve the robustness of evidence.

Historically, many interventions addressing domestic abuse have not been thoroughly evaluated so it is vital that new and existing programmes should be monitored and reviewed to improve the robustness of the evidence. Some evidence based or potentially effective domestic abuse interventions are highlighted below.

- **School-based awareness raising of domestic abuse** is known to achieve positive changes in knowledge and attitudes towards domestic abuse and prevent dating violence.
- **Campaigns to raise awareness of domestic abuse** is a fundamental step in victims and bystanders recognising domestic abuse. This should be combined with signposting the public and professionals to services.



'Bystander interventions' challenge harmful attitudes, language and behaviour relating to domestic abuse.

- **'Bystander interventions'** challenge harmful attitudes, language and behaviour relating to domestic abuse.<sup>83</sup> These interventions – from challenging a disrespectful statement to noticing signs of domestic abuse and offering support – can be undertaken by anyone. Solace Women's Aid provides training and materials via their website for everyone,<sup>84</sup> as well as information specifically for men.<sup>85</sup>
- **Offering safe opportunities to seek help** such as campaigns using code words that victims can use in specific circumstances to alert someone to abuse. As services have moved online, and in-person interactions are replaced with a digital offer, a hand signal or gesture may be preferred to a code word. Examples include the recent 'Ask for ANI', 'Ask for Angela', and the Zoom signal campaigns.<sup>86</sup>

- **Advocacy** interventions with victims are based on empowerment, discussing solutions, and setting goals to respond to their situation. These interventions usually link survivors with legal, police, housing and financial services, and many also include psychological or psycho-educational support. NICE recommends that all domestic abuse victims should be provided with advocacy and advice services tailored to their level of risk and specific need.<sup>87</sup> Evidence suggests that intensive advocacy may improve quality of life and reduce physical abuse for one to two years.<sup>88</sup>
- **Training of health care professionals** in domestic abuse education and advocacy may lead to an increase in awareness, and greater disclosure, identification and referral to domestic abuse services.<sup>89</sup> For example, data from domestic homicide reviews show us that a victim's contact with services may be limited to their GP so it is vital that GPs are skilled and proactive in recognising signs of domestic abuse and referring patients for urgent help.

The 'Identification and Referral to Improve Safety' (IRIS) training and support programme is an example of an effective health care training intervention, designed for GP surgeries.<sup>90</sup> Evaluation of IRIS showed improved identification of women experiencing domestic abuse and improved referral rates to specialist services (compared to surgeries not trained in IRIS).<sup>91</sup> A recent evaluation across GP surgeries in London showed that of the 144 surgeries trained in IRIS, a 30-fold increase in domestic abuse referrals was seen compared to the those surgeries without IRIS training.<sup>92</sup> These outcomes show that clinician behaviour can be changed in relation to domestic abuse enquiry and referral, for the benefit of the victim. A cost-effectiveness study showed the IRIS programme to have lower costs and greater effectiveness for GP surgeries, compared to surgeries offering usual care (not using IRIS).<sup>93</sup>

- **Independent Domestic Violence Advisors (IDVA)** are trained to address the safety of victims at high risk of harm from intimate partners, ex-partners or family members. There is evidence suggesting that IDVAs have a positive impact on the safety and well-being of victims experiencing extremely serious levels of domestic abuse.<sup>94</sup> This reduced risk of harm has some effect on reducing the risk of domestic abuse to children.
- **Multi-Agency Risk Assessment Conferences (MARACs)** are regular multiagency meetings to discuss high risk domestic abuse cases. A coordinated safety plan is enacted to support the victim. The victim is ideally represented by an IDVA. Research indicates that MARACs (and IDVAs) can improve victim safety and reduce revictimization, and therefore may be a highly cost-effective measure.<sup>95</sup>

## Perpetrator interventions

Interventions aimed at perpetrators can be either criminal sanctions, or perpetrator interventions and programmes. Only 1% of perpetrators receive any specialist intervention to challenge or change their behaviour.

NICE guidance states that *'There is lack of consistent evidence of the effectiveness of programmes for people who perpetrate domestic violence and abuse.'* However, *'such interventions are an important part of domestic violence and abuse services, and provided they are supported by robust evaluation to inform future commissioning decisions, should be recommended.'*<sup>96</sup>

NICE has also published quality standards for domestic violence and abuse (2016).<sup>97</sup> The standards are (1) asking about domestic abuse, (2) responding to domestic abuse, (3) referring to specialist services for victims, and (4) referring to specialist services for perpetrators.

## 9. SUMMARY AND RECOMMENDATIONS

This report shows that domestic violence and abuse is common, but often hidden and underreported. The impacts for victims, survivors, their families, and society are serious and wide-reaching. In preparing this report, we have reviewed the latest data, evidence and looked at current service provision.

Preventing domestic abuse from occurring must be a priority and we are supporting our schools to implement recent RSHE (relationships, sex and health education) that includes recognising domestic abuse and abusive relationships, coercive control, consent, and mutual respect in friendships and relationships. Looking ahead, the new multi-agency Domestic Abuse Local Partnership Board will be championing good practice in awareness raising, education and training and the provision of high-quality support and advocacy services. Services for victims (including children) and perpetrators will be further developed to meet the needs of diverse groups and people with protected characteristics, recognising that anyone can be a victim. Starting with partners on the Board, all organisations will be encouraged to adopt measures to keep employees and service users safe from domestic abuse including during home working, remote digital working, and consultations. The Board will also explore how we can share and learn from past and current domestic homicide reviews to understand how such tragedies can be prevented in the future.

**The following recommendations should, in addition to statutory duties for support for people living in safe accommodation, inform the Domestic Abuse Local Partnership Board strategy and delivery plan:**

- 1** The Domestic Abuse Board should support awareness raising of domestic abuse through coordinated, county-wide participation in a selected national campaign.
- 2** The Domestic Abuse Board should consider how bystander training could be utilised locally and promoted, as an evidence-based intervention to challenge harmful attitudes, language and behaviour relating to domestic abuse for people of all ages.
- 3** Buckinghamshire Council Community Safety team should consider how to increase the diversity within the domestic violence and abuse champions scheme by actively recruiting network members that reflect the diversity of people that may experience domestic abuse.
- 4** The Domestic Abuse Board should develop and roll-out high-quality, shared, scenario-based training across Buckinghamshire for key stakeholders and front-line staff. Primary care should also consider implementing the IRIS training package as an effective evidence-based training programme across Buckinghamshire.
- 5** The Domestic Abuse Board should oversee the development of a Buckinghamshire domestic abuse referral pathway for all staff to follow, to ensure timely and responsive delivery of services, fully understood by frontline staff and accessible to victims seeking help.
- 6** All Board member agencies to support the development of an evidence base for what works for perpetrators, to inform commissioning of promising interventions, and evaluation of their effectiveness.

## 10. GLOSSARY

**Adverse Childhood experience (ACE):** ACEs are stressful events occurring during childhood that directly affect a child or affect the environment in which they live (e.g. growing up in a house where there is domestic violence). ACEs can have long-term negative impacts on health and well-being.

**Child protection plan:** A plan drawn up by the local authority to set out how a child can be kept safe, how things can be made better for the family and what support they will need.

**Honour based violence:** A crime or incident which has or may have been committed to protect or defend the honour of the family and/or community.

**Independent domestic violence advisor (IDVA):** IDVAs support victims to reduce immediate risk and increase self-esteem and resilience. The aim of the service is for victims to effect change and keep themselves safe in the longer term.

**LGBT+:** People who are lesbian, gay, bisexual, transgender, or have another definition of their gender and sexuality.

**Multi-agency risk assessment conference (MARAC):** A multiagency panel producing a coordinated action plan to increase the victim/s safety and manage the perpetrator/s behaviour.

**Protected characteristics:** It is against the law to discriminate against someone because of the following protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, or sexual orientation. The Equality Act of 2010 protects citizens against discrimination.

**Stalking:** This can be a form of domestic abuse. It is a pattern of persistent and unwanted attention, and is often committed by ex-partners but can be committed by anyone.

# 11. APPENDICES

## I. Domestic abuse full definition

Full government definition of domestic violence and abuse:

- Behaviour of a person towards another person is domestic abuse if (a) the people are each aged 16 or over and are personally connected to each other, and (b) the behaviour is abusive.
- Behaviour is abusive if it consists of any of the following:
  - a. physical or sexual abuse
  - b. violent or threatening behaviour
  - c. controlling or coercive behaviour
  - d. economic abuse
  - e. psychological, emotional or other abuse

The definition covers different types of relationships including family members, ex-partners and those who are not cohabiting. Although the definition refers to people aged 16 or over, children can still be victims. If the abuser directs his/her behaviour at a child to be abusive to another adult, this is domestic abuse.

Controlling behaviour is defined as *“a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour”*. Coercive behaviour is defined as *“an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim”*. This can also include stalking, which is a pattern of persistent and unwanted attention.<sup>103</sup>

Economic abuse is wider than financial abuse, as described by the charity Surviving Economic Abuse: *“Economic abuse is designed to reinforce or create economic instability. In this way it limits women’s choices and ability to access safety. Lack of access to economic resources can result in women staying with abusive men for longer and experiencing more harm as a result.”*<sup>104</sup>

Psychological, emotional or other abuse can include controlling another person using emotional or manipulative methods such as shaming, criticizing and embarrassing. A consistent pattern of emotional abuse will have a negative effect on a victim’s self-esteem and mental health.

## II. Domestic Abuse Bill

The Domestic Abuse Bill 2021 was passed in April 2021.<sup>105</sup> It will:

- Widen the definition of domestic abuse to include other abusive behaviour as well as violent or sexual offences
- Improve the justice system to provide protection for victims, for example limiting or prohibiting cross-examination of victims

- Strengthen the support for victims of abuse by statutory agencies
- Appoint Domestic Abuse Commissioner (Nicole Jacobs was appointed in September 2019)

The Domestic Abuse Bill 2021 includes a number of statutory and non-statutory intentions that affect local authorities, some of which are summarised here:

***Local authorities in England to provide support\* to victims of domestic abuse and their children in refuges and other safe accommodation.***

- Local authorities in England to establish a multi-agency Domestic Abuse Local Partnership Board. The Board will:
  - Assess the need for accommodation-based domestic abuse services for all victims
  - Develop and publish a strategy for this provision, and use for commissioning decisions
  - Monitor and evaluate the effectiveness of the strategy, and report back to central government
  - Include wide representation (local authority, voices of victims and their children, domestic abuse charities, health care providers and police and other criminal justice agencies)

\* Support includes advocacy support, domestic abuse prevention advice, specialist support for victims with protected characteristics and/or complex needs, children's support, housing-related support, and counselling and therapy for adults and children.

***All eligible homeless victims of domestic abuse automatically have 'priority need' for homelessness assistance.***

- Currently, domestic abuse victims without a priority need (such as being pregnant) must show that they are vulnerable as a result of fleeing domestic abuse in order to access homelessness assistance. The Bill removes the need to prove this vulnerability.

***When rehousing an existing lifetime secure tenant, local authorities must honour this by granting a new lifetime secure tenancy in the case that the tenant or household member has been a victim of domestic abuse and is being rehoused as a result.***

***Introduce regulations and statutory guidance on Relationship Education, Relationship and Sex Education, and Health Education.***

***Invest in domestic abuse training for responding agencies and professionals.***

**Meeting:** Trust Board Meeting in Public

**24 November 2021**

<b>Agenda item</b>	BHT Strategy High Level Milestones – Quarter 2 Progress Update
<b>Board Lead</b>	David Williams, Director of Strategy
<b>Type name of Author</b>	Debbie Hawkins, Head of QI & Transformation
<b>Attachments</b>	None
<b>Purpose</b>	Assurance
<b>Previously considered</b>	29/09/2021 High Level Milestones presented to Trust Board 04/11/2021 Update on Q2 Milestones presented to Transformation Board

### Executive Summary

The BHT 2025 Strategy, approved at Trust Board in September 2021, included the high-level milestones relating to the delivery of the strategy.

This report is the first of a quarterly update to Trust Board regarding progress against milestones. This report covers Quarter 2 (Q2) of 2021/22.

Milestones are monitored on a monthly basis via Transformation Board, with achievements and risks/issues reported to Finance & Business Performance Committee on a monthly basis.

<b>Decision</b>	The Board is requested to <ul style="list-style-type: none"> <li>NOTE the update on the Q2 High Level Milestones</li> </ul>		
<b>Relevant Strategic Priority</b>			
<b>Outstanding Care</b> ☒	<b>Healthy Communities</b> ☒	<b>Great Place to Work</b> ☒	<b>Net Zero</b> ☒
<b>Implications / Impact</b>			
<b>Patient Safety</b>	Patient safety implications are addressed as part of the delivery of specific milestones.		
<b>Risk: link to Board Assurance Framework (BAF)/Risk Register</b>	<ol style="list-style-type: none"> <li>1. Failure to consistently provide quality care that is compassionate, cost effective and safe</li> <li>2. Inability to generate surpluses for capital development or investment in services</li> <li>3. Inability to leave an organisation with the capacity and capability to deliver our best in everything we do</li> <li>4. We do not recover services adequately, or fail to meet public/regulator expectations, and do not play a leading role in the health, economic and social recovery of Buckinghamshire</li> </ol>		

<b>Financial</b>	The financial implications linked to delivery of specific milestones are addressed through normal Trust processes.
<b>Compliance</b> <small>Select an item.</small> <b>Good Governance</b>	This report provide assurance against the delivery of key milestones.
<b>Partnership: consultation / communication</b>	The delivery of specific milestones is done in conjunction with relevant partners, with appropriate consultation as required.
<b>Equality</b>	Equality considerations are addressed as part of the delivery of specific milestones.
<b>Quality Impact Assessment [QIA] completion required?</b>	N/A for this report. QIAs are completed as required linked to specific milestones.

## 1 Introduction

1.1 The BHT 2025 Strategy, approved at Trust Board in September 2021, included the high-level milestones linked to the delivery of the strategy. This report is the first of a quarterly update to Trust Board regarding progress against milestones. This report covers Quarter 2 (Q2) of 2021/22. Milestones are monitored on a monthly basis via Transformation Board, with achievements and risks/issues reported to Finance & Business Performance Committee on a monthly basis.

## 2 Progress against Milestones

2.1 The Table below sets out progress against each of the Quarter 2 milestones by portfolio.

	Q2 Milestone	Update
Planned Care	<i>Video appointments (Phase 1) live in Pain Service, Rheumatology and Community Paediatrics, providing holistic virtual appointments for patients, improved patient experience and a reduction in the need for avoidable hospital visits</i>	DATE REVISED: The live date of end Sept '21 was revised to end Oct '21 due to system issues. The technology solution is now available following successful completion of testing. However, the earliest video appointments will be mid-November due to six week booking process. The rollout schedule is: Respiratory MDT Covid Clinic mid-Nov; Pain end Nov; Community Paediatrics Jan '22 (due to operational pressures); Rheumatology tbc (awaiting template changes). General Surgery and Plastics are planned for Dec '21, along with Clinical Psychology and Audiology.
	<i>Patient Initiated Follow Up (PIFU) live in Breast service, Pain, Plastics and Rheumatology, providing the opportunity for patients to be more fully engaged in their healthcare and ongoing health management</i>	COMPLETE: Patient-initiated follow-up (PIFU) has gone live in the four initial specialities as planned. This empowers patients to have control of when they are seen by the service rather than them attending pre-determined follow up appointments whether they need to or not, and enables patients to book their appointments or receive advice and guidance as and when they most need it. Rollout is continuing for seven additional services by end of 2021/22, with ENT (Aural) now included, and NSIC and Diabetes & Endocrine to follow. Further work is needed to implement full activity recording to meet national submission requirements.
	<i>Cancer Rapid Diagnostic Service (RDS) in place for Lung and Lower GI pathways (Wave 1), supporting earlier diagnosis and improved patient experience</i>	DATE REVISED: The milestone has not yet been met due to issues in successfully recruiting (similar issues have been experienced by Oxford); as such the RDS programme is yet to launch. Recruitment is underway for RDS Transformation Manager, Clinical Navigator and RDS Navigators. The MOU between Thames Valley Cancer Alliance (TVCA) and BHT has been agreed. Upon successful recruitment, delivery is expected to commence late Q3/early Q4.

	Q2 Milestone	Update
Integrated Communities	<i>'Start Well' ICP Plan agreed for 'Readiness to School' priority to support children be ready for school, and the overall aim of improving the mental health and wellbeing of children</i>	COMPLETE: The 'Start Well' ICP Plan for 'Readiness to School' has been agreed, following a workshop on 7 <sup>th</sup> July 2021 with attendance covering services working with children and young people in Buckinghamshire, including acute and community health, social care, education and mental health. The four high level outcomes relate to: school readiness, mental health, vulnerable children, and support for children in the community. The full report was shared at the Bucks Council Children's Senior Leadership Team in October in order to support a Partnership Board to follow through on actions linked to the aspirations. A further report will be shared at the Health and Well-Being Board in December.
	<i>Regular monitoring in place for elective care by ethnicity and deprivation quintile to ensure inclusive service provision</i>	DATE REVISED: The current waiting list has been analysed by ethnicity and deprivation quintiles in October. A monthly report will be provided as part of the elective recovery to monitor as a key performance indicator the percentage waits by ethnicity and deprivation in order to assure waiting list backlog is being picked up equitably. This will be provided from Nov '21. Separately a 'real time' assessment of the waiting list using multiple indicators through the CIPHA programme is being assessed to establish how this can support clinical prioritisation and decision making.
Diagnostics & Medicine	<i>Thames Valley Imaging Network established, providing the opportunity for sharing images, remote working and joint procurement of image sharing technology</i>	COMPLETE: The Thames Valley Imaging has been established following the approval of the MOU by Trust Boards. The programme roadmap and Letter of Agreement have been agreed (awaiting signature).
IT & Digital	<i>Integrated Voice &amp; Data Network in place, providing an integrated secure, resilient and high-performance data network across Buckinghamshire (BHT, Council and GPs) that can be easily extended to provide services to other partners</i>	DATE REVISED: The completion date has been revised from Sept '21 to Jan '22 due to delays to BT infrastructure delivery resulting from supply shortages. This has caused delays in dependent projects, including the Data Centre project which is currently expecting a revised go-live date from Q4 to Oct '22 (latter is partly also due to expansion of scope).
Estates & Commercial	<i>Innovation Centre Opened (Phase 1), providing a collaborative workspace and services for high potential start-up businesses, alongside a modern fit-for-purpose agile workspace for Trust staff</i>	COMPLETE: Phase 1 of the Innovation Centre at Stoke Mandeville successfully opened as planned. The Research & Innovation Department had their official launch to celebrate the Trust's new Research & Innovation Centre in October.
	<i>Strategic Outline Case Approved for site redevelopment of Stoke Mandeville Hospital and Wycombe General Hospital</i>	COMPLETE: The Strategic Outline Cases for Stoke Mandeville and Wycombe were produced and accepted by Trust Board. Permission was granted to move to the next stage which is the Outline

	Q2 Milestone	Update
People		Business Case – this is a combination of the two cases which will enable a decision on the preferred option.
	<i>BHT Zero Carbon Strategy published, setting out how the Trust can achieve the target to be net carbon neutral by 2040 (subject to investment)</i>	COMPLETE: The BHT Zero Carbon Strategy was approved by Trust Board in September, ready for publication. Grant funding to resource implementation of this cross organisational project is being explored.
	<i>New North Bucks PFI Soft FM contract starts, offering better value and improved quality</i> <i>South Bucks PFI Soft FM retender completed, offering better value and improved quality</i>	DATE REVISED: The go-live dates for both PFI contracts have slipped as PFI legal teams review documentation. The financial benefit of the North Bucks PFI contract will remain the same; re the South Bucks contract this will be confirmed once the outstanding issues and timescales are confirmed.
	<i>Action Plans delivered for Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) (as per plans agreed in 2020/21)</i>	PARTIALLY COMPLETE: Action plans for WRES and WDES have been to Trust Board in Sept '21 and are published on the Trust website as required. Any metrics not met have mitigating actions in place (as outlined in reports to Trust Board).
Finance & Improvement	<i>Fully costed Trust Financial Strategy approved, setting out long term financial model and strategic workstreams to support medium-term financial sustainability</i>	DATE REVISED: work is underway to develop the Trust's financial Strategy, however the date has been revised to Q3/early Q4 given the scale of work required to develop the workstreams to address the deficit.

**Meeting:** Trust Board Meeting in Public

**24 November 2021**

**Report from Chair of FBP Committee**

**Date of Committee: 19 October 21**

**Key agenda items considered:**

Item	Committee assured	Further work	Referral elsewhere for further work	Recommendation to Board
Monthly Integrated Performance Report and Recovery	Partial	<ul style="list-style-type: none"> <li>Report received night before meeting</li> <li>Need synthesis of measures (planning guidance; recovery plans; B2B letter; SPC rectifications; etc.) to simpler, shorter set of key metrics for focus</li> </ul>		Continuing and urgent focus
Recovery	Yes	<ul style="list-style-type: none"> <li>Committee explored H2 guidance; progress with mutual aid; governance of recovery workstreams; progress with workstream plans</li> <li>See comment above regarding reporting</li> <li>Workstream plans all need forward trajectories</li> </ul>		To note significant focus on Recovery across Trust
Month 6 Finance Report	Yes	<ul style="list-style-type: none"> <li>H1 breakeven success</li> <li>Requirement for system breakeven in H2 is a significant challenge and risk</li> <li>First articulation of timetable to develop</li> </ul>	<ul style="list-style-type: none"> <li>Confirmation and circulation of milestones for underlying</li> </ul>	To note

		<p>plan for underlying deficit – to be confirmed and circulated to Board</p> <ul style="list-style-type: none"> <li>• Overspend in pay continues to be a concern</li> <li>• £20m mitigations yet to be identified to ensure y/e forecast outturn is attained</li> </ul>	<p>deficit plan</p> <ul style="list-style-type: none"> <li>• Cost of recovery scenarios by November</li> <li>• Further work required to assess reasons for pay overspend and identify areas for further control/ mitigation in H2</li> </ul>	
Capital programme		<ul style="list-style-type: none"> <li>• Significant underspend; concern whether spend will be achieved in year</li> </ul>	<ul style="list-style-type: none"> <li>• Summary YTD spend against budget by project list required</li> </ul>	
Capital limits		<ul style="list-style-type: none"> <li>• Authorisation limits agreed in line with other Trusts</li> </ul>		
GIRFT in UEC		<ul style="list-style-type: none"> <li>• Complements system-led work on improving urgent pathway</li> </ul>		
Transformation and Efficiency Update	Yes	<ul style="list-style-type: none"> <li>• Request that the gross pay overspend is noted in the report going forward</li> <li>• Improved engagement reported, but significant gaps in CIP identification remain</li> </ul>		To note
Medicines management	Yes	<ul style="list-style-type: none"> <li>• Developing system-wide approach</li> <li>• Light on financial deliverables</li> </ul>		

Digital Strategy	Partial	<ul style="list-style-type: none"> <li>Concerns re. funding and rise in cost</li> <li>Progress noted</li> <li>Key themes agreed – continuing infrastructure refresh; maximally exploiting existing systems; develop the case for EPR</li> </ul>	<ul style="list-style-type: none"> <li>Strategy to be iterated accounting for feedback</li> </ul>	
BHPL annual report	Yes	<ul style="list-style-type: none"> <li>Approved with corrections</li> </ul>		
SCAS contract extension	Yes	<ul style="list-style-type: none"> <li>Approved</li> </ul>	<ul style="list-style-type: none"> <li>Need to provide current value/year</li> <li>Need to summarise key data rather than circulate whole of NHS Standard Contract</li> </ul>	<ul style="list-style-type: none"> <li>Approve at Board</li> </ul>
Dermatology business case		<ul style="list-style-type: none"> <li>Approved subject to:                             <ul style="list-style-type: none"> <li>TIF funding agreed</li> <li>Board paper includes outcomes/activity/benefits information</li> </ul> </li> </ul>		<ul style="list-style-type: none"> <li>Approve at Board</li> </ul>

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

- System breakeven requirement for H2
- Pay overspend continuing and un-mitigated gap on CIP
- Appointments cancelled by Trust – F&BP November
- Regulator conflicting messages – finance vs. recovery/performance
- Capital for digital spend

**Meeting:** Trust Board Meeting in Public

**24 November 2021**

**Report from Chair of FBP Committee**

**Date of Committee: 16 November 2021**

**Key agenda items considered:**

Item	Committee assured	Further work	Referral elsewhere for further work	Recommendation to Board
Monthly Integrated Performance Report and Recovery	Partial	<ul style="list-style-type: none"> <li>IPR document to be reviewed, re-set and triangulated to the Recovery plan. Exco to review plan to amend the IPR/.</li> </ul>		Continuing and urgent focus
Recovery	Yes	<ul style="list-style-type: none"> <li>Updated verbally from the actions post Recovery Board.</li> <li>Ongoing challenges with the endoscopies - looking at the outsourcing plan</li> <li>Bed occupancy 99% - so wholly challenged in this respect hospital wide.</li> </ul>		To note significant focus on Recovery across Trust
Compliance with CCA	Yes	<ul style="list-style-type: none"> <li>Self assessment of standards for EPRR – externally rated fully compliant.</li> <li>Committee noted partial compliance for business continuity and this has been referred to the EPRR committee to develop action plan to address</li> </ul>		

Depth of coding	Yes	<ul style="list-style-type: none"> <li>Improving the depth of coding; noted quality of data and accuracy.</li> <li>Need to improve the coding of co-morbidities as well as elective care</li> <li>To confirm that every episode is coded.</li> <li>To consider the financial impact of coding</li> </ul>		<p><b>Buckinghamshire Healthcare</b> NHS Trust</p>
Month 7 Finance Report	Yes	<ul style="list-style-type: none"> <li>Noted the £1.2m deficit headline position; does not include any mitigation from ERF income (in H2 plan, not yet finalised)</li> <li>Concern continues regarding the degree of risk in division forecasts of overspend</li> <li>Concern of divisions not delivering on CIP plans, and forecasting overruns.</li> <li>Pay overspends continue to be concern – see separate paper</li> </ul>		To note
H2 Financial Plan	Yes	<ul style="list-style-type: none"> <li>Latest H2 plan forecasting 35.7m deficit for the year. Inherent risks in the plan include                             <ul style="list-style-type: none"> <li>Inherent risks re divisional overruns and ability to mitigate these overspends</li> <li>Delivery of CIP/ efficiency targets a concern</li> <li>ERF income of £4.5m at risk</li> <li>Need to review the release of reserves from balance sheet to ensure consistent and appropriate practice</li> </ul> </li> <li>Noted that ongoing discussions are occurring with the ICS regarding the final planned allocation of ERF income from the ICS.</li> </ul>	BJ to engage with Paul O'G at GT regarding the development of the H2 plan, discuss management of provisions	Recommend to Board to approve the H2 plan noting the inherent risks associated with it. CEO/ CFO/ Chair of FBP have delegated responsibility to approve the final plan submitted to Regulator following further discussions with the ICS.

2021/22 Capital programme update	yes	<ul style="list-style-type: none"> <li>Forecast overspend of £575k which is being reviewed to ensure no overspend</li> <li>Significant concern re overrun and overspend of Paeds A&amp;E. Work underway to understand how to address overspend</li> <li>Concern from Committee regarding controls in place to manage overspends</li> <li>Question regarding lack of spending on capital plan eg medical equipment etc</li> </ul>	To ensure clear tie up between Risk registers and capital spend	To note
P2P/ BPPC update	Yes	<ul style="list-style-type: none"> <li>Noted additional work in progress to further enhance the P2P process.</li> <li>Agreed to recommendations subject to the SFI's being modified appropriately at the next revision date; streamlining approval of PO's over £1m where there are wholly linked to an approved contract / SLA.</li> </ul>	AD to confirm with the Internal Auditors that proposals meet good practice and they are comfortable with recommendations.	To note
Transformation and Efficiency Update	Yes	<ul style="list-style-type: none"> <li>Noted</li> </ul>	To share schedule of principles for budget/ CIP program for 22/23 – ie treatment of pay underspends	To note
Temp Staffing Analysis	Partial	<ul style="list-style-type: none"> <li>Noted paper and requested further analysis                             <ul style="list-style-type: none"> <li>additional financial analysis as set out by Exco</li> <li>Understanding if the existing controls in place are adequate for controlling pay spend or whether changes should be made</li> <li>Pace – Committee seeing assurance of what we will do differently to halt the pay overspends</li> </ul> </li> </ul>	Further paper to be prepared to return to FBP	To note

Digital Strategy update	n/a	<ul style="list-style-type: none"> <li>Comments from October Board now reviewed and considered – digital strategy being amended for re-presentation at FBP in January</li> </ul>		To note
Wycombe link bridge survey report	Yes	<ul style="list-style-type: none"> <li>Report concluded that Link Bridge is safe to use.</li> <li>Further work to do to calculate cost of ongoing repairs as set out in the report</li> </ul>		To note
Premises Assurance model	Yes	<ul style="list-style-type: none"> <li>A self assessment of the safety of premises – particularly from a patient safety viewpoint. Detailed self assessment – prepared in this way for the first time. Action plans in place to continue to improve areas where minor or moderate improvement needed.</li> </ul>		To note
Dermatology business case	n/a		Work still outstanding for AW/BJ re follow up points from October Board	

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

- H2 plan - several risks within the H2 plan calculation. Further negotiations with ICS still underway re ERF and so final H2 plan number yet to be finalised
- IPR - not giving a clear triangulation with the Recovery Plan – needs to be revised to allow better risk management and assurance.
- Ongoing concerns re pay overspends and control thereof
- Divisional outturns - still forecasting a larger deficit than within the H2 plan and so ongoing need for mitigation
- Risk to CIP / efficiency delivery for H2 plan
- Capital overspend to be curtailed and solution sought to manage the A&E Paeds overspend.

**Meeting:** Trust Board Meeting in Public

**24 November 2021**

**Date of Committee:** 20 October 2021

**Key agenda items considered:**

*Please note that this meeting was not quorate.*

Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
<b>NEWS Escalation Audit</b>	Partial assurance – concerns related to: - elevated mortality rates - overnight staffing - overall systemic issue - poor documentation Assurance taken regarding actions to address the above.	Update to Q&CG November 2021 with update on actions.  Quarterly report to Q&CG.	EMC for review due to level of risk	To note
<b>Surgery and Critical Care Division</b>	Partial Assurance - Noted balancing risks associated with long waits (104+ weeks) and clinical priorities. Data on quality to Committee	Update quality metrics tracked.  Update to Q&CG December 2021.	Continued monitoring by Q&CG	To note

<p><b>IPR</b></p>	<p>Yes Noted the following risks: - 2ww Breast Ca pathway related to Radiology staffing - Potential harm to late/non-presenters (national problem) - Impact of diagnostics on waits - Reduction in sepsis performance - Link between workforce and quality issues</p>	<p>Focussed table for surgical waiting times for P2 patients  Identification of specific workforce hotspot areas; apply targeted action plans to improve quality</p>	<p>Seek assurance from SWC re: national staff survey participation (19%)  Linked working between Q&amp;CG and SWC to triangulate vacancy rates and areas of poor quality</p>	<p>To note</p>
<p><b>Clinical Harms Review</b></p>	<p>Yes Noted the following risks: - Potential harm due to lack of access to children's services</p>	<p>Join System conversation re CYP services</p>	<p>Continued close monitoring by Q&amp;CG</p>	<p>To note</p>
<p><b>Non Site Specific Pathway Review</b></p>	<p>Yes</p>	<p>Final report to Q&amp;CG December 2021</p>	<p>Continued close monitoring by Q&amp;CG</p>	<p>To note</p>
<p><b>GIRFT Report</b></p>	<p>Yes</p>	<p>Six-monthly reporting to Q&amp;CG</p>	<p>Continued close monitoring by Q&amp;CG</p>	<p>To note</p>

<p><b>Mortality Report</b></p>	<p>Yes Reasons for high HSMR and the rectification measures related to Coding file transmission noted. Lessons learned with Covid-19 management for future similar events. Earlier admission to ICU beneficial. Overall BHT performed well.</p>	<p>n/a</p>	<p>Continued close monitoring by Q&amp;CG</p>	<p>To note</p>
<p><b>Safeguarding Annual Report</b></p>	<p>Yes Noted the following risks: - System wide resource limitations - Change in legislation</p>	<p>Targeted improvement efforts for training compliance</p>	<p>Continued close monitoring by Q&amp;CG</p>	<p>To note</p>
<p><b>SI Report (including Maternity)</b></p>	<p>Partial assurance – concerns related to October never events.</p>	<p>Seek assurance from lessons learned related to previous similar events.  Include benchmarking of SI rates</p>	<p>Continued close monitoring by Q&amp;CG</p>	<p>To note</p>
<p><b>External Reviews Update</b></p>	<p>Yes</p>	<p>n/a</p>	<p>Continued close monitoring by Q&amp;CG</p>	<p>To note</p>
<p><b>CQC Improvement Action Plan and Preparedness</b></p>	<p>Yes Noted risk that CQC preparedness is variable across the organisation – Trust-wide actions in place.</p>	<p>Ongoing organisational preparation</p>	<p>Continued close monitoring by Q&amp;CG</p>	<p>To note</p>

<b>Clinical Audit Update (including National Audit results)</b>	Yes	n/a	Continued close monitoring by Q&CG	To note
<b>Transfusion Annual Report</b>				
<b>Minutes</b>	Yes	n/a	Continued close monitoring by Q&CG	To note

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**Meeting:** Trust Board Meeting in Public

**24 November 2021**

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

**Date of Committee: 19 October 21**

**Key agenda items considered:**

Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
Meeting Minutes	Minutes approved	None	Refer to Audit Committee for noting	n/a
Blood Transfusion Annual Report	Deferred			
Endoscopy Decontamination Unit	Assured	Committee to be updated following completion of SI review process.	None	To note

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Integrated Performance Report (IPR)	Not considered – late paper			
Improvement Plan for Medically Optimised for Discharge (MOfD) Patients	Partially assured – risks noted as follows: - Ability to recruit to all posts to support action plans - Fragility of domiciliary care market - Impact of ambulance delays on hospital admissions.	None	n/a	To note
Cancer Report	Assured – noting a maintained conversion rate related to Ca breast referrals and additional escalation steps related to PTL.  Ongoing non-compliance with 62-day target, noting actions in place to improve this.	None	Return to Q&GC in December – paper for information. Noted that Cancer performance is an integral part of the Trust Improvement Programme; reporting to Board fortnightly	To note
Never Events	Assured	None	n/a	To note

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SI Report (including Maternity)	Assured	None	n/a	To note
Infection Prevention and Control (IPC) Report	Assured	Continue to source benchmarking data where possible	n/a	To note
Maternity Staffing, WBC & Ockenden Progress	Assured – noting the national midwifery staffing challenges and the number of workstreams to address this. Committee assured no impact on progress with Ockenden recommendations.	None	Consider referral of paper to Strategic Workforce Committee (SWC)	To note
Provision at Wycombe Birth Centre	Proposal approved	None	None	Recommend Board approval
CNST Sign Off	Proposal approved	None	None	Recommend Board approval
Maternity Safety Reports	Assured	None	None	To note

Safe & compassionate care,				
Safe Staffing (including Maternity)	Assured – noted improvements in weekend staffing planning	None	None	To note
Safe Staffing within the Community	Noted – including review of staffing structures within Community Services to prevent duplication of activities.	None	None	To note
Patient Story	Approved – noting lessons that can be learnt from both positive and negative patient experiences and use of AI.	None	None	For presentation at November Board
Patient Experience Annual Report	Assured – noting usefulness of regular updates	None	None	To note
National Inpatient Survey Results	Assured – noting usefulness of regular updates	None	None	To note
Corporate Risk Register (CRR)	Noted	Provide detail of those risks which sit under the ownership of Q&CG Committee	None	For presentation at November Board
Board Assurance Framework (BAF)	Noted	Provide detail of those risks which sit under the ownership of Q&CG Committee	None	For presentation at November Board

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Quality and Patient Safety Committee Chairs Report	Noted	None	n/a	n/a

**Emerging Risks noted:**

- Ability to recruit to all posts to support the Medically Optimised for Discharge (MOfD) improvement action plans.
- Fragility of domiciliary care market.
- Demand of winter months.
- Ambulance service delays; impact on hospital admissions.
- Compliance with 62-day cancer target.
- National midwifery staffing levels.
- Community staffing levels.
- Wycombe Birth Centre Future Plans
-

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**Meeting:** Trust Board Meeting in Public

**24 November 2021**

**Report from Chair of Strategic Workforce Committee**

**Date of Committee: 8 November 2021**

**Key agenda items considered:**

Item	Committee Assured	Further Work Required	Referral Elsewhere for Further Work	Recommendation to Board
Minutes of previous meeting	Assured	n/a	n/a	n/a
Chief People Officer Report	Assured	n/a – for ongoing monitoring through SWC	n/a	To note
Integrated Performance Report (IPR)	Assured – noting significant ongoing impact of COVID-19 on sickness absence/requirement to isolate	n/a – for ongoing monitoring through SWC	n/a	To note
Recruitment Update	Assured – noting excellent progress with international recruitment Assurance taken re: provision of support for international recruits	Utilise contacts and processes from successful international nursing recruitment to improve international recruitment of AHPs	n/a	To note

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Healthcare Support Worker (HSW) Update	Assured – noting achievements recognised nationally	n/a – for ongoing monitoring through SWC	n/a	To note
WRES & WDES plans	Assured	Review WRES data for medical staffing – Medical Staffing Team to review and report through to E,D&I Strategic Group.  Review and refresh ownership of staff networks where lacking  Align BHT ED&I stretch targets with those of the System	n/a	To note
Annual Staff Survey Update	Assured – noting improved position compared to last year for majority of staff groups	Targeted interventions required for medical staff	n/a	To note
Thrive@BHT Update	Assured – noting the impact of operational pressures on both the provision of training and support programmes and hygiene factors	Work initiated on culture and behavioural leadership framework initiated to support management of people through change	n/a	To note

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Freedom to Speak Up Guardian (FTSUG) 6-month Update	Assured – noting the significant impact of increased staffing within the service and subsequent outreach model	n/a – for ongoing monitoring through SWC	n/a	For consideration at Trust Board – requirement for 6 monthly review
Guardian of Safe Working Hours	Partially assured, noting: - junior medical staffing in ED; business case approved by Board - implications of rostering practice	Committee require greater assurance regarding operational issues within ED medical team	Refer back to Executive team for assurance	To note
Occupational Health & Wellbeing Update	Assured – noted that COVID-19 booster rates are likely to be under-reported due to accessibility elsewhere	Noted that formal announcement awaited re: mandatory COVID-19 vaccinations and potential need to replicate work in the Community with staff working within acute areas	n/a	To note
Quarterly Education Report	Assured – noted summary of BHT funding allocation following October Board discussion	n/a – ongoing monitoring at SWC	n/a	To note
2021 GMC Training Survey	Partial assurance – see further work required	Committee to seek further assurance regarding those actions related to Histopathology and Cardiology	n/a	To note

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Rostering Programme Update	Assured	n/a – ongoing monitoring at SWC	n/a	To note
BHT People Strategy	For information	n/a	n/a	To note
BOB ICS People Programme Update	For information	n/a	n/a	To note

**Meeting:** Trust Board Meeting in Public

**24 November 2021**

**Report from Chair of Audit Committee**

**Date of Committee: 4 November 2021**

**Key agenda items considered:**

Item	Committee assured	Further work	Referral elsewhere for further work	Recommendation to Board
Internal Audit Reports	Yes	Subject to further review on actions following audit	Will return to Audit Committee through action reporting	For noting
Payroll – reasonable assurance				
Maternity – Ockenden Report				
Part 1 – advisory				
Community				
Paediatrics – Reasonable Assurance				
Expenses – Partial Assurance				
Waste Management – partial assurance				
HSMR Coding- Reasonable assurance				

Rostering and Temporary Staffing – Reasonable Assurance				
LCFS Report Benchmarking Report on Single Tender Waivers	Yes	Subject to further review on STW	N/A	For noting
Corporate Risk Register	Yes	Work in progress with reporting being developed	N/A	For noting
Board Assurance Framework	Yes	Work in progress with reporting being developed and triangulation with risk and recovery reports	N/A	For noting
Single Tender Waivers	Yes	Yes – reporting format to be finalised	To be reported at next Audit Committee	For noting
Losses and Special Payments	Yes	No	N/A	For noting
Minutes of SWC/QCGC/F&BP	Yes	No	N/A	For noting

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

Wash up session with auditors delayed to 18 November

Triangulation of work to recovery actions

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**Buckinghamshire Healthcare**  
NHS Trust

**Meeting:** Trust Board Meeting in Public

**24 November 2021**

<b>Agenda item</b>	Corporate Risk Register (CRR)
<b>Board Lead</b>	Karen Bonner Chief Nurse
<b>Name of author</b>	Sandie Knight, Governance Manager
<b>Attachments</b>	Corporate Risk Register
<b>Purpose</b>	Assurance
<b>Previously considered</b>	EMC 02.11.2021 Audit Committee 04.11.2021 Q&CG 15.11.2021

### Executive Summary

Please note that this paper was submitted simultaneously to EMC and the Audit committee.

There are two new risks escalated for EMC approval for inclusion on the CRR:

- **CRR149** - Inadequate physical ED environment in terms of quality and capacity, prevents effective streaming, hinders flow, increasing the risk of delayed triage, unobserved deterioration, infection spread. Scored at 20 with a target completion date of 31/03/2022
- **CRR150** - Clinically inappropriate length of stay in ED including time to Triage, treat and discharge or admit. Scored at 15 with a target completion date of 31/03/2022

There are two risks where mitigations are now fully in place, and EMC are asked to approve removal from the CRR:

- **CRR138/PS179** - Improved ventilation required in clinical / ward areas at SMH
- **CRR127/Covid-19RR Ref12** - Increased risk of adverse impact on staff from BAME backgrounds if they become positive with COVID19.

There are several risks with updates and the Committee is asked to note these.

A heat map has been attached in Appendix 3 following a request from the Audit Committee in September.

This report was considered at the Executive Management Committee on 2 November 2021 and the above actions were approved. Further work was noted to be required to capture the top organisational risks by the COO with input from the CMO/CN for triangulation. These actions were endorsed by the Audit Committee.

The report was presented to Quality & Clinical Governance Committee on 15 November 2021 for information only. The Committee was informed of the plan to provide each Board Committee with those risks under their ownership in future months.

### Decision

The Committee is requested to review and approve the risks for addition to and removal from the Corporate Risk Register and note the updated actions.

Relevant strategic priority			
Outstanding Care <input checked="" type="checkbox"/>	Healthy Communities <input type="checkbox"/>	Great Place to Work <input type="checkbox"/>	Net Zero <input type="checkbox"/>
Implications / Impact			
<b>Patient Safety</b>		Identifies any potential patient safety concerns	
<b>Risk: link to Board Assurance Framework (BAF)/Risk Register</b>		Risks articulated in the CRR	
<b>Financial</b>		Risks articulated in the CRR	
<b>Compliance</b> <small>Select an item.</small> <b>Good Governance</b>		Risks articulated in the CRR	
<b>Partnership: consultation / communication</b>		Consultation and Communication identified in updated actions	
<b>Equality</b>		The Trust is committed to the fair treatment of all patients and service users, regardless of age, colour, disability, ethnicity, gender, gender reassignment, nationality, race, religion or belief, responsibility for dependents, sexual orientation, or any other personal characteristics.	
<b>Quality Impact Assessment [QIA] completion required?</b>		Not Applicable	

### 1. Purpose

This report provides the Committee with assurance the risk management process is complied with in the management and mitigation of the risks on the Corporate Risk Register (CRR) See Appendix 2.

### 2. Background

The CRR has been reviewed by each Director responsible for the risks. Many of the actions to mitigate the risks are being reviewed in the light of the impact of COVID 19 on the level of risk, mitigating actions, target dates and outcomes.

### 3. Updates:

The following Risks have been updated:

**CRR10/HR4/14** - Shortage of qualified nursing, Midwifery and AHP staff: The actions have been updated to reflect successful recruitment activity, both internationally and in the UK. The team are currently on target to meet the deadline of March 2022 for new recruits. The residual risk score has been reduced from 5x3 to 5x2.

**CRR88/S220/PA27** – Patient tracking: this risk has been reviewed and the target date extended from 31/10/2021 to 31/03/2022. This risk has also been included on the Specialist Services Divisional risk register (ref PA27) for additional mitigation and review.

**CRR115/PS118** – Medical gas pipework: The medical gas pipework has now been laid and a concrete plinth installed in readiness for the Oxygen tank. BOC are currently unable to confirm a definite date for the delivery of the tank due to supply issues and the target date has been extended from 31/010/2021 to 31/12/2021 to make allowance for this.

**CRR143/S246** – Ophthalmology service delays. The risk actions and gaps have been updated and the risk target date extended from 31/10/2021 to 30/03/2022. The 'on hold' list is increasing due to lack of staffing capacity and a further business case for additional establishment is pending. The request for reconfiguration of the Amersham space requires progressing through the Space Committee.

**CRR147/IT309** - Risk of disruption to Trust technology systems and services caused by cyber incidents: There is currently no change to the risk but at a risk review meeting on 6<sup>th</sup> October the team confirmed they are devising a paper for EMC to further define all the issues and the options available.

#### 4. Expired Risks which require urgent review

There are currently no expired risks.

#### 5. New Risks for approval from EMC to add to the CRR

The following risks are noted for EMC to approve for inclusion on the CRR

- **CRR149** - Inadequate physical ED environment in terms of quality and capacity, prevents effective streaming, hinders flow, increasing the risk of delayed triage, unobserved deterioration, infection spread. Scored at 20 with a target completion date of 31/03/2022
- **CRR150** - Clinically inappropriate length of stay in ED including time to Triage, treat and discharge or admit. Scored at 15 with a target completion date of 31/03/2022

#### 6. Risks for removal

The following risks are noted for EMC to approve removal from the CRR:

- **CRR138/PS179** - Improved ventilation required in clinical / ward areas at SMH: Portable IQEA air cleaner units have been issued to all clinical areas along with a SOP for use, and ventilation improvements in line with input from IPC. These mitigations have reduced the risk from a 16 to 12 thus removing the requirement for inclusion on the CRR.

The risk will remain on the divisional risk register for monitoring. A business case has been devised, based on the findings of a ventilation survey completed by an authorised engineer, to secure funding to improve ventilation in all areas. Work is scheduled to commence April 2022.

- **CRR127/Covid-19RR Ref12** - Increase risk of adverse impact on staff from BAME backgrounds if they become positive with COVID19: There is now no overall gap between BAME and non-BAME staff so the risk has been reduced off the CRR but will remain on the divisional register for monitoring.

## 7. Emerging Risks

1. **Surgical Floor:** A Risk assessment has been undertaken on the surgical floor for emerging risks (related to infection prevention and control, staff wellbeing, risk of patient absconding through the fire exit, storage space) and is currently being quantified. EMC will be notified of the outcome.
2. **Ward 18:** at EMC on 3<sup>rd</sup> August it was noted by the Chief Operating Officer that an operational risk assessment was required for wards 16, 17 and 18. The Heads of Nursing surveyed these areas with Matt Lee, Head of Security, and a representative from Estates. The outcome is that for wards 15, 16, 17 and 18 there is a requirement for the following security measures:
  - Access control to be installed and improved on doors to allow improved patient flow and staff safety
  - Intercoms changed/ installed, and handsets installed on each ward to enable staff to answer the main entrance door or their own ward's door
  - CCTV cameras installed within the wards and at main pinch points
  - CCTV monitors installed on wards, so staff have oversight of their own and surrounding areas
  - Medicine cabinets secured with Abloy Cliq (similar system installed in A&E)

A timeline for these actions is being devised and details will be provided in the next report to EMC.

3. **Theatres:** at EMC on 3<sup>rd</sup> August the Chief Operating Officer noted work was required around clinical practice, culture, staffing, productivity, leadership and safety within the Theatres and a panel to review actions would need to be set up. The surgical team have this under review and an update will be supplied in the next report.

## 8. Review of the Risk Register

The risk register and process are currently under review with a plan to move to Datix web version 14 which will enable robust tracking and auditing. The deadline will be subject to the staged installation of the Datix system but in the meantime, work continues with the divisions to improve their risk registers in preparation for the new Datix platform.

## 9. Recommendation

The Committee is requested to note the report and approve the requests for inclusion and removals for the Corporate Risk Register.

## 10. Appendices

Appendix 1

	Consequence Score (severity levels) and examples of descriptors				
	1	2	3	4	5
<b>Domains</b>	<b>Negligible</b>	<b>Minor</b>	<b>Moderate</b>	<b>Major</b>	<b>Catastrophic</b>
<b>Impact on the safety of patients, staff or public (physical / psychological harm)</b>	Minimal injury requiring no/minimal intervention or treatment.  No time off work	Minor injury or illness, requiring minor intervention  Requiring time off work for >3 days  Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention  Requiring time off work for 4-14 days  Increase in length of hospital stay by 4-15 days  RIDDOR/agency reportable incident  An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability  Requiring time off work for >14 days  Increase in length of hospital stay by >15 days  Mismanagement of patient care with long-term effects	Incident <u>leading to death</u>  Multiple permanent injuries or irreversible health effects  An event which impacts on a large number of patients
<b>Likelihood score</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<b>Descriptor</b>	<b>Rare</b>	<b>Unlikely</b>	<b>Possible</b>	<b>Likely</b>	<b>Almost certain</b>
<b>Frequency</b> How often might it/does it happen	This will probably never happen/recur  <0.1 %	Do not expect it to happen/recur but it is possible it may do so  <0.1 – 1%	Might happen or recur occasionally  1 – 10%	Will probably happen/recur but it is not a persisting issue  10 – 50%	Will undoubtedly happen/recur possibly frequently  >50%

Appendix 2 CRR  
Appendix 3 Heat Map

Corporate Risk Register	Divisional Risk Register	Division	Date added to CRR	Trust Objective	Description of risk	Unmitigated risk	Key controls	Risk Score			Gaps in controls	Actions to address risk, including target completion dates (bold) for each action.	Target overall completion date	Executive Lead	Predicted residual score		
								C	L	C x L					C	L	C x L
CRR 10	HR 4/14	Trust	24/11/2014	Implement new workforce models	Shortage of qualified nursing, Midwifery and AHP staff, which results in high reliance on temporary staffing (Bank and Agency) in some areas which could impact on the quality of patient care and the Trust financial position.	25 (5x5)	<ul style="list-style-type: none"> <li>Performance management of Recruitment Service - People Committee.</li> <li>Performance management of Divisions and Corporate Services</li> <li>Performance management of NHSP to ensure quality of temporary staff and high proportion of bank rather than agency staff. <ul style="list-style-type: none"> <li>Daily safe staffing huddles.</li> <li>Weekly safe staffing meeting to identify and review hot spots.</li> <li>Monthly vacancy heat map by cost centre.</li> </ul> </li> <li>Detailed recruitment plan under three strands - grow your own, UK candidate, International</li> <li>Continuation of approach to retention from Phase 4 NHSi retention strategy that focuses on three strands (recruit well / mid-career / 50+ programme). <ul style="list-style-type: none"> <li>Monitored through Strategic Workforce Committee.</li> </ul> </li> </ul>	5	4	20	<ul style="list-style-type: none"> <li>National shortage of registered nurses and midwives.</li> </ul> <p>The position was exacerbated by COVID-19.</p> <ul style="list-style-type: none"> <li>Possible increase in individuals leaving the profession. Reviewing the nurse establishment in response to Covid-19.</li> <li>Late confirmation from student nurses to offers of employment with the Trust.</li> </ul>	Trust-wide recruitment and retention plans are in place monitored through fortnightly workstreams. These focus on local, national and international recruitment of nurses. <ul style="list-style-type: none"> <li>Longer term plans: Bucks Health and Social Care Academy - 73 individuals have started undergraduate nurse degree programmes at our partner universities (62 adult nursing, 11 children nursing) in September 2021; 35 individuals have started midwifery courses.</li> <li>Use of apprenticeships: 31 individuals were recruited onto nursing associate apprenticeship and nurse degree programmes for 2020-21.</li> <li>Local plans for hotspot areas and recruitment to a wider range of roles.</li> <li>Recruitment of international nurses - target to recruit and relocate 222 nurses over 12 to 18 months. 10 cohorts (140 individuals) have arrived to date across March to Sept). Offers have been made to 222 nurses, the remaining 82 nursing due to arrive Oct - Dec. Of the 140 nurses that have arrived: 59 have completed OSCE, received their NMC registration and are now working as registered nurses.</li> <li>Contact with EU universities maintained - AHP staff, 5 due to join in Oct/Nov and further activities to take place. Meetings held with Portuguese partners during February 2021 - attended online jobs fair on 10 May 2021, 10 - 15 nurses expressed an interest.</li> </ul>	30/03/2022	Chief People Officer	5	2	10
CRR 27B	PS153	Property Services	20/10/2017	Estate strategy	<p>The SMH main HV/LV electrical supply is insufficient for the current needs of the Estate and is not resilient.</p> <p>In addition, due to the discovery of corrosion on the existing equipment, the installation of a new joint box and replacement switch gear and cables is also required.</p> <p>If external supplies fail the internal back up support generators will only support the power needs of the site for 4 hours.</p> <p>This will affect all clinical and non clinical services.</p>	25 (5x5)	<p>We have a generator supply system which will provide emergency power to all of the site.</p> <p>This project will re-structure the power supply systems to provide secure services.</p> <p>Initial 4 hour back up will require extra fuel deliveries to allow continuation of generator support and Clinical services. Contract in place.</p> <p>Individual medical equipment has limited battery back up for approximately 30 minutes.</p>	5	4	20	<p>Insufficient power supply</p> <p>Only one electrical supply cable, 2nd needed for resilience</p>	<p>HV/LV upgrade project now 65% complete. Expected completion date has now been extended by 3 months from 31/03/2021 to 30/06/2021 due to the discovery of corroded cables and switchgear which now needs to be replaced.</p> <p>New cabling and switch gear now on order to be installed.</p> <p>Transformers and distribution panel to be installed.</p> <p>Further delays caused by a reduction in the supply of steel and copper due to Brexit and priority for these items being given to local HS2 construction - target completion extended from 30/09/2021 to 31/12/2021.</p>	31/12/2021	Commercial Director	5	1	5
CRR 85		Trust	20/10/2017	Implement new workforce models	We have a shortage of junior doctors in the organisation. The specialities most affected are the medical specialities, paediatrics and T&O doctors. This has the potential to have a negative impact on patient care.	20 (4x5)	<ul style="list-style-type: none"> <li>Existing staff asked if they would like to work extra shifts.</li> <li>Use of temporary staff where possible. This is usually through the bank and often doctors who know the organisation. The switch from agency to bank has created a more stable temporary workforce. Consultants acting down policy in place.</li> <li>Resident Medical Officer (RMO) service in place in National Spinal-cord Injuries Centre to offer additional cover.</li> <li>RMO post incorporated into night rota for acute surgery at Wycombe and Stoke Mandeville Hospitals.</li> <li>Revised middle grade rotas in order to make them more resilient.</li> <li>Controls around leave booking is held at local level.</li> <li>Review of staffing levels against new Royal College of Physicians guidance. Medical rotas have been revised to increase cover to the out of hours teams. Safe medical Staffing review of the acute medical rota at Stoke Mandeville identified a shortage of specialist Registrar grade time in the week.</li> <li>E-rostering for medical staff - in place</li> <li>Annual Leave policy - in place</li> </ul>	5	3	15	<p>National shortage of doctors from key groups.</p> <p>There are identified gaps in rotas in medicine at registrar and consultant level. These gaps have increased with the expansion of the medical bed base due to Covid-19</p> <p>Covid-19 is also impacting on rotas due to the guidance on household contacts which is making the situation worse</p>	<ul style="list-style-type: none"> <li>Active recruitment continues in the challenged environment of a national shortage of doctors in speciality areas.</li> <li>E-rostering has supported good rostering practice, however it has also highlighted the gaps in rotas across the Trust.</li> <li>A report has been submitted to EMC in August ' Safe Medical Staffing' which has highlighted the challenges of meeting the royal college of physicians guidance and is subject to a business case currently with EMC/Board for consideration.</li> <li>Medicine is keen to actively recruit a mix of trust grade FY2s, PAs and ACPs, and is currently awaiting the outcome of this business case. Paediatrics already have Advanced Nurse Practitioners (x2) in post.</li> </ul>	31/03/2022	Medical Director	5	1	5

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CRR 88	S220, IM138 and IM 139, PA27	Trust	19/02/2018	Digital strategy	There is a risk that harm can come to patients if they are not tracked robustly and given appointments in a timely fashion. This includes: -Monitoring of hospital initiated cancellations -Tracking follow up appointments -oversight of patients put 'on hold' - incomplete clinic outcome forms  This has become increasingly visible through new reporting via Medway	25 (5x5)	IT reviewing process and considering alternatives to enable the repeated movement of patients to be clearly visible so they can be monitored and reviewed.  Outpatient review group. Compulsory follow up date to be in Medway. Working through On Hold lists for each SDU.	4	4	16	<ul style="list-style-type: none"> <li>'On hold' project and data validation exercise expanded to include cancellations due to COVID-19.</li> <li>Ability to be able to track non compliance with agreed standard operating procedures.</li> <li>Recovery plans and Outpatient capacity.</li> <li>Non compliance with cancellation process <ul style="list-style-type: none"> <li>Outpatient modernisation project.</li> </ul> </li> </ul> <p>• Additional resource agreed to commence on hold project: validation 'on hold' entries by reason, review of patients in progress, COVID-19 cancellations. Start 26/4/21.</p> <ul style="list-style-type: none"> <li>Establishing a single follow up PTL</li> <li>COVID-19 recovery plans and non face to face contacts to include appropriate 'on hold' patients. <ul style="list-style-type: none"> <li>Follow up dashboard to facilitate recovery plans by SDU</li> <li>Cashing up of clinics to be completed within 7 days</li> </ul> </li> <li>Secretaries review all 'On Hold' entries when typing up patient letters</li> </ul> <p>On hold project started - single PTL for follow ups in development, sampling analysis has been undertaken. Divisions focusing on closing down legacy stray pathways. Capacity piece commissioned to determine gap.</p>	31/03/2022	Chief Operating Officer	5	2	10	
CRR115	PS118	Property Services	12/11/2019	Estate strategy	The existing medical gas pipe work is not sufficient for current clinical needs.  In the event of an increased medical demand for oxygen such as a surge in Covid, there is insufficient infrastructure in place to deliver required supply.	20 (5x4)	Additional Vacuum Insulated Evaporator (VIE for bulk storage of Oxygen) installed  Pipework upgraded from the oxygen tanks to the main site at SMH Upgraded deliveries from BOC to ensure tank levels are greater than 50% Evaporators placed to support tank oxygen delivery (to assist with oxygen flow)  Oxygen concentrators (60) obtained to provide ward supplies to individual patients  Manifold provided with 20 cylinders to augment supply at front door (ED) Improvement of information flows using vitals and development of a live dashboard	5	3	15	<p>The current infrastructure is not designed to support the oxygen demand during a Covid surge</p> <p>Global shortage of building materials causing delays in construction.</p> <p>Due to Covid experience, additional / upgraded pipework is being requested by the Trust to the PFI to improve O2 flow rates ( project dates to be agreed).</p> <p>Clinical requirements for WH are currently being reviewed in terms of number of patients/ delivery methods that could be supported. S/B Manifold installed at Wycombe.</p> <p>The medical gas pipework has now been laid at SMH and a concrete plinth installed in readiness for the Oxygen tank. BOC are currently unable to confirm a definite date for the delivery of the tank due to supply issues and the target date has been extended from 31/01/2021 to 31/12/2021 to make allowance for this</p>	31/12/2021	Commercial Director	5	1	5	
CRR116		Trust	12/11/2019		The Datix system fails to function appropriately due to its age and unsupported infrastructure. It is not compatible with Windows 10.	20 (4x5)	Monitoring and vigilance and Workarounds Regular meetings and checks within the Patient Safety Team	4	4	16	<ul style="list-style-type: none"> <li>System performance discourages staff from reporting and managing incidents in a timely manner.</li> <li>The Trust reporting and ability to learn from incidents is affected due to the difficulty in obtaining information in a clear and timely manner.</li> <li>Datix cannot provide standard Technical back room support, and workarounds on the system to support functions are required and may introduce some unintended or unknown risk into the system.</li> <li>Risk of Business Continuity impact as the system may fail unexpectedly because the current version of Datix cannot be sustained or supported in the long term by the suppliers.</li> <li>There is an increasing risk the Trust will not be able to report incidents in a timely manner due to the poor performance and incapability of the system against national requirements.</li> <li>There is a risk that Patient Safety will be compromised through modules in Datix not optimised in interfaces, codes incompatible with national systems, inability to comprehensively benchmark, and an inability to identify risks at the earliest possible stage.</li> </ul> <p>The patient safety team monitor the system on a regular basis supported by IT. Facere Melius will support the Trust with the upgrade to version 14 of the Datix software. The current version of RLDatix (version 10) is out dated and is going to be replaced by a new improved RL Datix Web v14.</p> <p>All of the options have been considered and RLDatix is the most commonly utilised risk management system within the NHS, with 74% of NHS organisations stating that they used RLDatix, with 98% of those using RLDatixWeb v14.</p> <p>The programme will support the delivery of high quality, safe patient care and the upgrade will facilitate timely reporting and management of learning and incidents, complaints, concerns, claims, patient safety alerts and clinical and organisational risk. Dashboards will help you manage all these locally.</p> <p>The trust has appointed a team of experts to facilitate the upgrade, this will include designing new forms and providing training to staff. You might be contacted to provide input into form and dashboard development, review or test the new system. It is important to us that we have a functioning system which is fit for purpose and supports learning and improvement.</p>	01/04/2022	Chief Nurse	2	1	2	

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CRR 126	Covid-19 RR	Trust	01/04/2020	People are safe, supported and listened to	Increased impact on staff physical and psychological health and wellbeing from working during COVID-19 pandemic. Specific risks include: increased pressure in work environment- wearing of PPE for prolonged periods, increased end of life patients, caring for colleagues, working in new environments	25	<ul style="list-style-type: none"> <li>Comprehensive staff occupational health &amp; wellbeing offer - psychological and physical - in house and access to national programmes now supported with confirmed funding for social prescribing support via Lindengate and Horseheard.</li> <li>Weekly debriefs with CEO and regular communications</li> <li>Staff networks</li> <li>Strengthened collaboration with Clinical Psychology, Chaplaincy and OD Teams. Additional mental health specialist support in place.</li> <li>Employee Assistance Programme (Vivup) in place for nearly a year offering 24/7 support. Good levels of awareness and use.</li> <li>Strong wellbeing Comms plan in place providing information and links to a range of external support together with psychoeducational material.</li> <li>Continued promotion of Thrive at BHT campaign which reinforces the message that staff wellbeing is a priority and self care is essential.</li> <li>Developing return to work packs to support staff and managers with the transition of coming back to the workplace.</li> <li>Building strong partnership with BOB Mental Health Hub for additional in reach wellbeing support ie not just referring to them.</li> </ul>	5	4	20	<p>Impact of sustained pressure of managing COVID-19 is evolving and stress referrals have been steadily increasing year on year and in the past 3 months.</p> <p>Referrals for stress continue on an upwards trend.</p> <p>Lower uptake of COVID-19 vaccination from colleagues from some BAME backgrounds.</p>	<ul style="list-style-type: none"> <li>Thrive at BHT Care pack sent to all colleagues home addresses June. Similar to the Winter Care pack, this details: wrap around support offering from OH, Wellbeing, OD, HR and Chaplaincy. The Wellbeing service drop ins have been extended to more wards.</li> <li>Increased 'ward drop in support' offered in areas with high incidences of stress. 1:1 counselling resource prioritised to ensure waiting lists do not develop.</li> <li>In line with the social distancing rule development of COVID19 Schwartz rounds; After Event Reflections and other team support interventions (where the enhanced on line offering needs further interactions).</li> <li>Using all existing services (training, 1:1's, team support) to share what's available for colleagues. Disseminating information through Wellbeing Champions, Trust Networks and Junior Doctors Forum.</li> <li>Vaccination uptake - improved in response to actions in place to increase uptake including specific communications, an advice line and face to face appointments to discuss concerns. BAME uptake has also improved.</li> <li>Plans in place for Covid 19 booster vaccination.</li> <li>Wellbeing support for ICU colleagues in place. Small team/group recovery sessions are being offered to priority teams.</li> <li>Launch of high engagement, anti-bullying campaign mid June (running for 6 months); the programme is a high engagement campaign to create and embed a culture of respect and kindness across the Trust</li> </ul>	31/03/2022	Chief People Officer	5	2	10
CRR130	PS177	Property Services	20/10/2020	Estate strategy	<p>Wycombe Hospital. The concrete panels installed on the exterior of the tower block are at risk of falling away from the main building to the ground due to deterioration of the cast iron clips installed when the tower was constructed.</p> <p>The structural integrity of the tower block is under investigation as the last survey has identified potential failures.</p>	20	Scaffolding is currently erected with boarding to protect persons from smaller spalling concrete. Larger concrete panels which have been identified as concerns have been removed.	5	3	15	<p>Further scaffolding and boarding needed to protect from larger pieces of falling concrete.</p>	<p>More robust scaffolding and boarding to be erected to protect the pedestrian routes around the base of the tower block.</p> <p>Scaffolding to be in place by Mid December 2020</p> <p>Additional scaffolding and stronger boarding has been installed and following advice from structural engineers we are now extending the scaffolding around the whole building.</p> <p>Full condition survey to be completed by structural engineers.</p> <p>Decision on repair work to be agreed following recommendations made in survey.</p> <p>Remedial works to be implemented.</p> <p>Further investigation and testing of the structure and concrete chemistry is required to determine the continued safe use of the building.</p> <p>Continue to update the EMC and Trust Board on the Services and condition and patient experience.</p>	30/09/2022	Commercial Director	5	1	5
CRR139	S244 (Previously CRR68/ S228)	Trust	18/02/2021		<p>There is a risk of potential clinical harm attributed to patients waiting for elective surgery. This is as a result of the COVID -19 pandemic where elective surgery was reduced. This has also affected the delivery and sustainability of the national standard for Referral to Treatment Time (RTT)</p> <p>There is an increased likelihood of 52-week breaches occurring in all surgical specialities and treating patients classified as P2 within the mandated four weeks.</p>	20	<p>RTT performance is monitored through: Weekly Patient Tracking List (PTL) meetings. Weekly Access Performance Management Group (APMG) meetings. Monthly Divisional Performance Meetings</p> <ul style="list-style-type: none"> <li>Training programme established for IFR funding process and adherence to CCG criteria</li> <li>Evidence Based Intervention monitoring</li> <li>Recover capacity post COVID</li> <li>Additional Waiting List Initiatives</li> <li>Continuation of Vanguard facilities</li> <li>Performance trajectories in line with National targets</li> <li>Retaining elective activity in safe facilities</li> <li>Full demand and capacity review of all specialities to be repeated by October 2021.</li> <li>All appropriate appointments moved to virtual</li> <li>Referrals of all surgical specialities to be vetted</li> <li>Priority post COVID-19 elective recovery planning in place</li> <li>Maximise use of the Independent Sector</li> <li>Outsource work via the ICS as appropriate</li> <li>Business planning commenced to increase capacity in 21/22</li> <li>Patient communication:</li> <li>20,000 letters to patients waiting first appointment</li> <li>Refresh of prioritisation letters to patients on elective waiting list</li> </ul>	4	5	20	<p>Outpatient Clinic capacity is lower than 19/20.</p> <p>Elective capacity is lower than 19/20</p> <p>Capacity restrictions due to IPC Capacity does not meet backlog demand.</p> <p>Inability to recruit to nursing and medical vacancies across the Trust.</p> <p>Patient choice to defer treatment</p> <p>NHSE expectation to reduce elective operating in times of pressure in the system.</p>	<p>Increasing the amount of day case and elective surgery in line with IPC recommendations</p> <p>Maximise use of IS facilities</p> <p>Implement partial booking and Patient Initiated follow up which will support the teams to proactively plan the ambulatory pathways</p> <p>Harm assessment completed for each patient on the waiting list</p> <p>Individual clinical harm reviews for any 52-week breaching patient.</p> <p>Management plan for all patients over 104 weeks</p> <p>Prioritise capacity for highest clinical harm risk</p> <p>Trust wide RTT training programme completed.</p> <p>Recovery trajectory monitored through APMG and oversight provided at the elective care recovery group in line with NHSE Phase 3 requirements</p>	31/03/2022	Chief Operating Officer	4	4	16

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CRR140	OG11	Women, Children and Sexual Health Services	18/02/2021		The environment in which outpatient services are provided at SMH is leading to infection control risks, health and safety risk for staff and patients due to generalised ageing and disrepair of temporary building structure	20	Daily focus on maintaining cleanliness and safety and reporting of cleanliness and maintenance issues via helpdesk. Regular IPC audits to identify and manage infection control risks Reporting of building defects and identified repairs required to maintain to health and safety of patients and staff. temporary relocation of gynae clinics to other departments whilst repairs / permanent relocation considered	4	5	20	temporary building has been in place since 2007 therefore the efficacy of essential repairs is limited and not cost-effective  IPC audit results & environmental failures	Creation of new bespoke Paediatric Emergency Department supported with funding provided by NHS Improvement, programme is underway and scheduled for completion <b>31/12/2021</b>	31/12/2021	Chief Operating Officer	1	2	2
CRR141	Paeds 32	Women, Children and Sexual Health Services	18/02/2021		Insufficient capacity within the Paediatric Decisions Unit footprint for ongoing treatment of children and young children leading to periods of overcrowding.  Triage Process through Paediatric Decisions Unit inability to rapidly assess children who may be unwell	20	1. Weekly review of datix documenting the escalation into the outpatient area 5a and 5b. 2. Review of complaints related to the PDU environment and waiting times. 3. Daily review of patient attendance within PDU. 4. BHT Guideline 279.1 Paediatric Decisions Unit (PDU) Triage Guideline. Contains overcrowding tool for escalation. 5. Specific training for all nursing staff involved in triage as part of mandatory training. 6. G.P. streaming of minor illnesses to support urgent care pathway. 7. Use of outpatient area 5a and 5b to support early assessment of children and young people. 8. Identification of those children and young people who can remain in waiting area awaiting review by medical staff 9. Additional staffing for PDU overnight to support activity 10. Paediatric Senior Nurse support out of normal working hours 11. Emergency Department to support paediatric minor injuries flow to reduce triage times for children and young people who are acutely unwell. 12. Additional temporary staffing for PDU overnight to support increase in overall activity enabling the ability to increase the number of triaging staff. 13. Appointment of additional Matron to support the development of paediatric urgent care pathways	5	4	20	1. Continued review of triage pathways including minor illness and minor injuries exploring alternative pathways for triage of these patients.  2. Escalate to divisional board to support the physical expansion of PDU.  3. provision of appropriate space	Creation of new bespoke Paediatric Emergency Department supported with funding provided by NHS Improvement, programme is underway and scheduled for completion <b>31/12/2021</b>  Escalation plan agreed for autumn/winter 2021/2 – substantive recruitment to band 6 nurse posts to support escalation plus planned allocation of ward 9 to CYP until new observation area is constructed.	31/12/2021	Chief Operating Officer	5	2	10
CRR143	S246 (Previously S245)	Surgery	20/05/2021		As a result of the Covid-19 pandemic the ophthalmology service has a significant backlog of new and follow up glaucoma appointments (May 21 there are over 400 New referrals and 5000 follow ups unable to be reviewed due to lack of capacity). This has decreased from 1300 New referrals outstanding in July. This has been achieved through the use of an Insourcing provider. Therefore this increased level of activity is not sustainable.  The glaucoma service is at risk due to the large volume of patients requiring an appointment and the length of time that they are having to wait for this.  There is likely to be an increase in the number of Ophthalmology patients remaining 'On Hold' - waiting to be seen due to the lack of capacity.	20	Clear patient guidance for appointment schedule Additional Fellows in place Engaged with Getting It Right First Time team for NHS Improvement to implement the high impact interventions for ophthalmology. This is a year's programme commenced in July 2018 overseen by the Elective Care Steering Group Ophthalmology specific electronic patient record system now live for cataract patients, next sub speciality is for retinal patients. Completion date December 2021	4	4	16	Space for booking teams to be housed in one central location  Availability of physical space in the Mandeville Wing to accommodate the required levels of activity  Lack of nursing support for all the additional activity required within the department.  Challenge to recruit high quality Fellows.	Reconfiguration of Amersham space (replicating the efficient clinic set – up currently used for AMD) to create an enhanced ophthalmic service with increased workflow and capacity. This would future proof the service for the next ten years. Business case submitted to EMC. Pending service specification (August 21) and need to progress through Space Committee  Continue virtual glaucoma outpatient clinics at WH and SMH utilising AHPs and nursing staff to support. Pending recruitment of staff into posts (December 21). This will increase the number of patients reviewed (c60 patients per week on each site).  Working with NHSE national GIRFT South East of England programme - high volume glaucoma new clinics  Business case pending for additional establishment	31/03/2022	COO	4	2	8

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CRR145	RAD 49	Specialist Services	22/07/2021		Delay in the Cannon MRI scanner installation due to problems with the ceiling before it can be installed. As a result the second Siemens MRI scanner which is booked to be installed after the Cannon MRI scanner has arrived in the UK and is incurring a hibernation cost of £540/week until it is installed. In addition, the present MRI scanner is operating suboptimally and in the event of it requiring repairs, this will leave the Trust without MRI imaging capabilities which is a serious risk for the A&E department.	25	The MRI scanner and mobile MRI scanner at Wycombe are both fully functional but in the event of the MRI at SMH requiring repairs, urgent MRI scan requests or critically ill patients from SMH will not be able to be scanned at Wycombe.	4	5	20	Delays with the repairs to the ceiling before the Cannon MRI scanner can be installed.  Hibernation costs incurred for the Siemens MRI scanner.  Exponential increase in workload due to greater dependency on scanning for decision making following education in face to face clinics, and SDEC and MUDAS treating day cases as in-patients and requesting more urgent scans.  MRI requests increased from 6/day to 16/day.	Escalate to senior management for expediting the ceiling repairs 20/5/2021- delays with repairs in the ceiling repaired. Now further delays with plumbing which is preventing the installation. New proposed date is Nov 2021 (12 weeks after plumbing is repaired) 15/06/2021- Plumbing repairs proposed to be completed by 02/08/2021. Then the installation of MRI will commence and take 12/52 to completion 08/07/2021- Further delays with estates which will delay installation until April 2022	30/04/2022	Chief Operating Officer	2	2	4
CRR146	Card01	Integrated Medicine	28/07/2021		Ward 2a environment is a gap in compliance with Regulation 15 - Premises and Equipment - making sure that the premises where care and treatment are delivered are clean, suitable for the intended purpose and maintained. This has been highlighted by the CQC and is documented in their reports following their last two inspections. The situation remains a gap in compliance with national standards and presents a significant risk to patients if unresolved. Adverse publicity and loss of public and staff confidence may also result with the continued deterioration of the ward environment despite temporary fixes.	20	Discharge planning on admission which has reduced length of stay. Clear and consistent cohorting of patients. Culture of safety via Quality improvement huddles, embedded Safety Huddles and DFMs.  Strong Consultant and junior doctor presence. Consistent daily Ward round and twice daily Board rounds. Enhanced cleaning regime through COVID19. PPE champions in place. Enhanced IPC support and visibility 2a and HW site generally. Regular infection control inspections – monitored through Perfect Ward. Estates patchwork. Kitchen refurbishment – units, paintwork and flooring. Executive Team have visited and a proposal to move the Unit to an alternative location is being considered.	5	4	20	As the building fabric is beyond feasible repair the only option to resolve the risk is relocation of the service – there is no interim option available. Short term remedial work is undertaken as required but these are not long term solutions.	Development of further care at home services e.g. Endocarditis antibiotic therapy CD Cupboard replacement to meet existing regulations (hampered by asbestos). Options to convert the staff room provision to enable a discrete Clinic Room (e.g. for drug/IV preparation) are being considered. Awaiting Executive decision to approve and support ward relocation.	31/12/2021	Chief Operating Officer	0	0	0
CRR147	IT309	IT	29/07/2021		Risk of disruption to Trust technology systems and services caused by cyber incidents.		Cyber security accountabilities in place. Hardware & software patching up to date. Education and awareness of cyber risk. Regular auditing and monitoring of controls Data Centre business case approved 04/12 /2020. DSP Toolkit submitted on 30th June 2021 (with 8 areas on non-compliance, not all related to cyber). This is ongoing and being monitored by the Caldicott Committee.	5	3	15	• Cyber Security strategy being defined • Cyber Security role not in place but plans for replacement by September 2021. • Software moving out of mainstream vendor support	IG Mandatory training compliance to be escalated and reviewed by end Feb 2021 and 95% compliance will be achieved by 30/06/2021. CISO (Cyber Information Security Officer) – currently using West Midlands Ambulance Service expertise for requirements, whilst recruiting to internal post. DSP Toolkit Submission with evidence (30th June 2021). The Datacentre Review project will be delivering two new datacentre platforms for the trust & CCGs which will comply with NSCS's 14 Cloud Security Principles, and Cyber Essentials guidelines. Implementation of the new platforms is anticipated to be delivered by January 2022. Windows 10 project complete removes Win 7 risk – only a few legacy systems remain using Win 7 and plans in place to upgrade. 06/04/2021: Data centre - deployment to commence from April 2021 and will conclude by January 2022 by which time this will have a significant impact as a mitigation against this risk. Replacement of Cyber Security post will take place to make sure we have in house capability in the meantime this is being covered externally on contract.	31/03/2023	Director of Strategy	5	2	10
<b>New Risks</b>																	
CRR149		Integrated Medicine	28/10/2021		Inadequate physical ED environment in terms of quality and capacity, prevents effective streaming, hinders flow, increasing the risk of delayed triage, unobserved deterioration, infection spread.		Working flexibly with service layout and operational usage to meet fluctuating demand and staffing availability. Allocating best possible triage and streaming of attenders eg paed, covid, minor, majors etc. Daily Cleaning schedule. Auditing and monitoring arrangements via ED Nursing team and Sodexo. Allocated corridor nurses used when staffing allows. Crowding tool used. Ambulance crews to take 2 patients per crew to allow another handover and be released from the department. Oversight of queue by dedicated band 4 when staffing allows. Corridor SOP allows ambulance crews to stay with patients for up to an hour.	4	5	20	Clear documented clinically approved strategy to improve and or replace existing ED environment.	ED extension to increase clinically appropriate capacity.  Resus refurbishment as part of the WC&SH build.	31/03/2022	Chief Operating Officer	4	2	8

Corporate Risk Register	Divisional Risk Register	Division	Date added to CRR	Trust Objective	Description of risk	Unmitigated risk	Risk Score			Gaps in controls	Actions to address risk, including target completion dates (bold) for each action.	Target overall completion date	Executive Lead	Predicted residual score			
							C	L	C x L					C	L	C x L	
CRR150		Integrated Medicine	28/10/2021		Clinically inappropriate length of stay in ED including time to Triage, treat and discharge or admit.		Triage protocol incorporates (including Streaming Nr) Front Door Team. Treatment Nr to support Triage when Wait time increases. DTA times reported to site team and recorded on Medway. ED Consultant DTA. EOU admission packs are premade. Site team to prioritise DTA patients from EOU as part of the EOU SOP. Departmental and hospital escalation policy in use. Crowding tool used. Operational policy for medically expected patients. Acute care coordinator escalating to operational team when more than 5 patients are waiting to be seen by the medics. Use of EOU for appropriate ED patients to create capacity in the main department.	3	5	15	DTA times rely on Snr Speciality Decision Maker Streaming Nr Vacancies Treatment Nr Vacancy and Triage capability of Treatment Nr	Triage training to be undertaken for Nr team including Treatment Nr	31/03/2022	Chief Operating Officer	3	2	6

### Risk Profile – Corporate Risk Register – October 2021

Consequence	1	2	3	4	5
Likelihood	Key: ↑ = risk score has risen; ↓ = risk score has dropped; ⇔ = no change. The CRR changes on a monthly basis and the arrows indicate the change since the previous version (up to 4 changes)				
5		<b>CRR100</b> – Brexit impact on workforce (new 09/2018) ⇔↓⇔		<b>CRR139</b> - Potential clinical harm to patients on elective wait list (new 02/2021) ⇔⇔⇔ <b>CRR140</b> – Outpatient services environment (new 02/2021) ⇔⇔⇔ <b>CRR145</b> – MRI scanner installation (new 07/2021)⇔⇔⇔	
4				<b>CRR88</b> – Patient tracking and appointments (new 02/2018)⇔⇔⇔ <b>CRR116</b> – Out of date Datix system functionality issues (new 11/2019)⇔⇔⇔ <b>CRR143</b> – Ophthalmology Backlog (new 05/2021) ⇔⇔⇔	<b>CRR10</b> – Shortage of qualified nursing staff (new 11/2014)⇔⇔⇔ <b>CRR27b</b> – HV/LV insufficient supply (new 10/2017)⇔⇔⇔ <b>CRR126</b> – impact on staff physical and psychological health and well-being during covid-19 (new 04/2020)⇔↑⇔ <b>CRR141</b> – Insufficient capacity within PDU (new 02/2021) ⇔⇔⇔ <b>CRR146</b> – Ward 2a environment (new 07/2021) ⇔⇔⇔
3				<b>CRR138</b> – Increased risk of infection due to poor ventilation (new 02/2021) ⇔⇔↓ <b>CRR127</b> – Increased risk of adverse impact on BAME staff due to Covid-19 (new 04/2020)⇔⇔ ↓	<b>CRR85</b> – Shortage of Junior doctors (new 10/2017)⇔⇔⇔ <b>CRR115</b> – Medical gas pipework insufficient for current clinical need (new 11/2019)⇔⇔⇔ <b>CRR130</b> – Concrete building panel failure at WGH (new 10/2020)⇔⇔⇔ <b>CRR135</b> – Trust non-delivery of Operating Plan (new 11/2020) ⇔⇔⇔ <b>CRR147</b> – Disruption to Trust technology due to cyber incidents (new 07/2021) ⇔⇔⇔
2			<b>CRR131</b> – Risk of delayed diagnostics and treatments (new 10/2020) ⇔↓⇔		
1					

**To be removed from the Corporate Risk Register:**

- CRR138** – Increased risk of infection due to poor ventilation
- CRR127** – Increased risk of adverse impact on BAME staff due to Covid19

**Meeting:** Trust Board Meeting in Public

## 24 November 2021

<b>Agenda item</b>	Board Assurance Framework (BAF)
<b>Board Lead</b>	Neil Macdonald, CEO
<b>Type name of Author</b>	Joanna James, Trust Board Business Manager
<b>Attachments</b>	BAF Report October
<b>Purpose</b>	Assurance
<b>Previously considered</b>	EMC 02.11.2021 Audit Committee 04.11.2021 Q&CG 15.11.2021

### Executive Summary

The Board Assurance Framework (BAF) brings together in one place all the relevant information on the risks to the Trust's strategic objectives.

This report outlines the current position in terms of the identified risks to the Trust's strategic objectives as of end October 2021.

This includes:

- Sub-risk heatmap
- Risks by residual risk rating
- Direction of travel
- Action update
- Detail on all risk considered as 'very high' i.e. a residual risk rating of 15+.

The purpose of this paper is to inform the Board of the top organisational risks and the current management of these. The provision of this detail provides the Board with an opportunity to discuss the range of risks confronting the organisation, perceived gaps in control or assurance and the level of risk that this creates and support further strategic decision making.

This report was considered at Executive Management Committee on 2 November 2021. The Committee requested an overall review of the risks by the Board. Prior to this, risk owners will be required to review all risks and update risk ratings. This process is ongoing and will be supported by the Trust Board Business Manager. A Board Development session has been provisionally planned for December 2021.

The report was subsequently considered at Audit Committee on 4 November 2021. The Committee requested further information on Board Committee ownership of risks, a comprehensive update on overdue actions and greater oversight of links between those risks noted at Committee meetings, the recovery/improvement programme and the BAF. It was noted that these will be a work in progress but changes have been made to the attached report accordingly

The report was presented to Quality & Clinical Governance Committee on 15 November 2021 for information only. The Committee was informed of the plan to provide each Board Committee with those risks under their ownership in future months.

<b>Decision</b>				<p>The Committee is requested to:</p> <ol style="list-style-type: none"> <li>Review the range of risks and use the information to inform strategic decision making.</li> <li>Consider the assurances in place, identify gaps in controls and/or assurances and identify further actions as required.</li> <li>Review the emerging risks noted at Board and Board Committee meetings and consider reflection of these within the CRR/BAF frameworks.</li> <li>Note the additions to the report and make suggestions for further developments to reporting format to improve efficacy and ability for the Board to take assurance from reporting.</li> </ol>
<b>Relevant Strategic Priority</b>				
<b>Outstanding Care</b> ☒	<b>Health Communities</b> ☒	<b>Great Place to Work</b> ☒	<b>Net Zero</b> ☒	
<b>Implications / Impact</b>				
<b>Patient Safety</b>		Patient safety is fundamental across all four risks within the BAF, particularly related to Risk 1; Failure to consistently provide outstanding quality care that is compassionate, cost effective and safe.		
<b>Risk: link to Board Assurance Framework (BAF)</b>		This report relates to all risks and sub-risks within the BAF.		
<b>Financial</b>		Financial considerations are evident throughout the BAF, particularly related to Risk 2; Inability to generate surpluses for capital development or investment in services.		
<b>Compliance CQC Standards Good Governance</b>		An effective, comprehensive process is required to be in place to identify, understand, monitor and address current and future risks to the organisation and this is supported by effective use of the BAF.		
<b>Partnership: consultation / communication</b>		Internal collaboration to identify top four risks. Opportunities for collaborative system working identified within the details of the BAF.		
<b>Equality</b>		Specific attention given to issues related to equality in sub-risks 1.7 and 3.6.		
<b>Quality Impact Assessment [QIA] completion required?</b>		Not applicable		

See separate document; BAF Report October 2021

# **Board Assurance Framework (BAF) Quarterly Report November 2021**

## **1. Introduction**

The Board Assurance Framework (BAF) brings together in one place all the relevant information on the risks to the Trust's strategic objectives.

This is an update to the second report of the BAF since the introduction of the electronic reporting system and has an additional section; Emerging Risks noted from Board/Board Committee Meetings (section 7) for consideration against the information within the BAF and Corporate Risk Register (CRR) reports.

Within this update, a second appendix has been included which details the Board Sub-Committee ownership of risks within the BAF (see appendix II). This is a first iteration of Committee ownership and a further review of this will be conducted ahead of the next report.

## **2. Purpose**

The report outlines the current position in terms of the identified risks to the Trust's strategic objectives as of 17 November 2021. The Board is presented with the profile of all documented risk with detail on those considered as 'very high' i.e. a residual risk rating of 15+.

The purpose of this paper is to inform the Board of the top organisational risks and the current management of these. The provision of this detail provides the Board with an opportunity to discuss the range of risks confronting the organisation, perceived gaps in control or assurance and the level of risk that this creates and support further strategic decision making.

## **3. Heatmap**

As demonstrated by the below, the top scoring sub-risk (very high - score 16) is:

### **2.6 Inability to generate Trust level capital investment**

Appendix I provides more detail of this including a summary of the controls and assurances in place, planned actions with implementation dates, the sub-risk owner and the direction of travel of the residual risk rating since the last report.

Further information regarding all other risks (scored as high, medium and very low) can be found in the separate document; 'Full BAF Download November 2021'.

<b>Catastrophic (5)</b>					
<b>Major (4)</b>		4.5 4.6	1.1 2.5 3.7 1.4 2.7 4.1 1.6 3.1 4.3 1.7 3.2 4.7 2.3 3.3 4.8	2.6	
<b>Moderate (3)</b>			3.5 3.6 3.9 4.2	1.2 3.4 1.5 4.9 2.1 2.2 2.4	
<b>Minor (2)</b>		1.8 4.4	4.10		
<b>Negligible (1)</b>	3.8	1.3			
	<b>Rare (1)</b>	<b>Unlikely (2)</b>	<b>Possible (3)</b>	<b>Likely (4)</b>	<b>Almost Certain (5)</b>

The heatmap indicates that the majority of identified sub-risks are rated as having **high residual risk** (score 8-12).

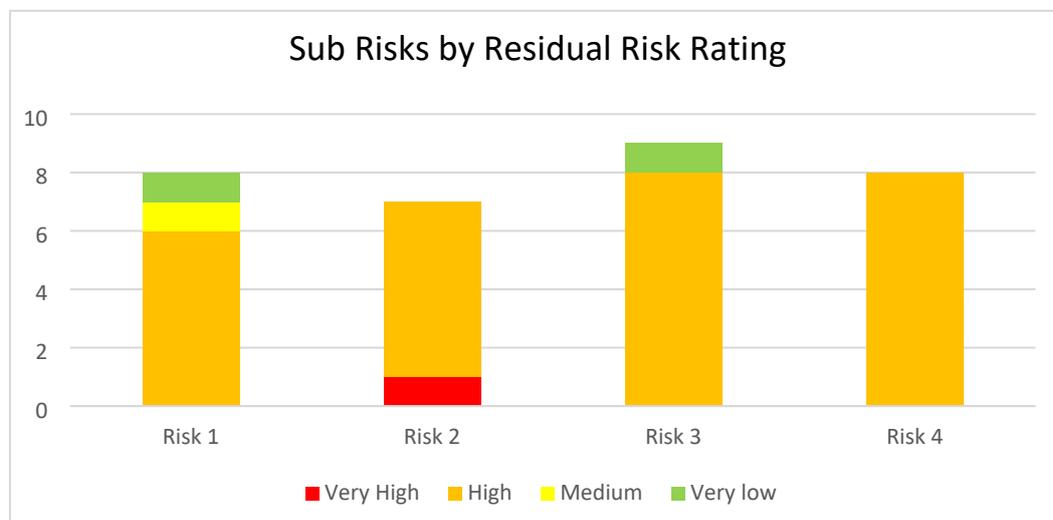
The below chart demonstrates the residual risk weighting for each of the four risks (R) within the BAF:

**R 1** - Failure to consistently provide outstanding quality care that is compassionate, cost effective and safe.

**R 2** - Inability to generate surpluses for capital development or investment in services.

**R 3** - Inability to lead an organisation with the capacity and capability to deliver our best in everything we do.

**R4** - We do not recover our services adequately, fail to meet public regulator expectations and do not play a leading role in the health, economic and social recovery of Buckinghamshire.



#### 4. Direction of Travel

Below is a summary of those sub-risks for which the residual risk priority has either increased or decreased since the previous report.

##### Increasing Residual Risk

There are no sub-risks for which the residual risk priority has been increased.

##### Decreasing Residual Risk

Ref	Sub-Risk	Aug 21	Oct 21
1.1	<b>Inadequate staffing levels to deliver outstanding quality care</b> Risk score reduced in view of progress against recruitment trajectories.	20	16
3.4	<b>Failure to secure necessary infrastructure changes linked to Buckinghamshire housing/growth strategies</b> Following discussion at EMC 02.11.2021 this risk rating was moderated against other risks within the BAF	16	12
3.6	<b>Not using integrated care records and data to manage whole population health and inequalities</b> Following discussion at EMC 02.11.2021 this risk rating was moderated against other risks within the BAF	16	9
4.9	<b>Underutilisation of effective data and business intelligence e.g. suboptimal access to and use of quality metric data</b> Following discussion at EMC 02.11.2021 this risk rating was moderated against other risks within the BAF	20	12

All other sub-risks have maintained the same residual risk score.

#### 5. Addition/Removal of Risks from the BAF

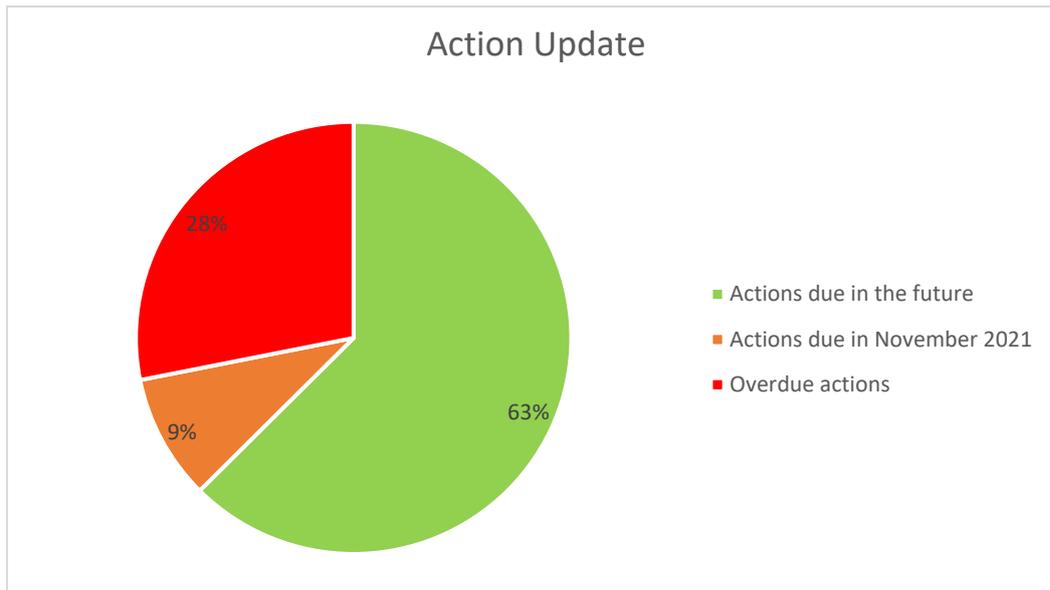
There have been no sub-risks added to nor any removed from the BAF since the report from **August 2021**.

#### 6. Action Update

At the time of writing this report, there are 64 open actions within the BAF, 22 of which have been updated since the last report. Of these updates, 13 relate to overdue actions.

The below chart demonstrates the proportion of actions that are overdue, due imminently and due at a future date (between November 2021 – September 2022).

Since the previous report to EMC and Audit Committee, the percentage of open actions that are outstanding has reduced from 51% to 28%. Further work is ongoing to provide timely updates to those actions that are due. During this same time period, 8 actions were closed (implemented) and 5 new actions were added.



Out of the overdue actions, it is noted that 13 of these sit with the Chief Operating Officer (COO) as Risk Owner. Note that whilst this is not displayed within this report, all of these have now been reviewed and updated. This information will be input into the BAF, taking the overdue actions down to 10%.

## 7. Emerging Risks noted from Board/Board Committee Meetings

The below table details those risks noted from each of the Board and Board Sub-Committee Meetings since the previous report (August 2021) for reference. Work is ongoing to jointly report the Corporate Risk Register (CRR) and the BAF.

Month	Meeting	Risks Noted	BAF Reference
Sep 2021	Audit	Cybersecurity; need for internal controls to mitigate risk of viral propagation between devices/systems as well as ongoing training for end user Ability to recruit and retain appropriately skilled IT staff Significance of potential interruption to SMH HV/LV power supply in the context of Brexit and priority HS2 construction work Potential implication of capital requirement and inferred risk to financial planning in view of the state of the Wycombe Tower estate Transparency of waiting list numbers to support clarity in discussion and decision making by the Board Limited resilience to MRI service in view of delay in installation of new scanner	Within CRR  Within CRR - 2.4  4.9 Within CRR
	F&BP	Shape of the waiting lists and 104 week waits Care home risks Recurrent challenge around endoscopy provision and what capital spend may be required to resolve that ERF income and the assumption that none will be won in September Divisional overspends which have brought the potential £20m risk in the H2 position Costs occurring from Data Quality and Net Zero Strategy	4.7 1.4 2.6 2.2 2.1 2.6
	Q&CG	Number of MOFD patients remaining in acute beds – noting renewed focus and work to ensure sustainability of improvement going forwards. Numbers/rates of particular infections – difficult to take assurance in the absence of comparative data Reduced PPE compliance – noting August particularly challenging due to junior doctor changeover. CQC Insight Report; areas where performance identified as 'much worse' balanced against assurance that can be taken from the report in view of the use of historical data. Related to expired clinical policies and guidelines – oversight of clinical effectiveness. Succession planning and sustainability related to EoLC as well as talent management and succession planning across the organisation.	1.4  4.9 - 2.9  4.5 1.1
	SWC	Increase in rate of COVID-19 cases within Bucks; potential impact for Trust workforce and operational pressures. Cost of living locally and impact on our ability to recruit from the pool of people who study locally but for whom home is not within the local area. Trust did not meet the target vacancy rate for HSW recruitment although noted that mitigations are in place and work ongoing. Staff survey; concern regarding level of engagement and results of next survey in context of last 18mths within NHS. Levels of sickness absence particularly related to stress and impact on our resilience, particularly during winter months. Lack of transparency within eRostering of protected characteristics of the workforce and impact on our ability to monitor equality.	1.4, 4.1 2.7  1.1  4.1  4.1

	Public Board	<p>Disproportionately long waits in comparison to peers</p> <p>Additional scrutiny from regulators</p> <p>Overall workforce resilience</p> <p>Absence of H2 guidance for Finance</p> <p>Delivery of Trust and Net Zero Carbon strategies related to finance implications</p> <p>Sustainability of improvement related to recovery resulting from the impending winter months, bed capacity and lack of physical space and the local and national situation related to domiciliary care providers</p> <p>Potential harm to patients who were late presenters and/or undiagnosed cancers</p> <p>Compliance with NICE guidance, particularly related to infection control</p>	<p>3.2, 4.7</p> <p>4.6</p> <p>1.1, 4.1</p> <p>2.1</p> <p>2</p> <p>3.3</p> <p>4.5</p> <p>4.5</p>
	Private Board	<p>Wycombe Tower; potential capital implications and clinical risk to IPC and quality of patient care</p> <p>Lack of H2 guidance leading to uncertainty on financial position, timelines for capital projects and divisional level deficits</p> <p>Trust-wide backlog maintenance and Wycombe Tower management</p>	<p>1.3, 1.8, 2.4</p> <p>2.1</p> <p>1.3, 2.4</p>
<b>Oct 2021</b>	F&BP	<p>Potential harm to patients following telephone incident</p> <p>Staffing levels within theatres</p> <p>Request for breakeven at H2</p> <p>Clash of regulator interest – financial/recovery</p> <p>Payroll</p> <p>Appointment cancellations</p> <p>Financial implications of digital strategy</p>	<p>-</p> <p>1.1</p> <p>2.1</p> <p>-</p> <p>-</p> <p>4.7</p> <p>2.6</p>
	Q&CG	<p>Ability to respond to elevated NEWS in line with national policy, documentation of response and overnight staffing levels.</p> <p>2ww breast Ca pathway; Radiology staffing levels and significant increase in demand</p> <p>Reduction in performance related to sepsis (noted during previous month only)</p> <p>Potential harm for late or non-presenters including CYP unable to access usual service provision due to COVID-19</p> <p>High vacancy rates and impact on quality; need for targeted action plans for hotspot areas</p> <p>Organisational preparedness for CQC inspection</p> <p>Ensuring effectiveness of actions taken in response to Never Events</p>	<p>1.1, 4.5</p> <p>1.1, 4.7</p> <p>-</p> <p>-</p> <p>1.1</p> <p>4.5</p> <p>4.5</p>
	Private Board	<p>Learning from historical never events</p> <p>Further inpatient COVID-19 outbreak and increasing overall rates</p> <p>Financial position v. recovery – associated conflicting regulatory demands</p> <p>Movement in financial position</p> <p>Specific financial risk related to Paeds ED capital</p> <p>Lack of overall forward view of workforce (noting plan for workforce strategy)</p> <p>Recovery post pandemic</p> <p>Unsafe staffing levels</p>	<p>4.5</p> <p>1.3, 1.8. 4.2</p> <p>2.1</p> <p>2.1</p> <p>-</p> <p>1.1</p> <p>4</p> <p>1.1</p>

## **8. Conclusion**

This BAF report provides the Committee with an overview of the current strategic risk. Further work is required to embed more dynamic use of the BAF into strategic risk management.

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

The Committee is requested to:

- a) Review the range of risks and use the information to inform strategic decision making.
- b) Consider the assurances in place, identify gaps in controls and/or assurances and challenge these accordingly identifying further action required as appropriate.
- c) Review the emerging risks noted at Board and Board Committee meetings and consider reflection of these within the current BAF framework.
- d) Consider those amendments to this report and make suggestions for further developments to this report to improve its efficacy.

## Appendix I – BAF Summary Table

The following table summarises, for all those risks rated as **very high**, the controls and assurances, actions, risk owner and residual risk priority with direction of travel since the previous report.

Ref	Sub-Risk Title and Effect (summary)	Owner/ Sub- Comm	Controls and Assurances (summary)	Actions (summary)	Residual Risk Priority
<b>Risk 2 - Inability to generate surpluses for capital development or investment in services</b>					
2.6	<p><b>Inability to generate Trust level capital investment;</b> Trust's capital resourcing currently insufficient to meet clinical objectives, both as a region and ICS capital funding requirements are above allocation; there will be affordability and operational limits to maintaining a capital programme at 2020/21 level.</p> <p>Lost quality and financial opportunities in estates and digital transformation.</p> <p>Risk of CQC compliance in adhering to budget constraints.</p>	DoF  (F&BP)	<p><b>Risk control;</b> continue to seek alternative funding solutions to address the capital funding gap</p> <p><b>Control assurance;</b> financial governance framework within place in the Trust</p> <p><b>Assurance gap;</b> Trust continues to have unfunded backlog maintenance and infrastructure</p>	<p>Assure ourselves that agreed capital plan is prioritised on need and is risk based (August 2021)</p> <p>Ensure residual risks caused by unaffordability are adequately documented and managed with Regulators (August 2021)</p>	<p>16 =</p>

## Appendix II – Board Sub-Committee Ownership

Board Committee	Executive Director	Sub-Risk
<b>Audit</b>	CEO CEO	4.5 Governance not always being both easy to navigate and enabling change whilst providing robust, forward looking assurance 4.6 The organisation (Board) being CQC-rated 'requires improvement' under the well-led domain
<b>F&amp;BP</b>	Dir of Strat Comm Dir COO DoF Dir of Strat DoF DoF COO DoF COO DoF Dir of Strat COO COO Dir of Strat Dir of Strat Dir of Strat COO Comm Dir CEO COO COO	1.2 Digital Immaturity 1.3 Estates infrastructure not fit for purpose (outdated, limits clinical care provision) 1.4 Inability to control out of hospital demand and capacity in primary and social care 1.5 Underlying financial deficit 1.7 Inequalities in access to care 2.1 Lack of strategic financial plan 2.2 Burden of cost from the pandemic including direct and indirect ongoing and future costs 2.3 Variation in the productivity of clinical service lines 2.4 Structural financial challenges – cost of infrastructure, PFI, corporate office costs 2.5 Fixed envelope funding model creates financial imbalance in the organisation 2.6 Inability to generate Trust level capital investment 3.1 Inability to deliver the Trust's strategic case for change 3.2 Inability to innovate and work with partners to deliver new models of elective care 3.3 Failure to reform our urgent care pathway and meet future urgent care health needs of the population 3.4 Failure to secure necessary infrastructure changes linked to Buckinghamshire's housing/growth strategies 3.5 Not realising the Trust potential as an anchor institution 3.6 Not using integrated care records and data to manage whole population health and inequalities 3.7 Gaps in partnership working (with education, social services, primary care networks, mental health and education) to fully integrate community services 3.8 Adverse contribution to climate change 4.2 Changes in the ICS and in Buckinghamshire in line with white paper; 'integration and innovation: working together to improve health and social care for all' 4.7 Lack of consistent attainment of key operational and performance standards 4.9 Underutilisation of effective data and business intelligence e.g. suboptimal access to and use of quality metric data
<b>Q&amp;CG</b>	CN CN CMO CEO CMO	1.6 Gaps in learning from incidents and best practice 1.8 Inadequate infection prevention or control due to issues with estates infrastructure 3.9 Inadequate oversight of direct and indirect clinical harm caused by the pandemic 4.5 Governance not always being both easy to navigate and enabling change whilst providing robust, forward looking assurance 4.10 Not being an organisation where innovation and new ideas can always thrive and be easily adapted
<b>SWC</b>	CPO CPO CPO CPO Comm Dir CPO	1.1 Inadequate staff resource to deliver 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 4.1 Pandemic related negative impact on morale, wellbeing and retention 4.3 Variation in organisational culture and behaviours 4.4 The workforce not always feeling that the organisation is as safe to work in as it can be 4.8 The organisation is not always inclusive and does not always treat people equally

<b>Report Date</b>	17 Nov 2021
<b>Risk Status</b>	Open
<b>Risk Area</b>	Board Assurance Framework, 1. Failure to consistently provide outstanding quality care that is compassionate, cost effective & safe, 2. Inability to generate surpluses for capital development or investment in services, 3. Inability to lead an organisation with the capacity and capability to deliver our best in everything we do, 4. We do not recover services adequately, fail to meet public / regulator expectations, and do not play a leading role in the health, economic and social recovery of Buckinghamshire
<b>Control Status</b>	Existing
<b>Action Status</b>	Outstanding

Board Assurance Framework / 1. Failure to consistently provide outstanding quality care that is compassionate, cost effective & safe									
Risk Title	Risk Owner	Effect	Inherent Risk Priority	Risk Control	Control Assurance (Assurance Source)	Assurance Gap	Residual Risk Priority	Action Required	To be implemented by
1.1 Inadequate staff resource to deliver outstanding quality care (insufficient levels of qualified, experienced staff and training opportunities)	Bridget OKelly	Inadequate staffing levels, greater than desirable levels of temporary staffing, retention challenges (workforce burnout)	I = 4 L = 5 Very High (20)	Trust wide recruitment plans in place: three strands - international, national (including recent graduates) and grow your own. International (non-EU) recruitment supported by national funding to bring in c200 overseas nurses between March 2021 and March 2022 Recruitment from Portugal continues, using established links with Universities. New graduate recruitment - fast track recruitment for students on placements at the Trust Through Bucks Health & Social Care Academy facilitating career pathways for non-medical careers Monthly update via IPR.	Vacancy rates reported monthly in integrated board report International recruitment programme reported through transformation board and SWC.	National shortage of registered nurses. Delays in conversion of overseas recruits due to the requirements of the IELTS/OET and the time it takes to register with the NMC and changes in immigration rules due to COVID Uncertainty around impact BREXIT will have on EU recruitment This position may be exacerbated by COVID-19 Reduction in overseas nurse recruitment due to COVID-19. Of 15 recruits in the May cohort, 6 are unable to travel due to COVID-19 restrictions. National stoppage to recruitment from India came into force in early May. Possible increase in individuals leaving the profession following Waves 1 and 2 of COVID-19	I = 4 L = 3 High (12)	Recruitment of international nurses - target to recruit and relocate 222 nurses over 12 to 18 months. Progress reported through IPR (monthly)	31 Mar 2022
								Retention - plan set out in Thrive@BHT to support the health and wellbeing of staff. Progress monitored through Transformation Board (monthly).	31 Mar 2022
1.2 Digital immaturity	David Williams	Sub-optimal use of data and more limited opportunity to transform pathways	I = 3 L = 4 High (12)	Digital Strategy	Digital strategy in place to invest in digital infrastructure and systems	Annual capital budgets to support implementation of the strategy Strategy shared at F&BP in September 2021. Final strategy to be shared in January 2022.	I = 3 L = 4 High (12)	Continue to seek capacity and capability in digital to implement plans. £500k case supported by Transformation Board August 2021.	30 Nov 2021
				ICT Board	ICT Board meets monthly to assess progress with annual projects/capital plan to improve digital maturity - monthly report to Transformation Board	None		Continue to seek external resources to support improved digital maturity Update end November 2021 - awaiting outcome of TIF bids.	30 Nov 2021
				Recovery Workstreams	Digital projects reported through recovery workstreams			Final digital strategy to be shared.	31 Jan 2022
1.3 Estates infrastructure not fit for purpose (outdated, limits clinical care provision)	Ali Williams	Poor quality estate eg flooring makes it harder and more costly to keep clean	I = 2 L = 3 Medium (6)	Regular audits and supervision of cleaning in hard to clean areas	Results of place audits and cleaning scores within the estates quarterly reports	Repair of high risk areas of estates are +£100m in backlog maintenance	I = 1 L = 2 Very Low (2)	Seek routes for capital investment to upgrade or replace estate	15 Jun 2022
1.4 Inability to control out of hospital demand and capacity in primary and social care	Dan Gibbs	Risk of harm in emergency department due to overcrowding and delays as capacity to manage high volumes of patients is extremely challenged. Risk of delays to ambulance handovers. Risk of extended length of stay in emergency department. Risk of resilience impact to staff.	I = 4 L = 5 Very High (20)	Place-based delivery board accountable to ICP board for delivering on admission avoidance and discharge agenda	Minutes of ICP delivery board Admissions avoidance action plan and delivery Discharge action plan and delivery	Track record of system sustained improvement delivery Evolving commissioning picture	I = 4 L = 3 High (12)	Urgent care strategy for Buckinghamshire to be developed. Update - UTC concept at SMH being implemented from January 2022	31 Jan 2022
				Place-based escalation protocol	Written escalation protocol Documented use of escalation protocol Annual review of protocol	Sign off by all partners Impact assessment of use			
				Thrice weekly long stay deep dives and daily discharge escalation calls to review patients with stakeholders and partners.	MOFD reporting in IPR Meeting records	Partner response time monitoring			
1.5 Underlying organisational financial deficit	Barry Jenkins	Reduced opportunity for service investment	I = 3 L = 5 Very High (15)	Continual scrutiny and pressure to deliver through PMO, FBPC, Deep Dives etc Continual search for new schemes Multi-year and future year savings pulled forward Planning and documentary evidence of CIPS on an ongoing basis. Corporate over delivery to assist clinical divisions Income generating proposals Estate Strategy	Budget setting, budget monitoring and performance monitoring process is in place.	-The historic issues underpinning the underlying organisational deficit will remain until system solutions are in place. -There is still lack of clarity on the H2 regime.	I = 3 L = 4 High (12)	Instigate a medium term financial strategy.	28 Feb 2022
		The Trust may not deliver its operating plan (or Forecast Out-Turn), meaning that statutory break-even is not delivered. The Trust may not be able to deliver its CIP Programme.				Continued proactive engagement with BOB ICS partners to facilitate a system driven solution to maximise opportunities for the Trust. Engagement with Regulator on challenges and opportunities for the Trust. eg Board to Board meeting		30 Sep 2022	

Risk Title	Risk Owner	Effect	Inherent Risk Priority	Risk Control	Control Assurance (Assurance Source)	Assurance Gap	Residual Risk Priority	Action Required	To be implemented by
1.6 Gaps in learning from incidents and best practice	Karen Bonner	Learning not systematic; opportunities missed to improve care	I = 4 L = 4 Very High (16)	Monthly reporting to EMC on learning from incidents	Monthly SI and incident report- shared at EMC, Quality Committee and Trust board	Divisional assurance of local learning and sharing	I = 4 L = 3 High (12)	External review of governance framework. Implementation date moved due to delay in report completion (FM).	30 Nov 2021
				Trust Patient safety Monthly Meeting	Trust Patient Safety Meeting held monthly chaired by the Chief Nurse and attended by all Divisional Heads of Nursing and or Chairs	confirmation of Divisional quality and patient safety meetings		Develop Trust Quality Strategy	31 Dec 2021
				Weekly Monitoring of datix incidents	Weekly reports on open datixes sent to all divisional leads	Datix version unable to identify trends		Upgrade Datix system	03 Jan 2022
1.7 Inequalities in access to care	David Williams	Continued growth of the health inequality gap and ongoing impact on Trust business	I = 4 L = 5 Very High (20)	Equality Impact Assessments	EQIA documents in every service change and business case	Ensuring every business case and service change has EQIA completed. Regularly reviewed by PPEDI group	I = 4 L = 3 High (12)	Now that benchmarking and data reports available; trend analysis to be conducted on a monthly basis to ensure services are being recovered inclusively. To start from December 2021.	31 Dec 2021
				Patient and Public Equality Diversity and Inclusion Group	Minutes, Workplans and Action plans from meetings	Group has met three times since June 2021 - action plans to be developed linked to community engagement, reducing health inequalities, accessible information standards and data monitoring to be discussed at Quality Committee in September 2021			
				Public Health reports and population health benchmarks	Up to date reports on health inequalities by locality, geography, condition and ethnicity and deprivation	regular detailed reports to be provided including from population health national commission linked to covid			
				Reports on complaints, patient experience by protected group and geography	Regular monthly reports for PPEDI group, Quality committee and trust Board	Reports broken down by geography, deprivation and protected groups			
				Waiting list and other services delivery assessed by ethnicity and DQ to ensure we are delivering an inclusive service	Reports	Pop health support being provided to give us this monitoring data - hopefully by July. Still awaited for end of August 2021			
1.8 Inadequate infection prevention or control due to issues with estates infrastructure	Karen Bonner	Potential for nosocomial (hospital-acquired) infections	I = 4 L = 4 Very High (16)	Cleaning audits	Audits are completed In line with the National Standards of Healthcare Cleanliness 2021. To ensure the Trust meets the requirements of CQC outcome standard Regulation 15 key criteria (1 and 2) in the Health and Social Care Act Code of Practice 2015 in terms of legal responsibilities for a cleaning lead, personal responsibilities, the need for audit, governance and reporting.		I = 2 L = 2 Medium (4)	Ensure clinical oversight of cleaning audits	30 Jul 2021
				Daily IPC huddles	Daily IPC team huddles to identify areas of focus	Require assurance that local safety huddles take place include IPC		Building work in specific parts of the estate to make it compliant - e.g. Dermatology/Resus. As identified in the Risk Register.	30 Nov 2021
				Out Break meetings (Adhoc)	adhoc outbreak meeting in cases of MRSA, COVID, CDiffe	Assurance shared learning a local divisional level			
				Quarterly Infection prevention and Control Committee	Quarterly meeting Agenda Purpose The Committee exists to maintain an overview of infection control priorities within the Trust, and to link this into the clinical governance and risk management processes. It will ensure that infection control issues are appropriately managed within the hospital.				

**Board Assurance Framework / 2. Inability to generate surpluses for capital development or investment in services**

Risk Title	Risk Owner	Effect	Inherent Risk Priority	Risk Control	Control Assurance (Assurance Source)	Assurance Gap	Residual Risk Priority	Action Required	To be implemented by
2.1 Lack of strategic financial plan	Barry Jenkins	Route to financial stability unclear Medium term financial overview is impacted.	I = 3 L = 5 Very High (15)	A robust budget setting and monitoring process is in place with regular dialogue with Regulator and ICS partners.	Scheduled meetings with regulator and ICS Partners	System levels solutions are not yet in place to enable a strategic financial plan to be set.	I = 3 L = 4 High (12)	Instigate a medium term financial view to enable a strategic financial view to be taken to address underlying system deficit.	28 Feb 2022

Risk Title	Risk Owner	Effect	Inherent Risk Priority	Risk Control	Control Assurance (Assurance Source)	Assurance Gap	Residual Risk Priority	Action Required	To be implemented by
2.2 Burden of cost from the pandemic, including indirect and direct ongoing and future costs	Barry Jenkins	Structural change to our business operating model	I = 3 L = 5 Very High (15)	Ongoing monitoring and regular liaisons with regulator and ICS partners to ensure service continuity.	Regular meetings to address areas of concern/focus.	There are limitations in place in the Trust's ability to plan for the full impact of the pandemic, such as ongoing additional staffing costs.	I = 3 L = 4 High (12)	Ensure that the financial plan reflects the cost implications of the additional burden of cost from the pandemic. For update end October - awaiting H2 guidance. For update end November - awaiting Board sign off for H2 plan.	24 Nov 2021
2.3 Variation in the productivity of clinical service lines	Dan Gibbs	Failure to maximise use of clinical resources and reduce waiting lists / improve access / meet regulatory standards.	I = 4 L = 5 Very High (20)	Elective Care transformation workstream established with a brief to create specialty by specialty productivity workstreams. GIRFT review board in place Productivity metrics included in Divisional integrated performance report to allow review and action planning.	Monthly exception reports to transformation board Minutes of GIRFT board Monthly divisional IPR Minutes of divisional monthly performance review	All specialties having plans All specialties having had gift reviews. Ability of business intelligence teams to provide data	I = 4 L = 3 High (12)	Business Intelligence to be transitioned into Ops to reprioritise and align production with business requirements Theatre utilisation metric to be reviewed Productivity partner / operational support to be procured Specialty level productivity programmes to be produced once 4eyes work concluded.	02 Jul 2021 30 Jul 2021 06 Aug 2021 27 Aug 2021
2.4 Structural financial challenges – cost of infrastructure, PFI, corporate office costs	Barry Jenkins	Inability to deliver strategic plans and maintain services and activity levels at required levels.	I = 3 L = 5 Very High (15)	In acknowledging the funding gaps ensuring there is continual engagement with the NHSI on the inherent risks.	Regular engagement with Regulator to ensure risks and challenges are discussed and acknowledged.	System wide solutions are not yet in place to address the structural financial challenges faced by the Trust.	I = 3 L = 4 High (12)	Seeking alternative funding solutions to address the funding gap and infrastructure constraints. Update February 2022 - pending update on New Hospital Programme.	28 Feb 2022
2.5 Fixed envelope funding model creates financial imbalance in the organisation	Dan Gibbs	Block contract for locally commissioned services does not reflect the cost of meeting regulatory standards.	I = 5 L = 5 Very High (25)	Weekly review of activity against elective recovery fund in place	Recovery updates - weekly report Recovery update monthly to F&BPC & TB	ERF may only be in place for FY2122	I = 4 L = 3 High (12)	New contract discussions with commissioners as NHS moves through H2	01 Oct 2021
2.6 Inability to generate Trust level capital investment	Barry Jenkins	The Trust's Capital resourcing is currently insufficient to support it's clinical objectives. As a region and as an ICS, our capital funding requirements are above allocation. In the context of this system affordability, there will be affordability and operational limits to maintaining a capital programme at the levels undertaken in 2020/21.  Lost quality and financial opportunities in both estates and digital transformation.  Possible risk of CQC compliance in adhering to budget constraints.	I = 4 L = 5 Very High (20)	To continue to seek alternative funding solutions to address the Capital funding gap. Capital plan reviewed by the Capital Management Group (CMG) and Finance and Business Performance Committee (F&BP) on a monthly basis.	A financial governance framework is in place in the Trust.	The Trust continues to have unfunded backlog maintenance and infrastructure.	I = 4 L = 4 Very High (16)	Ensure residual risks caused by unaffordability are adequately documented and managed with Regulators. Ongoing regular review is required. Date set February 2022; engagement for next years capital plan.	28 Feb 2022
2.7 Gaps in workforce supply: local/SE region cost of living prohibitive and national workforce shortages in some professions	Bridget OKelly	Increased temporary staffing costs	I = 4 L = 4 Very High (16)	Recruitment plans - three strands - overseas, local recruitment and grow your own NHS Professionals partnership contract supports best opportunity to fill with bank rather than agency Regional system programme supported by CEOs in place to develop sustainable system approach to the management of temporary staffing	Integrated Board Report includes recruitment service metrics, vacancy rates and high level spend on bank and agency Divisional performance reports to include bank and agency spend. Contract management of NHSP to ensure quality of temporary staff and high proportion of bank staff and reduction of agency staff International recruitment monitored through Transformation Committee and Strategic Workforce Committee System temporary staffing approach monitored through Transformation Committee and Strategic Workforce Committee. At a system level, monitored through BOB ICS Senior Leadership Group	National shortage of registered nurses. Delays in conversion of overseas recruits due to the requirements of the IELTS/OET and the time it takes to register with the NMC and changes in immigration rules due to COVID Uncertainty around impact BREXIT will have on EU recruitment This position may be exacerbated by COVID-19 Reduction in overseas nurse recruitment due to COVID-19 Of 15 recruits in the May cohort, 6 are unable to travel due to Covid-19 restrictions. Possible increase in individuals leaving the NHS	I = 4 L = 3 High (12)	Recruitment plans - international, UK, grown your own. Reported through IPR (monthly)	31 Mar 2022

**Board Assurance Framework / 3. Inability to lead an organisation with the capacity and capability to deliver our best in everything we do**

Risk Title	Risk Owner	Effect	Inherent Risk Priority	Risk Control	Control Assurance (Assurance Source)	Assurance Gap	Residual Risk Priority	Action Required	To be implemented by
3.1 Inability to deliver the Trust's strategic case for change	David Williams	Impact on medium- and long-term sustainability	I = 4 L = 4 Very High (16)	BHT 2025 strategy and implementation plan - approved at Public Board September 2021. Quarterly reporting of milestones to Board.	Strategy document - full and executive Summary. Implementation plan		I = 4 L = 3 High (12)	Consistently review capacity and capability to deliver case for change; rolling action.	31 Dec 2021
				Business case linked for resources to support case for change for consultancy and communications and engagement work	Business case to June Private Board	Need resources in 2021/22 to implement case for change consultancy support - approval for support for outline business case in July 2021 - awaiting CCG support for communications		External company to design new branded materials in line with strategy. Launch materials with colleagues.	31 Dec 2021
				Minutes and actions from the Transformation Board	Monthly transformation Boards will track progress on deliver of agreed milestones and actions linked to the case for change	Agreed milestones by end of June 2021 . Milestones agreed at transformation Board in August 2021 -closed		Launch public engagement programme linked to strategy launch in July 2021 For review March 2022 - seeking support for Communication and Engagement Programme from CCG.	31 Mar 2022
				Strategic Delivery Board minutes and actions linked to deliver of the Trust's outline business case. Name changed to Hospital Infrastructure Group - governance approved at Transformation Board in August 2021.	Governance group established to steer the delivery of the OBC linked to Stoke Mandeville and Wycombe Hospital developments	Need to establish Group by the beginning of September 2021			
3.2 Inability to innovate and work with partners to deliver new models of elective care	Dan Gibbs	Missed opportunities to remodel future elective pathways	I = 5 L = 5 Very High (25)	Acute collaboration workstream (ACW) at ICS level focussed on strategic development of elective services in three domains - MSK, head & neck, ophthalmology	Minutes of ACW Strategic development plans	Does not cover all specialties Plans in development	I = 4 L = 3 High (12)	Specialty level innovation strategy	31 Mar 2022
				Elective care transformation workstream in place - developing pathway specific innovations e.g. WARP in orthopaedics, robotic surgery in abdominal specialties	Exception report to transformation board	Level of programme support limited		Strategic plans for elective care development in ICS	01 Apr 2022
3.3 Failure to reform our urgent care pathway and meet future urgent care health needs of the population	Dan Gibbs	Clinical, operational, financial, and regulatory consequences	I = 5 L = 5 Very High (25)	A&E delivery board brings together partners to agree, develop and monitor plans to address challenge	Minutes of AEDB	Pandemic may disrupt Partner landscape changing	I = 4 L = 3 High (12)	Develop integrated UTC model with local partners including GP federation and commissioners.	27 Sep 2021
				Emergency care improvement plan in place, aiming to deliver national requirements of same day emergency care, 111 first, frailty and other ambulatory care pathways	Exception reporting to transformation board Quarterly update to F&BPC	Pandemic may disrupt Partner landscape changing National standards to change		Design and implement interim UTC model for Q3	01 Oct 2021
				Paeds A&E development in progress will provide integrated solution for children's pathways and create significant space in Stoke Mandeville ED to allow acute floor transformation to take place.	Minutes of programme board Completed project	Unseen / unknown estates risks e.g. lack of pipework survey		Acute floor transformation - redesign of use of space when paed's A&E complete	01 Dec 2021
3.4 Failure to secure necessary infrastructure changes linked to Buckinghamshire's housing / growth strategies	David Williams	Public trust and confidence damaged, long-term viability impacted	I = 4 L = 5 Very High (20)	Access to proposals for housing developments and response to proposals in terms of health impact for each proposal	Database of proposals	None	I = 3 L = 4 High (12)	Work with partners to ensure health requirements are included in council development plans	31 Dec 2021
				Bucks ICP estates group considers impact on estate and works with partners on plans		None		Continue to submit s106 and CIL claims for resources to cover impact on housing growth on NHS	31 Dec 2021
				Involvement in Buckinghamshire development plans	impact on health of developments recognised in plans	Need to be part of the new process from Bucks Council			
				Minutes of Buckinghamshire Growth Board	assesses impact of growth strategies	None			
				responses to s106 and CIL requirements acknowledges impact on health of growing population - s106 and CIL awards made for health to cover impact	S106 and CIL award assurance	little awards provided so far for £16m of applications			

Risk Title	Risk Owner	Effect	Inherent Risk Priority	Risk Control	Control Assurance (Assurance Source)	Assurance Gap	Residual Risk Priority	Action Required	To be implemented by
3.5 Not realising the Trust's potential as an Anchor Institution	David Williams	Services not aligned to community / stakeholder needs; missed opportunities to economically support local population	I = 3 L = 3 High (9)	Engagement in Buckinghamshire Growth Board	Minutes of meetings		I = 3 L = 3 High (9)	Launch the Trusts 2025 strategy to engage in a 'big conversation' about health and well being and the NHS. Dependent on ICS and CG support.	31 Mar 2022
				Ensuring all contracts for services have environmental, staffing and local procurement specifications to make sure we are having a positive impact on the community	Contracts and specifications	In all new contracts and specifications ensuring follow good practice in employment and environmental and incentives to employ locally		Assure all new contracts meet environmental and employment standards linked to anchor institutions	31 Mar 2022
				Net Zero action plan	Develop roadmap to support carbon net zero across the Trust	Roadmap to net carbon zero and implementation		continue to foster community support and engagement in the local NHS	31 Mar 2022
				Plan to support career pathways, apprenticeships and access into the NHS at entry level (including volunteers) through training hub and health and social care academy	Reports	Numbers of apprenticeships, employment opportunities taken from DQ areas, career pathways and information linked		Actively publicize to the community and involve colleagues in local and national campaigns for inclusion and health and well being casues	31 Mar 2022
				Plans to support the health and well being of our staff and their families	Evidence and assurance on the improving health and well being of our 6,000 colleagues	Assurance and evidence that health and well being of colleagues is improving through HR and staff survey indicators. Regular monitoring and health checks?		Offer entry into NHS through apprenticeships, volunteering etc to help and support the local employment and the local economy - offering everyone development and career pathway opportunities - target 144 new start apprenticeships (inc 50 health care support workers) by March 2022	31 Mar 2022
				Play an active role in community engagement - supporting local voluntary and community groups and creating mechanisms whereby communities can actively engage in the NHS	Evidence of volunteering and active engagement in the community	Community engagement activity monitored and assessed by the PPEDI group			
3.6 Not using integrated care records and data to manage whole population health and inequalities	David Williams	Preventative health strategies and clinical services not aligned to community / stakeholder needs	I = 3 L = 4 High (12)	Clinicians having access and utilising the shared care record to manage patient care	access to shared care record, utilisation reports	SCR is accessible but multiple processes, systems and culture do not make it easy for clinicians to access and use the SCR	I = 3 L = 3 High (9)	Change and adapt clinical processes to embed shared care record and population health into everyday practice. Agree priorities for these processes (eg. elective recovery, patient flow)	30 Dec 2021
				Regular reports and benchmarks on population health management including risk stratification , smoking status, ethnicity and deprivation by PCN, locality group and practice. Also by area eg waiting lists	Regular reports	We do not have access and can view regular reports. Capacity and capability to deliver effective analysis and reports		Working with the ICS and system partners to ensure population health data becomes part of our way of managing patient care and supporting strategic decision making	31 Dec 2021
				Utilisation report on usage of the shared care record to compare and benchmark	report to Digital Baord	reports are not available and will need to be generated on a monthly basis - access to shared care data warehouse required		Following provision of reports to assist with waiting list management; develop case studies to support.	31 Mar 2022
3.7 Gaps in partnership working (with education, social services, primary care networks, mental health and education) to fully integrate both adults' and children's community services	Dan Gibbs	Community services do not provide outstanding care in a timely and affordable manner	I = 5 L = 5 Very High (25)	Director of Transformation for Community Services appointed to lead integration piece for the Trust	Job description Contract	In post from 1/7/21	I = 4 L = 3 High (12)	Implement single discharge pathway for Buckinghamshire	30 Sep 2021
				Place based delivery group in situ to deliver integration agenda	Minutes of ICP delivery group	Track record on sustained change partner landscape evolving		Develop and agree integration plan for community services	30 Sep 2021
3.8 Adverse contribution to climate change	Ali Williams	Trust has a negative impact on the local environment and global climate	I = 1 L = 2 Very Low (2)	Develop and implement a roadmap to move to net zero	Recruit resource	Roadmap is under development will require corporate resource to own delivery of the plan	I = 1 L = 1 Very Low (1)		

Risk Title	Risk Owner	Effect	Inherent Risk Priority	Risk Control	Control Assurance (Assurance Source)	Assurance Gap	Residual Risk Priority	Action Required	To be implemented by
3.9 Inadequate oversight of direct and indirect clinical harm caused by the pandemic	Andrew McLaren	Patient harm occurs due to delayed treatment as a result of the pandemic	I = 3 L = 4 High (12)	Flag on Datix for reporters to indicate Covid issue	Provide evidence that flag is on Datix system and being used appropriately	Evidence of Covid flag on Datix	I = 3 L = 3 High (9)	Audit of appropriateness of P1-4 categorisation for elective surgery	31 Aug 2021
				Patients on waiting lists have been prioritised by risk	Assurance that risk prioritisation is complete and appropriate with minimal harm being reported through Datix system	Evidence of prioritisation process Audit of accuracy of appropriateness of risk allocation Waiting list data needs to include ethnic and deprivation metrics		Ensure ethnicity details and deprivation status is recorded in elective waiting lists	30 Sep 2021
				System wide Covid Harms Group established to review harm and enhance visibility across system	Provide evidence of systemic review of Covid harms Work with CCG governance team to improve harm reporting across system and develop learning	System review of potential Covid Harms Link primary care, mental health and secondary care risks in governance process Ensure primary care incidents are shared across system		Ensure ethnicity and deprivation metrics recorded in waiting lists are monitored to ensure equality of access to surgery / treatment	31 Dec 2021

**Board Assurance Framework / 4. We do not recover services adequately, fail to meet public / regulator expectations, and do not play a leading role in the health, economic and social recovery of Buckinghamshire**

Risk Title	Risk Owner	Effect	Inherent Risk Priority	Risk Control	Control Assurance (Assurance Source)	Assurance Gap	Residual Risk Priority	Action Required	To be implemented by
4.1 Pandemic-related negative impact on morale, wellbeing and retention	Bridget OKelly	Low staff resilience and wellbeing negatively contributing to engagement, productivity, happiness at work, and potentially the quality of care provided; retention challenges	I = 4 L = 5 Very High (20)	Staff reporting of sickness through First Care monitored by OH and contact made in accordance with Trust policies to support individuals. Staff testing in place to confirm COVID-19 infection - also Lateral Flow testing available to all staff to monitor asymptomatic cases. Advice on self care and clinically extremely vulnerable working from home available to all staff PPE FIT testing training; PPE buddies to support this Comprehensive vaccination programme through BHT Hospital HUB. Working with system to facilitate staff testing and vaccinations, across all areas, as required by national direction Staff support regarding resilience and wellbeing available to all staff. Thrive@BHT is our comprehensive plan to support our people's (individuals, teams and managers) morale, wellbeing, which will support retention.	Regular communication on sickness reporting requirements given Staff testing (symptomatic and asymptomatic) monitored through OH, ensuring staff are being tested in line with national guidance and reported nationally and to SWC Staff advice on clinically extremely vulnerable provided and circulated each time guidance is updated. Staff reminded of channels of support through OH, health and well being sources available and FTSUG - BHT Winter CARE pack published 29 September 2020. Thrive@BHT launched - pack to be published w/c 17 May Management of Firstcare contract in place and with regular reviews to improve user experience. Dedicated reporting processes in place - giving same day absence data and detailed insights. OH has contacted every patient-facing staff member who has not yet taken up the offer of a vaccine. Regular communications and FAQ sessions are held to inform staff about the vaccine.	Staff concerns over shielding self and family due to Covid risk causing return to work concerns Staff working long hours and high intensity of work affecting resilience and leading to sickness absence, in particular for stress related issues. Overall uptake of vaccine is now at 90%; uptake is lower for some staff groups of different ethnicities	I = 4 L = 3 High (12)	Plans set out in Thrive@BHT to support the health & wellbeing of staff	31 Mar 2022
4.2 Changes in the integrated care system and in Buckinghamshire in line with the requirements of 'Integration and innovation: working together to improve health and social care for all' white paper published 2021	Neil Macdonald	Potential loss of system leadership and diversion of resource	I = 3 L = 5 Very High (15)	CEO participation in both ICP Board and ICS Senior Leadership Group. Chair attends ICS Chair's Group.	Monthly meeting attendance as confirmed in meeting minutes.	Reliance on a single individual.	I = 3 L = 3 High (9)	Future Board development session on White Paper. Publication of Trust strategy. Establishment of Provider Collaborative plan.	30 Sep 2021

Risk Title	Risk Owner	Effect	Inherent Risk Priority	Risk Control	Control Assurance (Assurance Source)	Assurance Gap	Residual Risk Priority	Action Required	To be implemented by
4.3 Variations in organisational culture and behaviours	Bridget OKelly	Higher than optimal levels of bullying; negative impact on staff engagement and productivity	I = 4 L = 4 Very High (16)	Thrive@BHT programme - comprehensive 2 - year programme focussing on organisational culture and behaviours. Includes programmes for individuals, managers and teams.	Uptake of programmes in Thrive@BHT will be reported to Strategic Workforce Committee FTSUG guardian provides quarterly reports to EMC and SWC and 6 monthly reports to the Board Guardian of Safer Working Hours provides quarterly reports to EMC and SWC and 6 monthly reports to the Board Bi-monthly meetings of JMSC provide staffside with the opportunity to feedback themes Monthly E,D&I Committee includes chairs of staff networks opportunity to provide qualitative feedback Annual Staff Survey Monthly Pulse Surveys introduced in February 2021 Monthly reports through Transformation Board.	Unequal experience for BAME colleagues Differences in experiences of teams across the Trust	I = 4 L = 3 High (12)	Actions set out in Thrive@BHT programme	31 Mar 2022
4.4 The workforce not always feeling that the organisation is as safe to work in as it can be	Ali Williams	Negative impact on staff engagement and happiness at work; reputational damage	I = 2 L = 3 Medium (6)	Opportunities for staff to feel listened to and issues raised are risk assessed and when appropriate are acted upon	Regular listening meetings with staff working in poor quality buildings space committee to implement changes documentation of significant issues on the risk register regular agenda forum at the health and safety committee for staff to feedback	The estate has a £200m backlog maintenance issue and lack of capital to address the estates issues	I = 2 L = 2 Medium (4)	Implementing the new CAFM system will ensure all concerns are logged and appropriately prioritised	25 Mar 2022
4.5 Governance not always being both easy to navigate and enabling of change, whilst providing robust, forward-looking assurance of risk	Neil Macdonald	Inefficiencies; processes not completed in a timely manner; erosion of desire to innovate and improve; inadequate foresight of organisational risk	I = 4 L = 3 High (12)	Performance framework. EMC workplan. Board and Committee structures. Internal and external audit. External benchmarking (CQC).	Meeting minutes.	Organisational understanding, clarity of structures, paper-based systems.	I = 4 L = 2 High (8)	Review of governance to be completed. Implementation date moved to end November - awaiting report from FM.	30 Nov 2021
								Implement digital risk management system - Datix upgrade.	31 Mar 2022
4.6 The organisation (Board) being CQC-rated 'requires improvement' under the well-led domain	Neil Macdonald	Increased levels of regulatory oversight and potential loss of freedom	I = 4 L = 3 High (12)	Board development plan. Financial recovery (removal of Undertakings). Trust People plan. External review underway of Trust's governance framework.	Annual Governance Statement and Trust self-certification for 2020-21.	Changing regulatory framework in the context of ICS development.	I = 4 L = 2 High (8)	Refreshed Board well-led action plan and external review for 2021-22.	31 Dec 2021
4.7 Lack of consistent attainment of key operational and performance standards	Dan Gibbs	Political mistrust / lack of confidence in management	I = 5 L = 5 Very High (25)	Elective Care Recovery Oversight Meeting - weekly oversight review with Divisional Directors to review position against agreed trajectories	Minutes of ECROM Weekly reports	BI capability May change in H2	I = 4 L = 3 High (12)	Agreed recovery trajectory for emergency care	30 Jul 2021
				Elective care recovery trajectories agreed covering RTT, diagnostics and cancer	Trajectories included at Trust level in IPR and reported on accordingly. At specialty level and report in Divisional IPR			Subject to potential further disruption by pandemic	Forward capacity plan to deliver RTT, cancer and diagnostics return to compliance
				IPR review at EMC, FBPC, TB	IPR produced monthly with spotlights, actions and exceptions	BI capability			
				Monthly divisional performance reviews in place	Divisional IPR Minutes from performance review	BI capability			
4.8 The organisation is not always inclusive and does not always treat people equally	Bridget OKelly	Negative impact on staff engagement and productivity; reputational damage; consequential impact on patients	I = 4 L = 4 Very High (16)	Actions set out in WRES and WDES action plans Staff networks in place and involved in policy development Union networks involved in policy development Monthly E,D&I Meeting includes chairs of staff networks and key individuals from people directorate to track progress	Workforce Race Equality Standard metrics measure annually - from staff survey questions Public Sector Equality Duty Reports annually Equality Impact Assessments 6 monthly reports to SWC and Board Equality impact on all formal papers	WRES: Despite improvements in disciplinary and improvement metrics, we have not yet achieved parity. WDES: Deterioration in recruitment metric; parity not achieved.	I = 4 L = 3 High (12)	Actions set out in WRES and WDES plans	31 Mar 2022

Risk Title	Risk Owner	Effect	Inherent Risk Priority	Risk Control	Control Assurance (Assurance Source)	Assurance Gap	Residual Risk Priority	Action Required	To be implemented by
4.9 Underutilisation of effective data and business intelligence, e.g. suboptimal access to and use of quality metric data	Dan Gibbs	Inefficient organisational management, inadequate oversight of risk, and inadequate ward to board assurance	I = 4 L = 5 Very High (20)	Data Quality Group meets monthly with approved Data Quality Policies and strategies.	Minutes, workplans and action logs	Ensuring all colleagues across the trust understand the importance of recording data accurately, completely and in a timely manner	I = 3 L = 4 High (12)	Ensure sufficient capacity and capability to support BI within the BI team - recruit to Head of BI post	24 Sep 2021
						lack of structured data sources hampers data quality		Continue to review existing reporting mechanisms with Divisions and Corporate depts	30 Dec 2021
				Digital strategy	Strategy document September 2021	Revised digital strategy to incorporate information and business intelligence strategy		Develop a business case and roadmap to a data warehouse - no capital resource to accelerate in 2021/22	25 Mar 2022
				External assurance on data through CQC insights, Dr Foster and IQVIA sources. External audits on data quality	Reports to Data Quality Group	none - capacity to follow up review actions and follow up. Shortage of business analytical capacity			
				Suite of IPR, Divisional and dashboards, including Qlickview to monitor performance	daily, weekly and monthly reports	Lack of a data warehouse and digital data collection involves manual collation of data and time consuming processes for BI and operational teams.			
4.10 Not being an organisation where innovation and new ideas can always thrive and be easily adapted	Andrew McLaren	Inability to transform care and clinical models in a way that is fit for the future	I = 2 L = 4 High (8)	Review of governance framework to ensure learning and best practice adoption is embedded across the organisation. Completion of Innovation Centre as hub for R&I teams and space for teams to come together and share new practice. Digital infrastructure upgrades to give capacity for new technology adoption. Continued rollout of QI programme.	Governance review, QI rollout plan, R&I strategy.	None identified.	I = 2 L = 3 Medium (6)	To develop the Trust's Quality Strategy with a focus on the Appreciative Inquiry - Board session planned	30 Jul 2021
								To use the Innovation Centre as hub for creative pathway design and innovation sharing	29 Oct 2021
								To link together the overall communication strategy to focus on shared learning and organisational wide Quality Improvement	31 Dec 2021

**Meeting:** Trust Board Meeting in Public

**24 November 2021**

<b>Agenda item</b>	Buckinghamshire Healthcare Projects Ltd (BHPL) Annual report 2020/21		
<b>Board Lead</b>	Commercial Director		
<b>Type name of Author</b>	Deputy Commercial Director		
<b>Attachments</b>	Annual report		
<b>Purpose</b>	Assurance		
<b>Previously considered</b>	BHPL Board on 30 September 2021, F&BP on 19 October 2021		

### Executive Summary

Buckinghamshire Healthcare Projects Ltd (BHPL), a wholly owned subsidiary company of BHT has operated as a trading company for three years and is now well-established, providing outpatient pharmacy services on three sites and a café. BHPL's primary social objective is to provide services and innovations that make a positive impact on society and the environment, in support of the overall health and care objectives of its' parent company, Buckinghamshire Healthcare NHS Trust.

The key 2020/21 highlights were:

- The company has grown its annual revenue to £5M, it now employs 20 staff and remains profitable
- During the pandemic, BHPL, as a group company, were able to support the Trust in a number of additional ways, including creating a staff wellbeing space in the café and distributing free meals to staff (suspending trading temporarily), and keeping Amersham pharmacy open, enabling BHT pharmacists to be redeployed to deliver clinical care.
- BHPL have just been awarded Social Enterprise status and have for the first year in these accounts adopted the principles of The Blueprint for Better Business.

<b>Decision</b>	The Board is requested to note this report
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### Relevant Strategic Priority

<b>Outstanding Care</b> <input checked="" type="checkbox"/>	<b>Healthy Communities</b> <input checked="" type="checkbox"/>	<b>Great Place to Work</b> <input checked="" type="checkbox"/>	<b>Net Zero</b> <input type="checkbox"/>
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### Implications / Impact

<b>Patient Safety</b>	BHPL follows the same governance principles and adopts the same policies and procedures as the trust to ensure it meets high standards
<b>Risk: link to Board Assurance Framework (BAF)/Risk Register</b>	Not applicable
<b>Financial</b>	BHPL positively contributes to the financial position of the parent company
<b>Compliance</b> <small>Select an item.</small> <b>Good Governance</b>	BHPL as a wholly owned subsidiary company is required to report to its parent company

<b>Partnership: consultation / communication</b>	BHPL works in partnership with the Trust
<b>Equality</b>	In line with Trust policies, all services provide by BHPL consider equitable access for all, regardless of gender, disability and any other protected characteristic
<b>Quality Impact Assessment [QIA] completion required?</b>	N/A



2020/  
2021



# Annual Review



**Buckinghamshire  
Healthcare Projects Ltd  
(BHPL)**

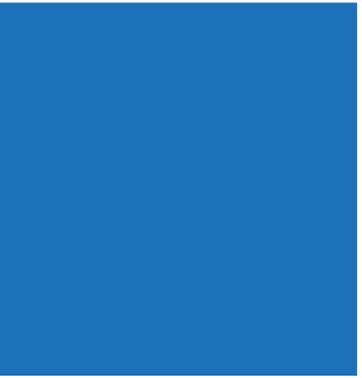
A wholly owned subsidiary of



**Buckinghamshire Healthcare**  
NHS Trust



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A wholly owned subsidiary of



**Buckinghamshire Healthcare**  
NHS Trust

# Directors Overview



BHPL, a wholly owned subsidiary of BHT, has operated as a trading company for three years and is now well-established, providing outpatient pharmacy services on three sites and a café.

BHPL's primary social objective is to provide services and innovations that make a positive impact on society and the environment, in support of the overall health and care objectives of our parent company (Buckinghamshire NHS Healthcare Trust).

The Directors have been delighted this year to adopt the **Blueprint for Better Business** in terms of its principles of operation and to this end have also applied for social enterprise status, formally defining this purpose in the Company's articles of association.

2020 and the COVID-19 pandemic has been a unique and difficult year for all and there is no doubt that the pandemic has brought BHPL's social objectives to the forefront of the culture that underpins our Company.

We recognise in particular, the role the café has played in enabling a number of staff suffering from trauma and long covid to gradually phase their return to work, in providing volunteer opportunities for gardening, personal development and wellbeing.

We have had to make many service adaptations. For the Outpatient Pharmacy this involved environmental and working space restrictions, the loss of much of its' outpatient activity, and the challenge to support the wider NHS. This was done through adapting services to cancer drug preparation and home delivery where appropriate.

Café Oasis closed to trading for part of the year but provided NHS staff with free meals and a much needed rest and recuperation facility.

As demonstrated throughout this Annual Report, BHPL has successfully continued to perform above targets against plan, in both gross revenue terms and profit. It has expanded the outpatient pharmacy service across all three main hospital sites and is well placed to expand into new business areas.

The company has grown its annual revenue to £5m, it now employs 20 staff, and contributed circa £300k cash benefit to its parent company in this financial year.

Colleagues have worked tirelessly to ensure the safety of patients, their continued access to prescription medicines and much needed space at Stoke Mandeville for staff to rest and recuperate. We remain strong and well positioned to resume our expansion plans, which were put on hold as we redirected our focus during COVID-19 to wellbeing which demonstrated our ability to be flexible. We are proud of everyone in BHPL who have achieved so much in the face of one of the biggest health crisis' the world has ever encountered.

Alison Williams  
**Director**

Rachel Devonshire  
**Director**

Barry Jenkins  
**Director**

# 2. Performance Highlights



## 2.1 Outpatient dispensing services

### QUALITY:

In terms of quality, we delivered our contractual KPI's for waiting times and dispensing errors, and our patient satisfaction score was 82%.



### SATISFACTION

Furthermore, a survey conducted with BHT Pharmacy colleagues, who previously carried out both inpatient and outpatient roles, confirmed the dedicated and separate outpatient pharmacy services had helped them to spend more time with ward-based clinical activities. This was a recommendation by the Lord Carter's "Review of hospital pharmacy services", and a key driver for setting up the dedicated outpatient pharmacy from the outset.

### SERVICE:

Throughout the pandemic, we continued to put patients first by ensuring they received their medications in a timely manner. Our staff and NHS volunteers personally made more than 100 deliveries to patients' homes.

100 Deliveries



We also developed an electronic version of outpatient prescriptions, which enabled virtual consultations. In collaboration with BHT pharmacy colleagues, prescribers and the wider staff groups, we stepped into re-open the Amersham pharmacy at the time when BHT pharmacy had to re-direct their resources to cope with the pandemic.

### PEOPLE:

We continued our emphasis on staff wellbeing throughout, and all our staff had access to the same occupational health and wellbeing services offered to BHT colleagues.

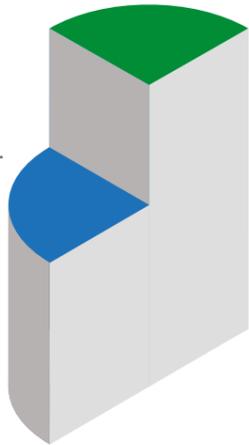


We have been able to successfully internally promote our Senior Pharmacist to Lead Pharmacist and our Team Leader to Operations Lead, who has oversight of the day to day operations across all three sites. We were pleased that our succession plans were in place to enable these two members of staff to advance their careers. Also, all staff were given ample protected learning time and were signed up to various NVQ courses, all of which has helped us to achieve our people strategy.

**MONEY:**

Throughout this challenging time, we adapted our operational approach which successfully achieved a 20% revenue growth. We also maintained a strong focus on cost controls, delivering a profit before tax of £166k, despite encountering a 15% reduction in outpatient prescription activities.

► **£166k Profit**  
before tax



**20%**  
Revenue Growth



**Niranjan Annamalai**

**MESSAGE FROM THE SUPERINTENDENT PHARMACIST:**

*“I want to thank my colleagues for their commitment, resilience and hard work through which we achieved so much this past year. The consistent achievements, performance of our business and the success of delivering service across three sites demonstrated what we could achieve. I am confident that we will deliver more progress for our stakeholders and sustained, compelling results going forward by continuing our focus on staff wellbeing, inclusion and diversity to generate innovation and drive performance.”*



**BHT Pharmacy Staff views\*- 2 years post separation of In-patient & Out-patient dispensing activities**

<p><b>Impact on Job</b></p>	<p><b>Q1. Do you feel, the separate outpatient dispensing service has a positive impact on your job role compared to having both inpatient and outpatient service together?</b></p>	<p><b>96%</b> Of respondents answered yes to this</p>
<p><b>New Opportunities</b></p>	<p><b>Q2. Do you feel, you were able to take on newer roles due to the dedicated outpatient dispensing service?</b></p>	<p><b>59%</b> Of respondents answered yes to this</p>
<p><b>Focus on Core Role</b></p>	<p><b>Q3. Do you feel, you were able to spend even a little bit more time on your core role due to the dedicated outpatient dispensing service?</b></p>	<p><b>96%</b> Of respondents answered yes to this</p>
<p><b>Promotions</b></p>	<p><b>Q4. Do you feel the dedicated outpatient dispensing service helped you to focus on what matters the most in your job role and helped with any career progression, within the department?</b></p>	<p><b>77%</b> Of respondents answered yes to this</p>
<p><b>Service Rating</b></p>	<p><b>Q5. Considering your previous experience in outpatient dispensing prior to the changes, how do you rate the new dedicated service?</b></p>	<p>Average rating <b>4.6</b> ★★★★★</p>

\* During May 2020, A survey was conducted through survey monkey over a two-week period among 38 Pharmacy staff who worked in both areas prior to separation of services. The response rate was 71%.

Buckinghamshire Healthcare NHS Trust (BHT) Pharmacy Staff views about dedicated outpatient pharmacy services from the above survey.

# 2.2 Retail



The café offers an important and valued rest environment in the NSIC for staff and patients and continues to receive excellent feedback

“ You know I have been going into Café Oasis since day one, and I must say over the last year I have seen the staff and café grow, become confident in what they do. ”

“ What a lovely relaxing atmosphere this café is. ”

“ Always a nice salad or two on offer, they now do beautiful taste salad box with chicken, ham, tuna cheese, with even a optional dressing of your choice ”

“ The coffee is quality, don't ever change it!! ”

“ I cant believe the staff make the sandwich's, paninis and everything else themselves that day, they are a credit to the food industry, keep it up! ”

“ The menu is full of such tasty fresh choice, from breakfast to lunch, and the pastries are to die for!!! ”

“ The food is always tasty and fresh, with a great variety on the sandwiches paninis and toasties ”

“ Its nice to see a lovely laid out counter so eye appealing, makes you want to buy one of the pastries every time I go in. ”

“ Fantastic atmosphere, the staff in the café are so helpful and are always laughing and happy, which was lovely to hear, shows they enjoy what they do, and with confidence and with flare too. ”

Café Oasis on the SMH site opened for trading in December 2019 and delivered its initial quarter objectives of building service reputation, increasing footfall, and undergoing full decoration and menu revamp by April 2020.

When the COVID-19 pandemic hit, the impact was substantial, with the café closing to paying custom and being contracted to provide NHS staff with free meals and a quiet place for rest and recuperation.

The cafe re-opened to paying customers late summer 2020, but business remained significantly impacted as the footfall on the hospital site was reduced as elective, outpatient activity were mostly ceased, and visitors not allowed on-site for much of the year.

Income for 2020/21 was £0.25m. Given the trading circumstances the café has done extremely well to limit losses to a small amount.

The café is now fully open, trade is steadily recovering, although the opportunity continues to be restricted as hospital footfall remains reduced. The café offers an important and valued rest environment in the NSIC (National Spinal Injuries Centre) for staff and patients and continues to receive excellent feedback.

“ Having somewhere in a hospital to go that are able to supply not only good quality food but fresh, it is such a delight that you can not get the freshness and quality anywhere else in the hospital. ”

# 3. Financial Summary

## Income Statement for the Year Ended 31 March 2021

	31.3.21	31.3.20
<b>TURNOVER</b>	<b>£5,258,206</b>	<b>£4,309,480</b>
Cost of sales	£4,369,969	£3,573,941
<b>GROSS PROFIT</b>	<b>£888,237</b>	<b>£735,539</b>
Administrative expenses	£744,914	£519,180
<b>OPERATING PROFIT</b>	<b>£143,323</b>	<b>£216,359</b>
Interest receivable and similar income	£66	£711
<b>PROFIT BEFORE TAXATION</b>	<b>£143,389</b>	<b>£217,070</b>
Tax on Profit	£25,371	£45,419
<b>PROFIT FOR THE FINANCIAL YEAR</b>	<b>£118,018</b>	<b>£171,651</b>



## Balance Sheet 31 March 2021

	31.3.20		31.3.20
<b>FIXED ASSETS</b>			
Tangible assets		£34,054	£34,339
<b>CURRENT ASSETS</b>			
Stocks	£239,577		£230,263
Debtors	£617,008		£584,800
Cash at bank	£521,011		£291,994
	<b>£1,377,596</b>		<b>£1,107,057</b>
<b>CREDITORS</b>			
Amounts falling due within one year	£1,113,661		£960,925
<b>NET CURRENT ASSETS</b>		£263,935	£146,132
<b>TOTAL ASSETS LESS CURRENT LIABILITIES</b>		£297,989	£180,471
<b>CREDITORS</b>			
Amounts falling due after more than one year		£-	£500
<b>NET ASSETS</b>		£297,989	£179,971
<b>RESERVES</b>			
Retained earnings		£297,989	£179,971
		<b>£297,989</b>	<b>£179,971</b>



# 4. Statement of responsible business principles

**BHPL follows the five principles of a purpose driven business developed by Blueprint for Better Business as set out below:**

1. Has a purpose which delivers long term sustainable performance
2. Honest and fair with customers and suppliers
3. A responsible and responsive employer
4. A good citizen
5. A guardian for future generations

## **1. HAS A PURPOSE WHICH DELIVERS LONG TERM SUSTAINABLE PERFORMANCE**

Operates true to a purpose that serves society, respects the dignity of people and so generates a fair return for responsible investors. Enables and welcomes public scrutiny of the alignment between stated purpose and actual performance.

This is the first year that BHPL has adopted the responsible business principles and a significant step forwards has been the company has updated its articles of association to state clearer objects i.e. purpose of the company.

**This is now as follows:**

*The company's primary social object is to make a material positive impact on society and the environment by providing services and innovations that support the overall health and care objectives of its primary shareholder.*

## **2. HONEST AND FAIR WITH CUSTOMERS AND SUPPLIERS**

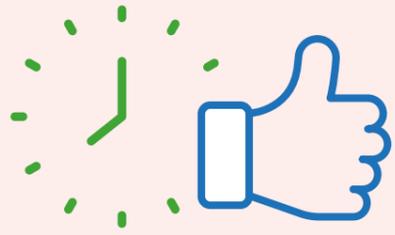
Seeks to build lasting relationships with customers and suppliers. Deals honestly with customers, providing good and safe products and services.

Feedback from both the pharmacy and the café demonstrates how positive customers are about the services they receive.

BHPL is committed to treating suppliers in a fair and respectful way. The company endeavours to pay all due invoices within agreed credit terms and engages early to prevent payments delays. In 2020/21, all purchase invoices were paid, on average, within 31 days of invoice date.



## 2.1 Pharmacy feedback



“The **outpatient service** has helped **free up a lot of time** to complete my usual job.”



“Always taking on **new challenges.**”



“The team are **very approachable.**”



“**very positive** team attitude”.



“doing an **amazing job** supporting our pre-reg pharmacist’s training.”



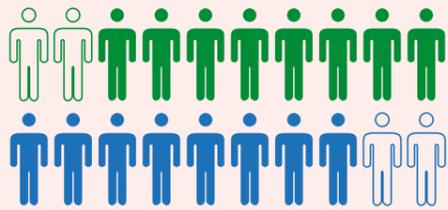
“The team aims to be **helpful** and **friendly.**”



“very **keen on** taking on a lot of **challenges.**”



“The service provided is **very efficient.**”



“The team are **wonderful, very approachable** and **helpful** and communicate well.”



“The service is **well managed** and delivers a **safe** and **efficient service.**”



“I think the **patient feedback** for the outpatient pharmacy **speaks volumes** as **waiting times** have **reduced.**”



“**Brilliant service**”



“An **excellent service** and a pleasure to work in on the odd occasion I do so.”



“**Amazing** outpatient staffing team; they are **really hard-working** and **friendly.**”

### 3. A RESPONSIBLE AND RESPONSIVE EMPLOYER

**Treats everyone with dignity and provides fair pay for all. Enables and welcomes constructive dialogue about its behaviour in keeping true to its purpose. Fosters innovation, leadership and personal accountability. Protects and nurtures all who work for it to ensure people also learn, contribute and thrive.**

At the start of this financial year all salaries were reviewed to ensure we were meeting market rates and were paying fairly by job role. We also introduced a discretionary performance related bonus scheme which is linked to the annual business plan, behaviours and values. All colleagues have access to and are encouraged to seek personal development and training as part of their annual appraisal process and a number of internal promotions this year demonstrate that people have developed their skill sets to enable them to step into new roles.

### 4. A GOOD CITIZEN

**Considers each person affected by its decisions as if he or she were a member of each decision-maker's own community. Seeks and provides access to opportunities for less privileged people.**

Before the pandemic, café oasis offered volunteering opportunities and six people were very much part of the café team. Many of these volunteers had

protected characteristics, therefore, to keep them from harm, it was felt that the café should not continue offering these opportunities until such time that it was safe to do so. On a positive note during summer the café has restarted volunteer opportunities to tidy the café garden as this is outdoor work, which has created a relaxing and healthy environment for staff.

**Makes a full and fair contribution to society by structuring its business and operations to pay promptly all taxes that are properly due.**

BHPL submits monthly tax returns to HMRC and fully pays all due taxes as soon as they are due.

### 5. A GUARDIAN FOR FUTURE GENERATIONS

**Honours its duty to protect the natural world and conserve finite resources. Contributes knowledge and experience to promote better regulation for the benefit of society as a whole rather than protecting self-interest. Invests in developing skills, knowledge and understanding in wider society to encourage informed citizenship.**

BHPL has been an active participant in supporting BHT to develop its net zero roadmap and has signed up to the removal of single use plastics pledge. Café Oasis looks to secure its supply of food products from as local a source as possible to reduce its carbon impact and add additional value to the local economy.





# 5. Forward View

We fully expect the impact of the pandemic moving to become an endemic continues to disrupt business and the outlook for trading over the next immediate twelve months will be difficult, 2021/22 will be a year where revenue remains mostly flat to 2020/21 out-turn levels as the country moves to a more normalised business environment and whilst we invest in bringing on board some senior hires to be able to grow the business.

In addition to our existing business areas, Directors and shareholders have approved that the Trusts private healthcare business will transfer to BHPL once resource is in place. The company is currently recruiting for an experienced private patient manager to lead on the development of this business.

The next three-year objectives for the company are to treble revenue to £15m, achieve Social Enterprise

status, achieve CQC accreditation to be able to broaden activities in healthcare, and ultimately return 23% gross profit. The company has a resource plan to drive the growth including the employment of a Managing Director within 21/22.

In terms of responsible business practices BHPL will continue to work alongside BHT to move towards net zero by 2040.

Quality	People	Money	Innovation and Digital adaption
We continue to focus on delivering safe, responsive, efficient customer friendly services.	We focus on providing an exciting job in a conducive environment, with many opportunities for continual learning to enhance long-term career opportunities	Increase Revenue and deliver growth by investing effectively in our business, developing our people	We will embrace newer technologies that will increase our operational efficiency.

## OUR THREE-YEAR GROWTH PLAN FOR PHARMACY@BUCKS IS AS FOLLOWS:

New Business:	New Business:
New outpatient pharmacy in A&E at Stoke Mandeville (2022)	▶ Provide a minor ailments service in the new pharmacy
Existing Business:	New Business:
Outpatient Pharmacy in Amersham, Stoke Mandeville and Wycombe	▶ Open retail pharmacies in Stoke Mandeville and Wycombe

## OUR GROWTH PLAN FOR CAFÉ OASIS IS AS FOLLOWS:

New Business:
Salon Oasis in NSIC
Existing Business:
Café Oasis in NSIC



Pharmacy  
@Bucks



Buckinghamshire Healthcare  
NHS Trust

**Meeting:** Trust Board Meeting in Public

**24 November 2021**

<b>Agenda item</b>	Corporate Safeguarding team Annual Report.
<b>Board Lead</b>	Karen Bonner Chief Nurse
<b>Type name of Author</b>	Tina Charlton Deputy Chief Nurse and Louise Pegg Head of safeguarding Adults
<b>Attachments</b>	Integrated Safeguarding Annual Report
<b>Purpose</b>	Information
<b>Previously considered</b>	Quality Committee 20 October 2021

### Executive Summary

The Integrated Safeguarding Team purpose is to enable everyone within BHT to undertake their role, fulfilling their obligations to safeguard.

This is fulfilled by delivery of: Advice and support, oversight of training and education, safeguarding supervision, supporting the sharing of information with the partners as appropriate, including the MASH.

There has been an overall increase in, quantity and complexity, in all aspects of safeguarding work for both adults and children throughout the year which is summarised in the report.

The report also summarises the work in supporting vulnerable groups including: Maternity; Children Looked After (LAC); Learning Disability; Dementia and Delirium. There is a summary of achievements within the team.

The report ends with a summary of risks mitigations and recommendations. The greatest risk to BHT is the changes which will occur as a result of the change in Legislation to Liberty Protection Safeguards replacing current DOLS (Deprivation of Liberty Safeguards). This is expected in April 2022 and a code of Practice was expected to be published in September 2021 we await publication with the associated guidance.

This paper was considered at Quality and Clinical Governance Committee on 20 October 2021. The Committee took assurance from the paper, noting the system wide resource implications and the change in legislation. It was noted that targeted improvement efforts for ongoing training compliance were ongoing.

<b>Decision</b>	The Board is requested to note the report
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### Relevant Strategic Priority

<b>Outstanding Care</b> <input checked="" type="checkbox"/>	<b>Healthy Communities</b> <input checked="" type="checkbox"/>	<b>Great Place to Work</b> <input checked="" type="checkbox"/>	<b>Net Zero</b> <input type="checkbox"/>
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### Implications / Impact

#### Patient Safety

Safeguarding is facilitating safety for all people in a partnership approach. This paper outlines how BHT has fulfilled this obligation over the last year.

<b>Risk: link to Board Assurance Framework (BAF)/ Risk Register</b>	BAF 1 1.1, 1.4, 1.6, 1.7
<b>Financial</b>	Increased demand outlined in the paper may require increased resource to maintain our statutory obligations
<b>Compliance</b> Select an item. Select CQC standard from list.	Safe “service users must be protected from abuse and improper treatment”.
<b>Partnership: consultation / communication</b>	Safeguarding the population of Buckinghamshire is done in partnership with all statutory organisations working in the area particularly the Local Authority and Police as well as health partners and the CCG.
<b>Equality</b>	Health inequalities are avoidable, unfair and systematic differences in health and experience between different groups of people. The trust is committed to the safeguarding all children and adults, regardless of age, colour, disability, ethnicity, gender, gender reassignment, nationality, race, religion or belief, responsibility for dependents, sexual orientation, or any other personal characteristics.
<b>Quality Impact Assessment [QIA] completion required?</b>	No

Please see report attached.

## APPENDICES

Appendix 1: slide 24 the safeguarding strategy at the end of the report



BHT Safeguarding Team

# Integrated Safeguarding Annual Report

2020/2021

Presented October 2021



# Executive Summary

The corporate Safeguarding team core function is to enable everyone in BHT to undertake their role, fulfilling their responsibility to safeguard. The team achieves this in the following ways:

Advice and support to practitioners on request

Safeguarding Supervision ( group supervision)

Oversight of training it's content and the requirements for different roles

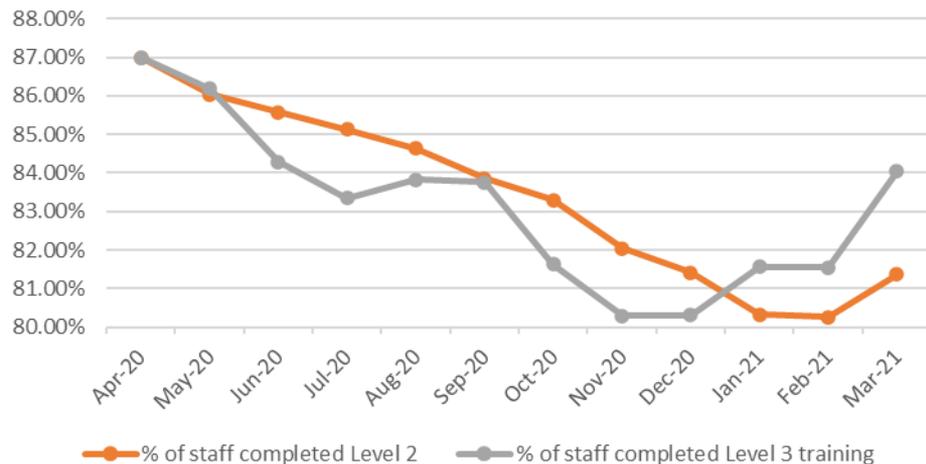
MASH ( Multi Agency Safeguarding Hub) support giving Health information to this process with Health Visiting Service and other information sharing as required to safeguard

There has been an increase in activity in every aspect of safeguarding work during 2020- 20221. This is reflected in increases in:

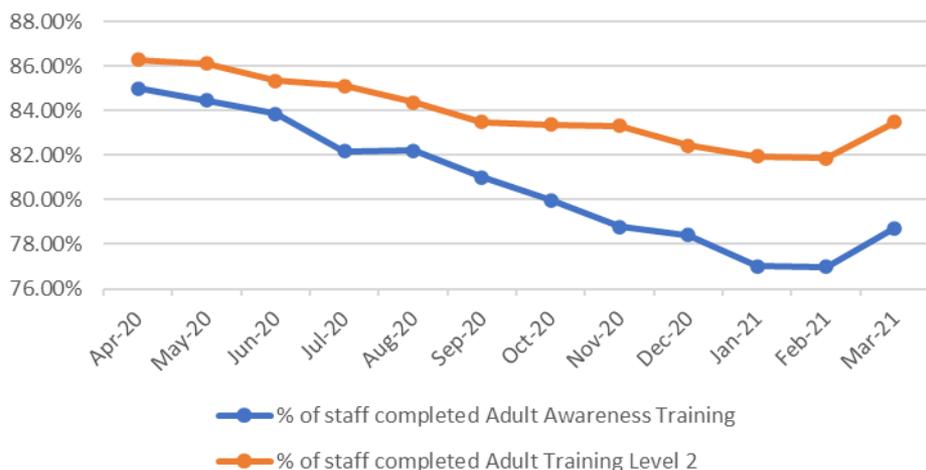
Requests for Individual Support	MASH Referrals
Referrals to the Local Authority for safeguarding Adults	Strategy meetings
Applications for Deprivation of Liberty	Dementia Screening
Admission for children requiring mental health support	S42 enquiries

# Training- L 1-3 Children and Adults

## Training Compliance Safeguarding Children



## Training Compliance Safeguarding Adults



### Overview

The corporate safeguarding team offer a suite of face to face and e learning training packages and is aligned with the Intercollegiate Documents:-Adults(2018); Children(2019).

During part of 2020/2021 it has been necessary to remove face to face training and deliver via MST.

This is a model we will be taking forward to the next year to ensure we can offer a range of training delivery methods.

### Analysis

A downward trajectory across the reporting period with a slight upwards trajectory being evident toward the end of that period. The drop in compliance can be attributed to staff acuity and winter pressures.

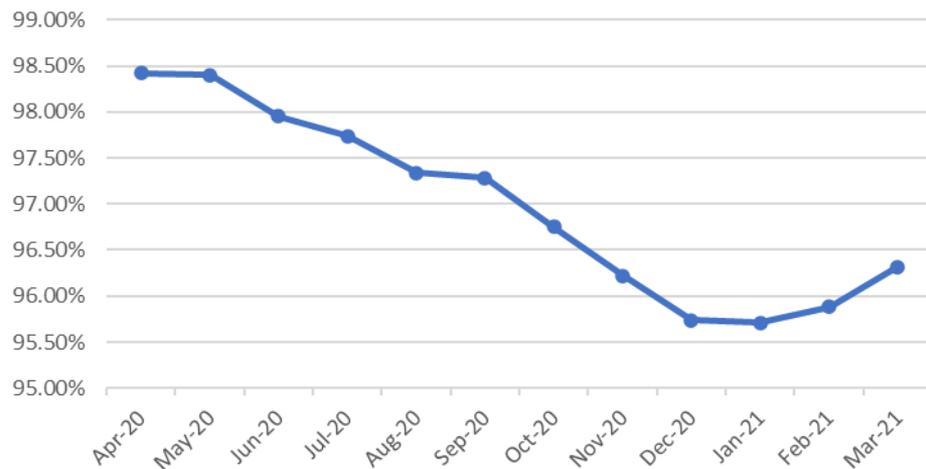
The aim for the coming year is to establish and sustain and increase in compliance The Trust Safeguarding Committee assertively monitors training data with the aim of ensuring that any falls in compliance can be quickly addressed.

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

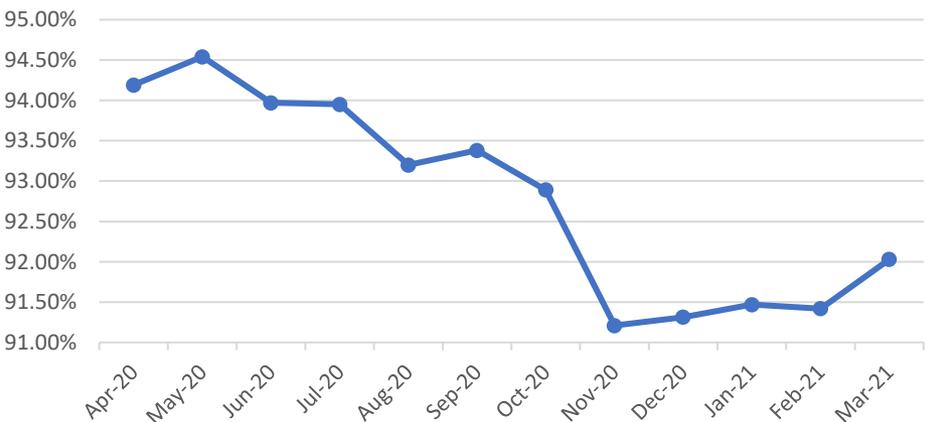
Training data reported to the Safeguarding Committee will include a breakdown of different staff and professional groups to be able to target for improvement those identified as being non-

# Training- Mental Capacity Act and DoLS

**Mental Capacity Act training compliance**



**Deprivation of Liberty Safeguards Training Compliance**



## Overview

A key issue to be considered in the forthcoming year is that of legislative change around MCA and the move towards Liberty and Protection safeguards to replace DoLS.

This will likely have a significant impact on working practice, with associated resource issues.

A business case will be prepared after the publication of the code of practice which will seek to gain Executive support to underpin the required changes, although the details are not yet known.

## Analysis

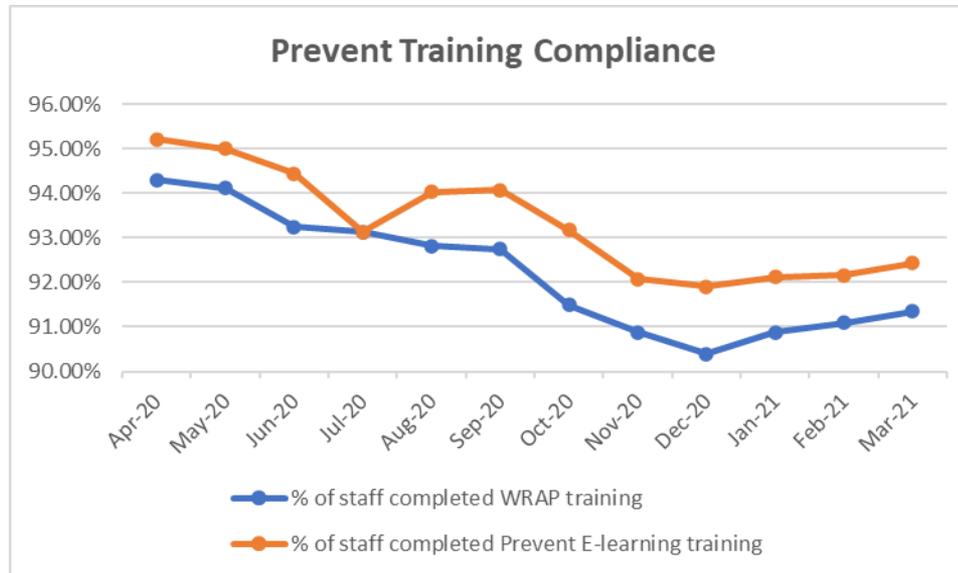
The data for MCA and DoLS training compliance for the current reporting period indicates a downward trajectory but demonstrates a good compliance, nevertheless.

The aim for the forthcoming year is to build on this achievement and maintain levels. Incorporating the guidance from the code of practice, awaiting publication.

When analysing divisional activity around MCA and DoLS it is evident that staff are accessing advice and requesting training however it is not always clear how training is then put into practice. Therefore, some consideration as to how we can provide assurance related to the impact of training will need to be made.

An audit plan includes an MCA and DoLS audit for Q3 of 2021.

# Training-Prevent



## Overview

Prevent is part of the Governments counter-terrorism strategy known as CONTEST. Raising awareness of the health sectors contribution to the Prevent strategy is crucial as we are best placed to identify individuals who may be groomed into terrorist activity. All clinical staff within the Trust are required to attend PREVENT WRAP (Workshop to Raise Awareness of Prevent) training or complete the approved e-learning package.

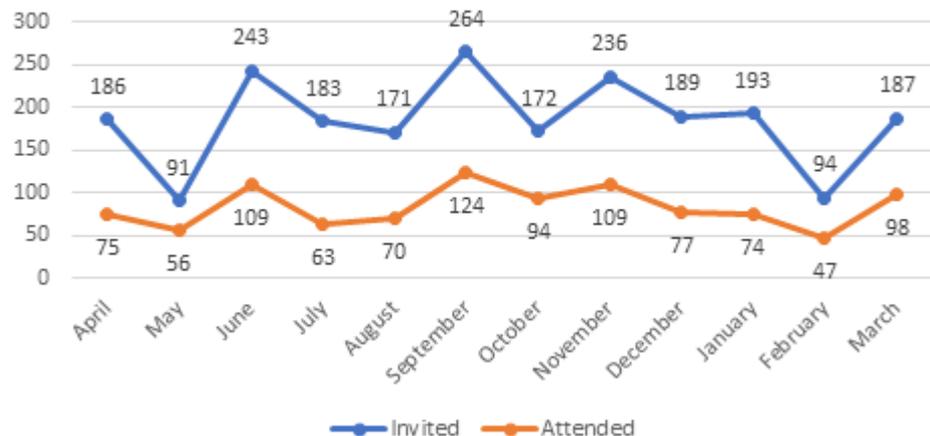
## Analysis

Whilst a downward trajectory is evident compliance remains good and an upward trajectory is noted towards the end of this reporting year.

We have received 0 referrals noting a Prevent concern this reporting year which is a decrease in previous years. Further work will be required across the network to understand why there has been a decrease in referrals.

# Supervision

Childrens supervision - How many invited vs how many attended 2020-2021



## Overview and Analysis

Safeguarding Supervision groups have continued this year for all clinical staff working with vulnerable families. The team have dynamically provided supervision to ensure cases are discussed and reflected on thus facilitating learning and allowing challenge in a safe environment to ensure effect safeguarding practice.

The data shown in the graph demonstrates that supervision sessions across the reporting period were delivered consistently however there appears to be a significant difference between the number that was invited in comparison to how many attended. Further work this forthcoming year will allow this data to be strengthened and analysed further.

The safeguarding team has continued to identify groups of staff that would benefit from joint adults and children's safeguarding supervision. This has been a very good piece of joint working that is continuing to evolve.

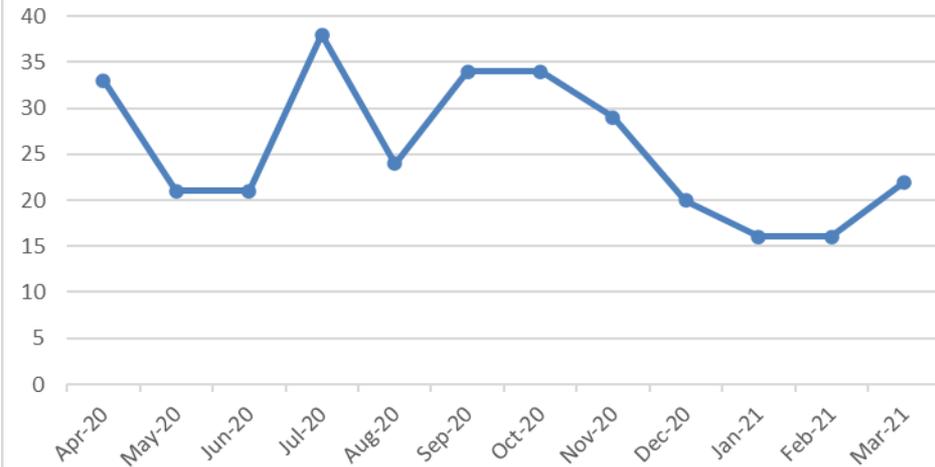
They has been Supervisor's training delivered across BHT in order to deliver more sessions. Safeguarding are actively trying to target adult supervisors in particular.

Area for further development:

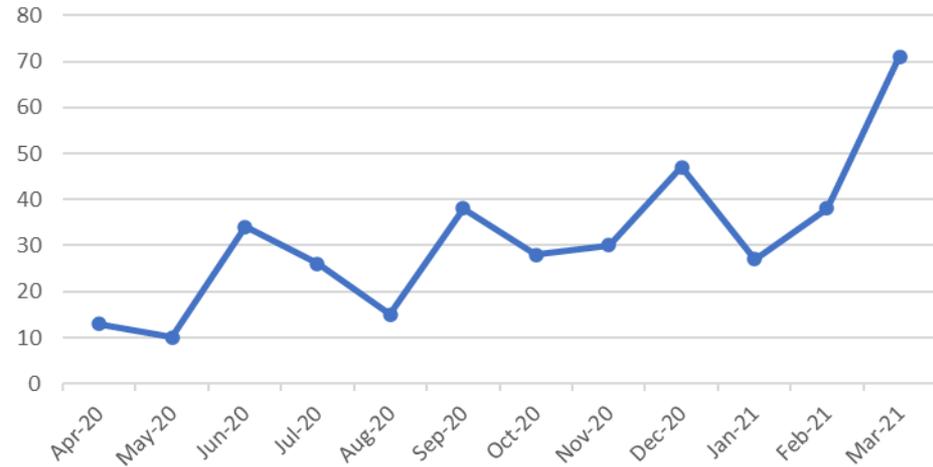
- Development of a safeguarding adult supervision pathway  
This is an ongoing priority. Adult safeguarding supervision has evolved significantly with the successful launch of integrated child and adult groups and adult focused groups in key areas.
- Data sets to be strengthened

# Advice and support

### Child Advice given



### Adult Advice given



## Overview

Safeguarding team run a duty system Monday-Friday 8-4. Data in the graphs above indicate how many requests for advice and support were made across BHT for the reporting period.

During this reporting period data is fairly high level and changes have been made across this forthcoming year to ensure we can analyse data by categories of abuse or concern and by divisions.

## Analysis

Children's data demonstrates a sharp peak in June as children returned back to schools and an increase in children presenting with mental health concerns.

Across children and Adults requests for support peaked during the start of the winter lockdown and continued to a sharp upward trend. Self Neglect, Neglect /acts of omissions and Domestic Violence and Abuse were the main themes of staff requiring support. This intelligence is used to inform the forthcoming years training and to deliver targeted training.

# Multi-Agency Working

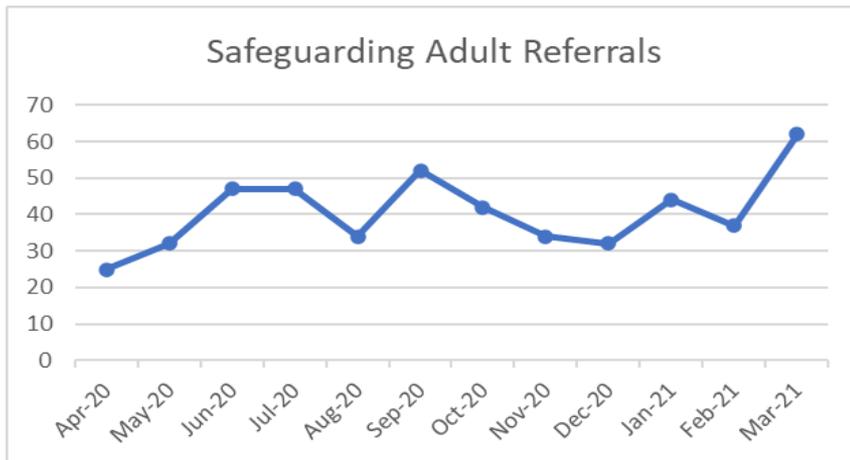
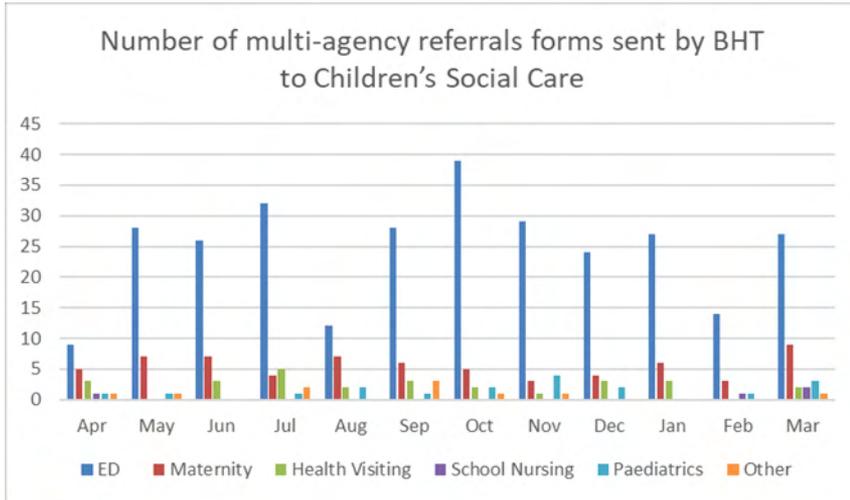
## Overview and Analysis

Safeguarding is everybody's business and everybody has the right to live a life that is free from harm and abuse. Buckinghamshire Healthcare NHS Trust (BHT) has a statutory duty to ensure that all people who use its services are protected from abuse and that their rights are upheld. Employees of BHT are duty bound to raise a referral if they are concerned about an adult or child.

Children's Referral Activity: Data demonstrates that during this reporting year there was a spike in referrals to social care in October. This is mainly due to children returning to school after national lockdown. The majority of referrals are from ED this is to be expected given this is the front door to the organisation.

Adults Referral Activity: There is an evident upward trend in activity for this reporting year compared to previous years which is an indicator of the positive impact of training and support provided to BHT staff. Some of the rise in referral activity may be attributed to adults developing care and support needs and becoming at risk as a direct result of Covid-19. Further analysis will need to be made in order to understand this more fully. Overall BHT has seen an additional 64% increase in referral activity in comparison to the previous reporting year.

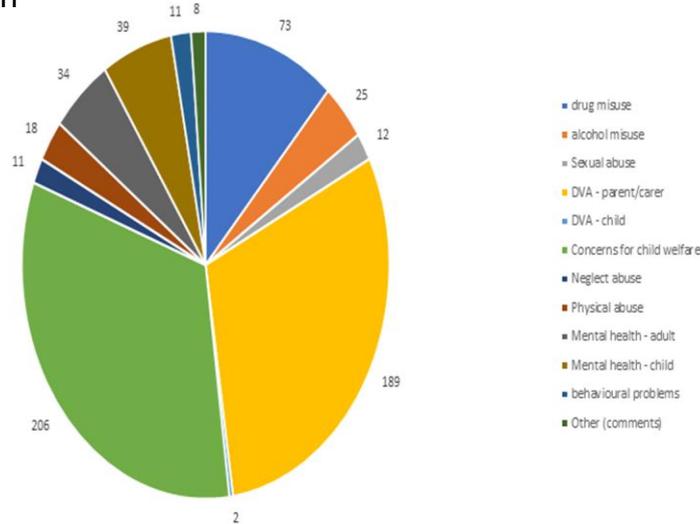
BHT will be aiming to benchmark data against other Trusts for the forthcoming year.



# Categories of Abuse-

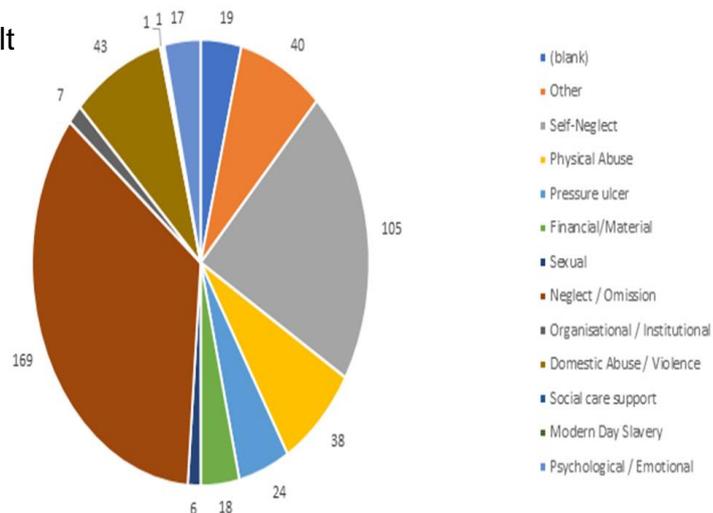
## Children

MASH Enquiry Concerns 2020/21



## Adult

2020/2021 Adult Referral categories of Abuse



## Overview and Analysis

The graphs shown here depict categories of abuse as captured by MASH referrals and safeguarding adult that have been raised by BHT.

There has been an increase in Domestic Violence referrals to MASH. This is reflected in the National picture. The Office of National Statistics (2020) comments that there was an increase in demand for Domestic Abuse victim services during Covid-19 pandemic.

The lower graph demonstrates the most reported categories for adult safeguarding alerts is Neglect/Acts of omissions and Self-neglect.

In response to the rise in some areas of abuse the safeguarding team instigated the following:

- DASH train the trainer-this upskilled staff in order to recognise and respond to DVA.
- A L3 Self neglect training package was written-this empowered staff to better identify and respond to concerns relating to self neglect.
- Joint L3 training packages to promote 'Think Family'
- Began to deliver some supervision sessions jointly across CYP and adults
- Safeguarding began work with the Falls lead, TVN and pharmacy leads to better empower staff to recognise and respond to safeguarding concerns in relation to same.

# Care Act (2014) S42 Enquires (Provider Led)

## Overview and analysis

The Care Act 2014 (Section 42) requires that each local authority must **make enquiries**, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect.

The local authority can delegate enquiries to providers where it is seen that the provider is most appropriate agency to complete this.

The process for managing S42 within BHT has been reviewed. The Safeguarding team maintain oversight of all S42 and communicate with the relevant divisions accordingly.

Each division is responsible for tracking and actioning any actions and the relevant HoN is responsible for the sign off each report.

The safeguarding team will work to create an aggregated high level action plan during this forthcoming year.

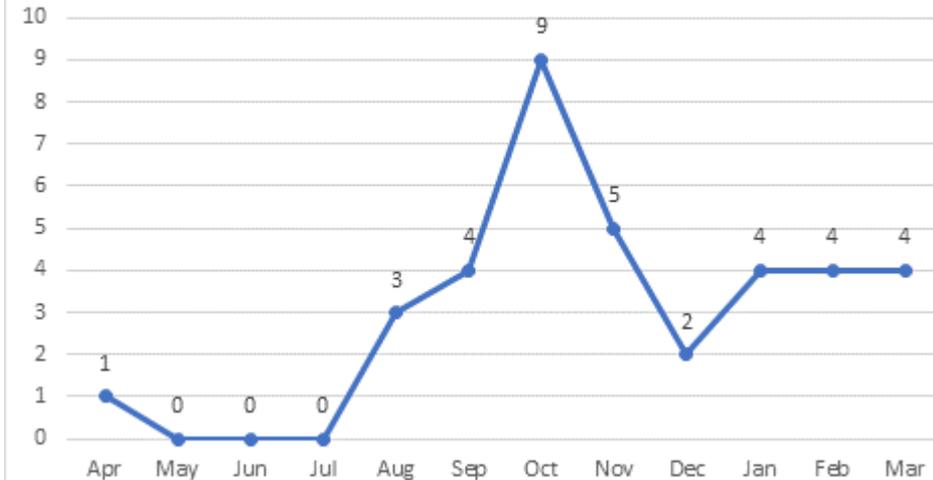
There is a peak in S42 delegated enquiries in the month of October and this could be attributed to the peak in September of an increase in adult referrals that month.

Thematics for S42 are demonstrated in the graph. A BHT Task and Finish group is focusing on hospital discharges following an increase in S42 concerns.

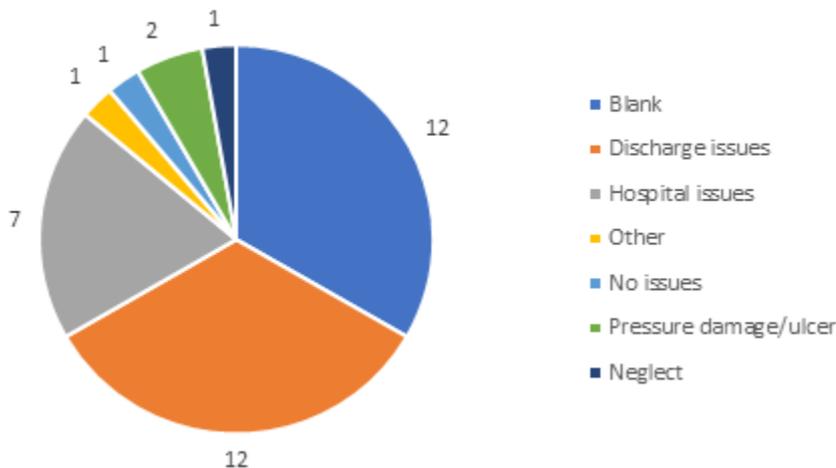
It is difficult to predict how many S42 will be delegated to BHT and this figure is not always correlated to the amount of referrals made by BHT.

For the next reporting year BHT will work with the relevant agencies (CCG, ICS) to ensure governance around S42 is reviewed.

Number of S42's 2020-2021



Themes of S42's 2020-2021



These graphs demonstrate year on year growth of the safeguarding activity across adults.

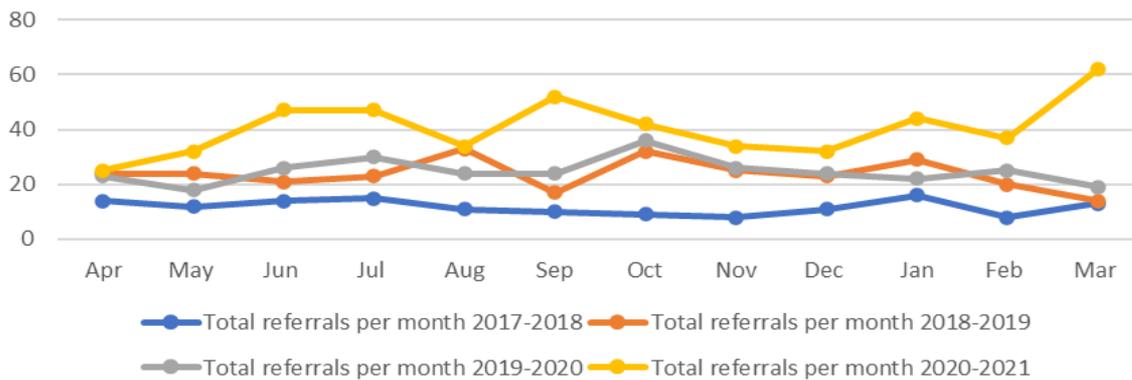
There is an evident upward trend in activity for adult referrals this reporting year compared to previous years which is an indicator of the positive impact of training and support provided to BHT staff. Overall BHT has seen an additional 64% increase in referral activity in comparison to the previous reporting year.

Nationally there is an average increase of 13.9 % year on year of DoLs applications being made since 2013-2014 (NHS Digital). BHT is seeing over and above the national increase with a 36% increase from the previous year and a 54 % increase from 2018-2019. Further work will need to be completed to understand why this is. Some of the increase can be attributed to an increase in staff knowledge and enhanced policy and legal literacy.

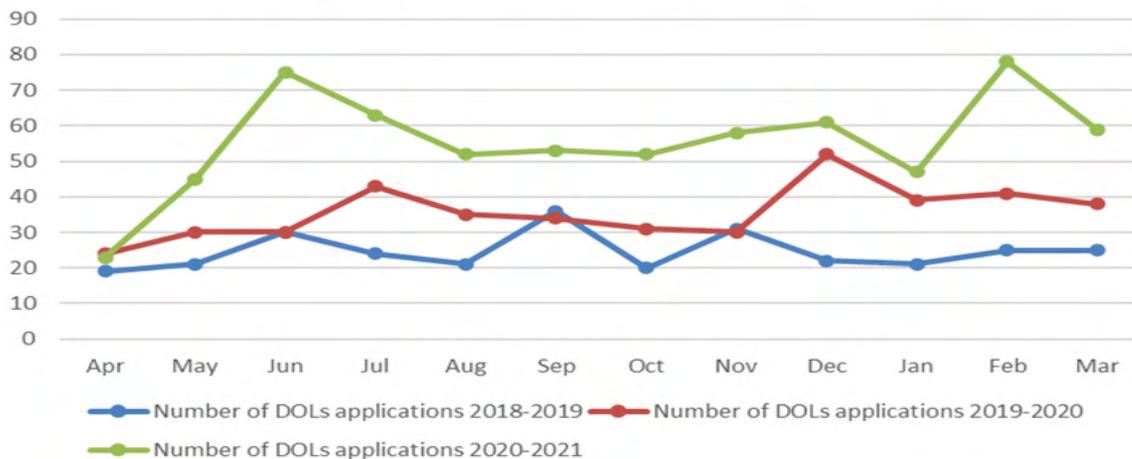
It is clear that with the increase in volume of referrals being made by BHT and the forthcoming changes to the legislation means that the resource previously identified will need to be reviewed to support the system. This will be clarified following the publication of code of practice.

# Increase in activity year on year

Comparison of Safeguarding Adult referrals per year

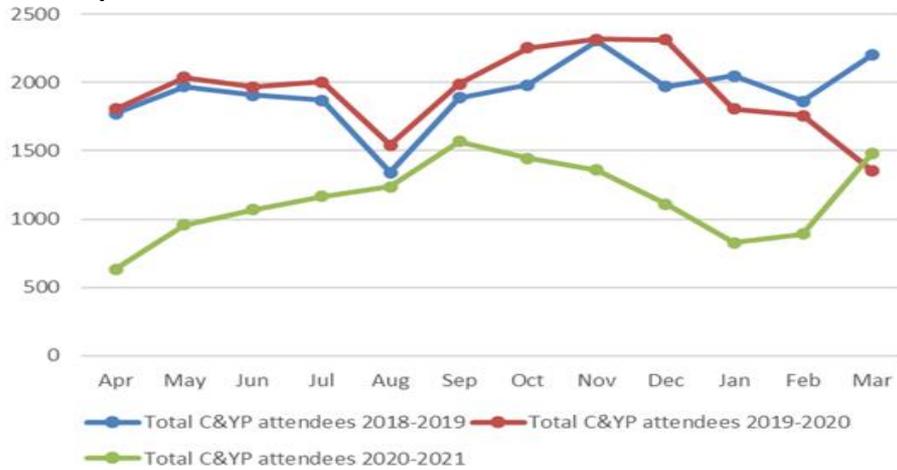


Comparison of DoL's applications by year



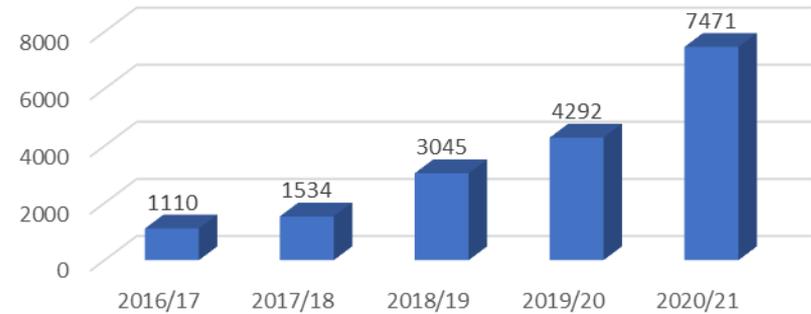
## Children & Young People Emergency Department Attendances

### Graph 1

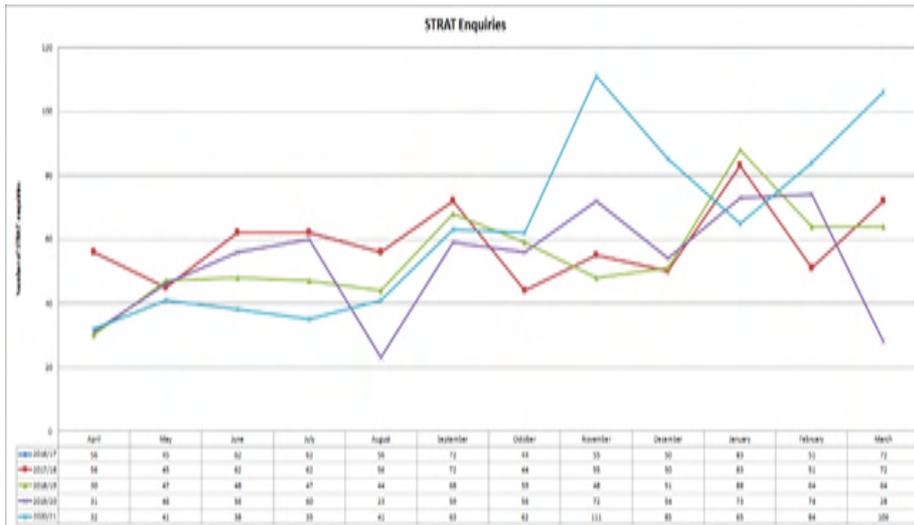


### Graph 2

## MASH Enquiries



### Graph 3



## Overview and Analysis of Children's Activity

The number of ED attendances (Graph 1) has decreased for this reporting year compared to previous years. This is thought to be behaviours around the national lockdown.

There is a marked increase in MASH enquiries (Graph 2) which are requesting Health Information.

Graph 3 demonstrates year on year increase of Strategy enquiries. This suggests that the MASH enquiries are leading to significant concern and the need for a strategy discussion.

The overall increase in workload relating to Children's enquiries since 2016 is an increase of 673%,

In order to keep up with the increase in workload during 2021-2022 a full review of the MASH provision will need to take place with our partners to ensure that BHT are 'Working Together' (2018) compliant.

# Audit

In order to assure the board both internally and externally, that healthcare is being provided in line with relevant standards, BHT safeguarding team have commissioned audits and engaged with multi agency auditing. There is an audit plan for the forthcoming year.

## **Deprivation of Liberty Safeguards (DoLs) audit**

The action plan focused on three main strands:

- Process both internally and externally.
- Practical application of the legislation.
- Training needs analysis.

## **Safeguarding Supervision Record Keeping Audit 5986**

The action plan focused on the following actions:

- Communication plan
- Revision of training plans to ensure an increased capacity
- Data and information flow
- Revision of the structure of the supervision discussions

## **Safeguarding Adults**

The action plan identified medium and low priority actions and these focused on three main strands:

- Quality assurance around provided led S42;
- Training and lessons learned.
- Incident reporting specific to safeguarding adult concerns.

## **Chaperone Policy Audit**

A clinical audit action plan was created and led by the Surgery and critical Care division. High priority actions were identified that focused on two main stands:

- Patient information.
- Policy literacy relating to staff.

# Audit

## Learning Disability Benchmarking

The LD nurses again completed the NHS improvement standards benchmarking exercise in January 2020. The standards aim to promote greater consistency of care nationally and Trusts are required to submit statistical data and identify patients and staff to take part in a survey. The standards are divided in to 3 areas.

- Respecting and protecting rights,
- Inclusion and engagement and
- workforce.

## Section 11 Audit

The Children's Act (2004) places statutory obligation for named agencies and individuals to co-operate to safeguard children and promote their welfare.

Section 11 of the Act makes clear to whom this duty applies and indicates that they must make arrangements for ensuring that their functions are discharged, having regard to the need to safeguard and promote welfare of children.

BHT took part in a Section 11 audit in this reporting year however at the time of reporting the results were not yet available.

# Safeguarding Adults Reviews (SARs), Domestic Homicide Reviews (DHRs) and Serious Practice Reviews

BHT has a statutory requirement to engage in any multi-agency serious practice reviews (formally Serious Case Reviews), Safeguarding Adult Reviews (SAR's) or Domestic Homicide Review's (DHR's) where we have had involvement in the care of the victim, perpetrator or their family, if relevant. These reviews may be commissioned by the local authority, but some could be commissioned outside of our local authority.

Work for the forthcoming year will be to strengthen the DHR process internally and to ensure that staff understand their duty in relation to case reviews.

BHT continues to contribute appropriately to statutory multi-agency reviews aimed at learning lessons from adverse outcomes in respect of safeguarding incidents and events. These reviews to which BHT currently contributes are included in the table below.

	2019	2020
Child serious case reviews (SCRs);	3	2
*Safeguarding Adult Reviews (SARs)	1	5
*Domestic homicide reviews (DHRs)	Data not available at time of reporting	4
Learning disability death reviews (LeDeRs)	8	7

\*BHT not involved in all of these at a panel level

# Health Assessment Activity for Children Looked After (CLA previously LAC)

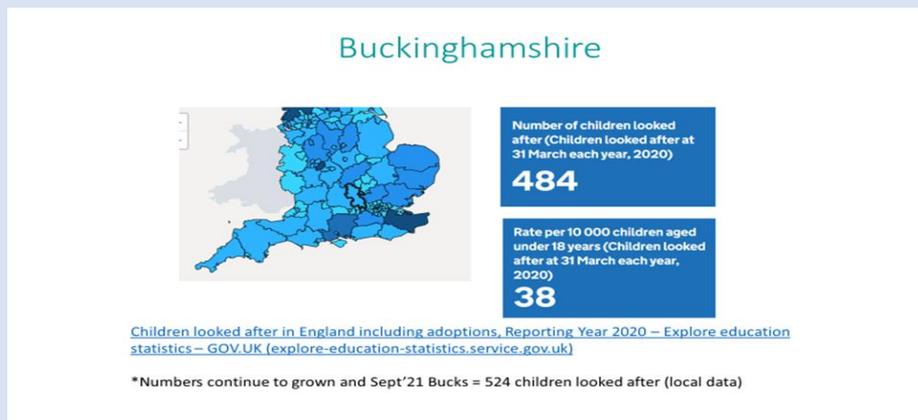
Please note: the term LAC is used in this report as this reflects the wording used in statutory guidance; however, it is recognised that some children and young people prefer alternative terms such as Child Looked After or CLA

- Health assessments are not an isolated event, but part of the dynamic and continuous cycle of care. Specialist nurses are case loading children looked after with health assessments becoming part of a continuous cycle of SMATER care planning and not isolated events.
- Children's homes within the county have allocated named specialist nurses.
- Specialist nurses being present at Foster Carer support groups.
- Specialist nurses engaging in activities with the 'We do care' children in care council.

Initial IHA's	2019/20	2020/21	2021- to date	Reviews RHA's	2019/20	2020/21	2021- to date
Total number	167	184	69	Total number	423	432	223

During the financial year 2020/21 41% of the RHA's were for 'in county' children and 59% placed out of the county.

46% of all the RHA's were achieved within statutory timescales. For the RHA's that breached statutory timescales 34% were 'in county' children and 56% for children placed out of county. BHT do not undertake the Out of Area assessments but are responsible for reporting these.

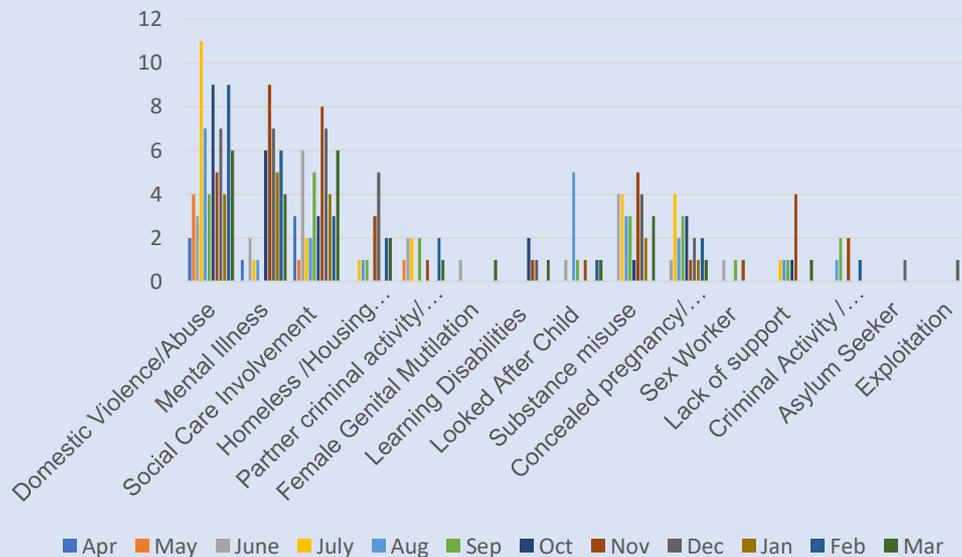


# Maternity

Graph 1 - Number of women with safeguarding referrals due to give birth



Reasons for Safeguarding Referral



## Overview and Analysis

The midwifery safeguarding team have continued to support women and families with safeguarding concerns.

There were 158 safeguarding referrals during the year. This equates to 3.41% of births at the Trust during 20/21.

Graph 1 shows a sustained increase in the number of women giving birth with safeguarding concerns particularly during the national lockdowns.

The most frequent reasons for safeguarding referrals during this period are domestic violence/abuse; mental illness; previous or current social care involvement and substance misuse. An increase in violence against women during the pandemic was reflected across the country.

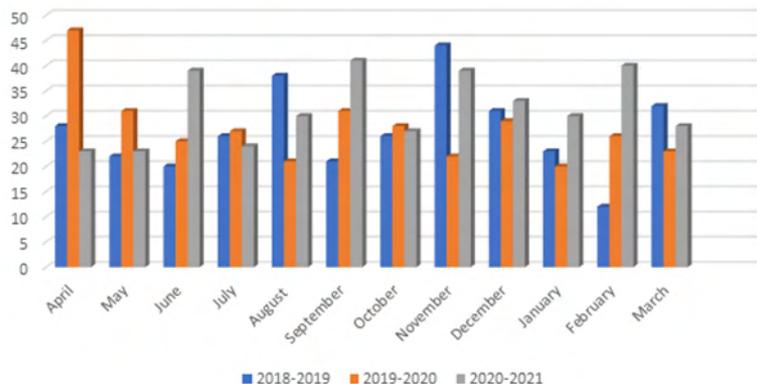
The majority of referrals were for multiple reasons rather than a single indication; reflecting the complex social and psychological needs of women during pregnancy and the first few days after birth.

During the pandemic the number of babies suffering from non accidental injuries increased nationally. The safeguarding midwives developed a training video for staff to aid them in discussions about coping with a crying baby before parents were discharged. An information leaflet for parents based on Hampshire's ICON campaign was also developed.



# Learning Disability

Chart Title



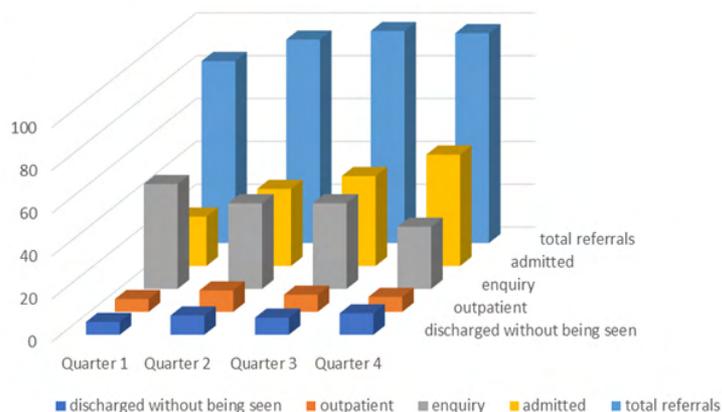
## Overview and Analysis

The LD nurses have continued to support individuals with a learning disability and autistic people to have their health needs met during this challenging year. Referral data has shown another slight increase on previous years and a total of 387 referrals were received during the 12month period. The reasons for referral include enquiries, patients admitted to hospital and outpatient appointments.

The first graph shows the number of referrals by months for the last 3 years.

The nature of referral or reason for support altered during the different stages of the pandemic. Initially there was an increase in the number of enquiries made and a reduction in admissions as individuals and carers were reluctant to come to hospital. However, by quarter 4 this was reversed with more patients being admitted to the Trust. The patients that are recorded as being discharged without being seen are those who have been admitted over the weekend when there is not an LD service.

reason for referral



The most common cause of death for people with a learning disability nationally is pneumonia/ aspiration pneumonia. Within Buckinghamshire Healthcare Trust there were 13 deaths in 2020/2021, 7 were male and 6 were female and aspiration pneumonia was the main cause of death.

Cause of death	Covid	Pneumonia /aspiration	Sepsis	Stercoral perforation	Ischemic stroke	End stage renal failure
Number of deaths	3	6	1	1	1	1

# Learning Disabilities

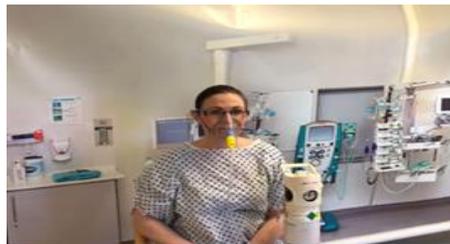
Within a LeDeR report specific to Covid published November 2020 the following themes and areas of improvement were identified and detailed in the table to the left.

Identifying deterioration in health	LDLNs attend the managing deteriorating patients work group and promote the importance of visual observation of patients who may not tolerate all observation procedures due to anxiety, confusion, or sensory issues. The LDLNs also worked proactively with the CLDHT to identify vulnerable patients and ensure regular contact and monitoring during the lockdown periods
DNACPR-The media reported nationally that DNACPRs were being written for all people with a learning disability during the early stages of the pandemic.	The LDLNs have always monitored the DNACPR documentation to ensure the terminology and the recording is correct. Next year the plan is to formally audit the quality and accuracy of the completed DNACPRs for people with a learning disability
Diagnostic overshadowing	Through training and regular patient visits the LDLNs advocate for patient need and ensure that diagnostic overshadowing does not occur.
Reasonable adjustments	Carers are reminded to ensure patients have the Grab sheet or passport with them during an admission to hospital. This enables easy identification of reasonable adjustments that a patient requires to ensure they have their health needs met appropriately.

# Learning Disabilities

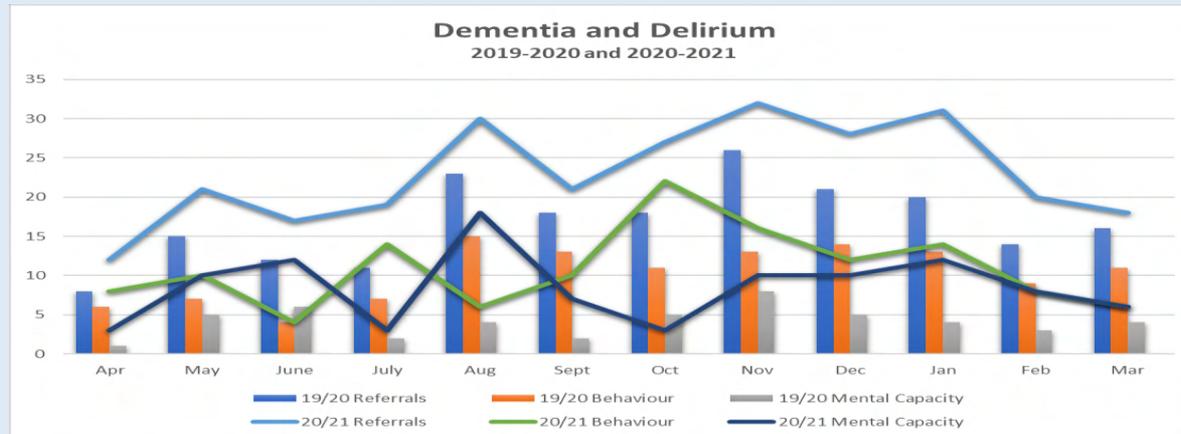
As an example of work to support patients and reduce anxieties the LD nurses developed 2 short films with the help of the communications team and simulation department.

In addition, guidance information and resources regarding Covid, self isolation, and staying safe were added to that Trust intranet to support staff caring for patients who may have been admitted to the hospital. The resources were also shared with colleagues in the Community Learning Disability Health team and social care teams.



# Dementia and Delirium

- Dementia and Delirium are core syndromes seen in any care setting.
- Within the acute and community inpatient beds there will be patients admitted with a known dementia and recognition of the stage and type of dementia will help plan and personalize the care experience.
- However, despite the National Dementia Strategy focusing in improving rates of dementia diagnosis via referrals to Memory Clinic Buckinghamshire has remained in the lower quartiles and failed to maintain the national average of 69% so our services are also key in identifying undiagnosed cases of Dementia.
- The Dementia and Delirium Team has actively worked towards ensuring the Single Question Identifying Dementia is asked on admission both through education and working alongside staff. A positive response should be clinically assessed and then referred to Memory Clinic on discharge with that assessment playing a key part in assisting Memory Clinic. The Geriatricians and Neurologists can assist in making a diagnosis in certain situations.



- Delirium is a separate syndrome to Dementia and has its own tools for assessment using the Acronym PINCH MEE. Delirium rates have increased during COVID 19 and the Team have worked with the CCG to develop an assessment pathway outside of the acute Trust.
- The Dementia and Delirium Team have seen a steady increase in the number of referrals with key themes being management of behaviour ( ideally without sedation) and mental capacity. The Team lead case conferences on some treatment decisions and ethical dilemmas and ensure the person with Dementia and or Delirium and those closest to them family wise are included in decision making. This alongside the education packages they deliver keeps the Team focused on the Trust commitment to Safe and Compassionate Care Every Time.

Risks and Mitigation	Recommendations
<p>Gaps in practical application and staff knowledge and awareness of MCA and DoLs. New legislative changes due in 2022.</p> <p>Increase in DoLs applications year on year meaning safeguarding team can not provide the required level of scrutiny to the applications.</p> <p>This is mitigated by BHT staff flagging the most urgent DoLs.</p>	<p>Respond to the awaited LPS code of Practice due for publication. Consider the recruitment of MCA and LPS Lead within BHT to allow BHT to meet new responsibilities.</p> <p>Review the capacity for the administration that increased DoLs and LPS will require.</p>
<p>Training compliance remains challenging across the organisation due to operational pressures.</p>	<p>New face to face training developed to increase relevance to clinical staff. Training Matrix has been reviewed.</p>
<p>With the changes in the Domestic Abuse Bill there will be a need to upskill staff in relation to DVA.</p>	<p>Engagement in the Multi Agency Domestic Abuse Board (Deputy Chief Nurse attends) Multi Agency Training to be developed, Consideration with partners of the recruitment of an IDVA ( Independent Domestic Violence Advisor) .</p>
<p>Increase in volume and complexity of the safeguarding work within BHT requiring constant prioritisation of cases within the team.</p>	<p>Review of team structure and capacity including the consideration of a Head of Safeguarding and a Named Dr for Safeguarding Adults (not statutory but often provided in provider organisations)</p>
<p>In relation to S42 there is limited high-level oversight of actions</p> <p>Currently actions are tracked by individual divisions.</p>	<p>Safeguarding to create an aggregated S42 action plan</p>

# Achievements

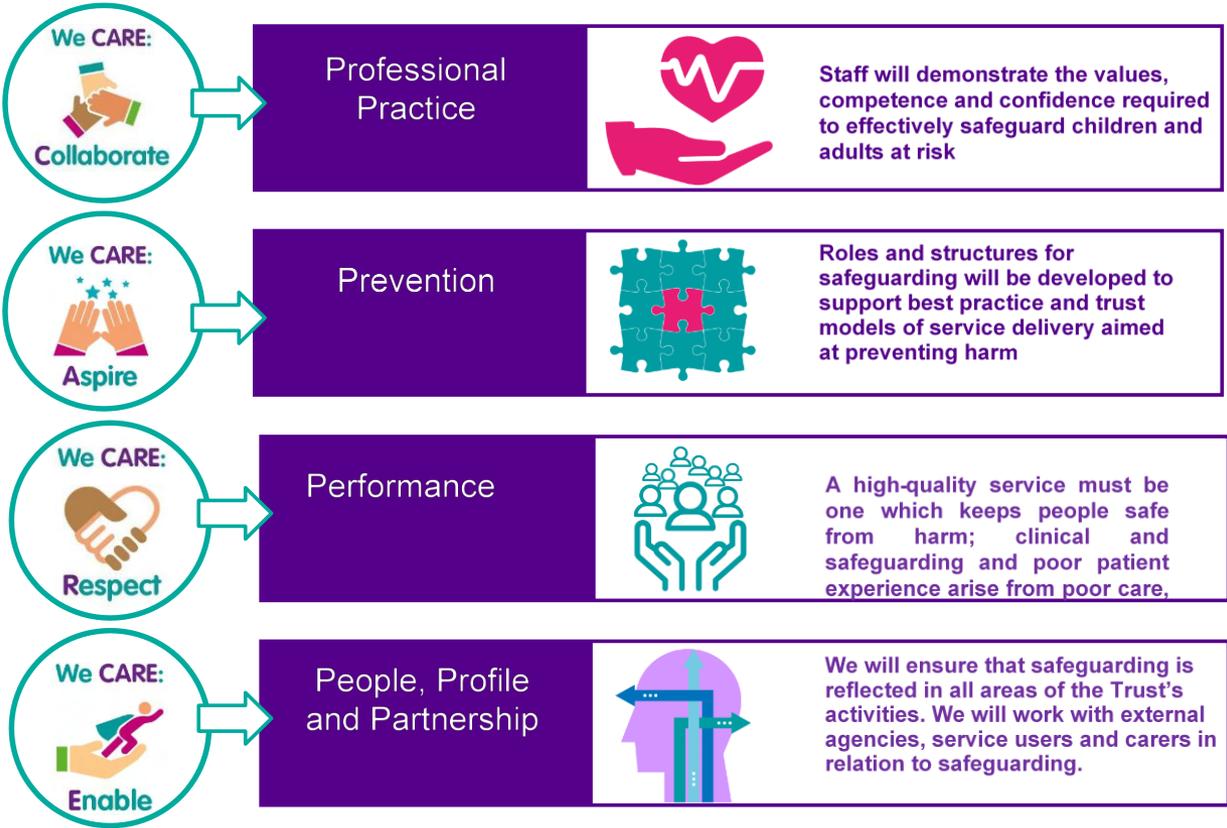
The following provides an update on the progress made by the integrated safeguarding team against objectives set out in the Safeguarding Annual Report for the year 2019/20

Objective for 2020/2021	Update
Successfully recruit into current vacancies to ensure that the Integrated Safeguarding Team are fully established and functioning.	All vacancies have been successfully recruited into.
Development and publication of a training 'passport'	This training passport is developed and available for employees to use.
Develop training packages to ensure that all sessions have an up-to-date teaching plan with regular reviews and to develop a quality assurance tool.	There is a training suite of L2 and L3 safeguarding packages that are evidence based and that are regularly reviewed. All sessions have a lesson plan and have been standardised.
Further work will be developed in order to expand on the work already undertaken in relation to 'Think Family'	The Safeguarding Team continue to promote the Think Family approach in all their training sessions to help practitioners consider the parent, the child and the family as a whole
Development of a standalone 'Managing Allegations' policy	The safeguarding team worked collaboratively with the HR team to develop this policy. It is due for completion in 2021.
Work to support BHT in identifying and supporting staff to maintain what will be a change in compliancy in safeguarding training as set out in relevant documents	This work has been ongoing across 2020 and will be live during this forthcoming year.
Development of a safeguarding adult supervision pathway	This is an ongoing priority. Adult safeguarding supervision has evolved significantly with the successful launch of integrated child and adult groups and adult focused groups in key areas.

# Appendix 1

## Safeguarding Strategy 2021/2022

### Safeguarding Strategic Aims 2021/2022



**Meeting:** Trust Board Meeting in Public

**24 November 2021**

<b>Agenda item</b>	Data Security & Protection Toolkit Submission Update
<b>Board Lead</b>	David Williams, Director of Strategy & Business Development, Senior Information Risk Owner
<b>Type name of Author</b>	Lorraine Pask, Information Governance Manager
<b>Attachments</b>	Data Security & Protection Toolkit Improvement Plan Update
<b>Purpose</b>	Information
<b>Previously considered</b>	Executive Management Committee 28/9/2021

### Executive Summary

The Trust submitted the 2020-2021 Data Security & Protection (DSP) Toolkit on 30<sup>th</sup> June 2021 with the status 'Standards Not Met, Plan Agreed'. This paper sets out the current improvement plan position and gaps to meeting the outstanding standards.

The Board are asked to note the plans in place for meeting certain standards and the identified risks to achieving all of the required standards by the December 2021 deadline.

This paper was noted by the Executive Management Committee.

### Decision

The Board is requested to note this report.

### Relevant Strategic Priority

<b>Outstanding Care</b> <input checked="" type="checkbox"/>	<b>Healthy Communities</b> <input checked="" type="checkbox"/>	<b>Great Place to Work</b> <input checked="" type="checkbox"/>	<b>Net Zero</b> <input type="checkbox"/>
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### Implications / Impact

#### Patient Safety

Patient safety and care delivery could be jeopardised through loss, or loss of access to medical records.

Patient privacy and safety could be breached through inadequate data security controls and the organisation could face substantial financial penalties under GDPR and DPA 2018 regulations.

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

Quality of care

Failure to consistently provide outstanding quality care that is compassionate, cost effective & safe – digital immaturity

#### Financial

Patient privacy and safety could be breached through inadequate data security controls and the organisation could face substantial financial penalties under GDPR and DPA 2018 regulations

<b>Compliance CQC Standards Person-centred Care</b>	Links to CQC KLOEs
<b>Partnership: consultation / communication</b>	Links to BOB/TVS qualifying standards for shared care record – BHT proposed lead data controller across the ICS
<b>Equality</b>	The security of personal data through systems, processes and people safeguards everyone's privacy and data security. IG training not only supports systems and data but ensures a culture of data security from all colleagues through paper and IT systems.
<b>Quality Impact Assessment [QIA] completion required?</b>	No

## **Information Governance and Data Security Protection Toolkit Report**

### **Update on achieving Standards Met for 2020-2021 submission**

#### **1 Background and context**

The Data Security and Protection Toolkit (DSPT) is an online self-assessment tool that allows organisations to measure their performance against the National Data Guardian's 10 data security standards. All organisations that have access to NHS patient data and systems must use this toolkit to provide assurance that they are practising good data security and that personal information is handled correctly.

In March 2019 NHS Digital changed the format of the toolkit to be more prescriptive and introduced standards that can only be either met or not met. They also added the ability for larger organisation types such as NHS Trusts to submit a 'standards not met' assessment, which would need to be accompanied at submission by an action plan to be approved by NHS Digital, with a completion time frame of approximately three to six months.

At the end of May 2021, a report was submitted to EMC outlining the identified gaps in achieving All Standards Met for the final toolkit submission for the period 2020-2021.

The paper;

- highlighted the key areas of concern that were still being worked on following the independent audit of the Toolkit evidence currently in place,
- included a copy of the improvement and action plan to be submitted to NHS Digital
- flagged, in advance, that the Trust would have to submit the toolkit with 'standards not met' along with an action plan and obligated time frame for completion, in line with NHS Digital submission process.

An update on progress against the agreed action plan also has to be submitted to NHS Digital during September 2021.

This paper provides an update on the progress made towards achieving the required standards for 2020-2021 and summarises the updates to be presented to NHS Digital. The committee is asked to note the contents of progress and approve the work-off plan

#### **2 Gaps identified in achieving "Standards Met" for the DSP Toolkit 2020-2021 submission**

In April 2021 the annual DSPT audit was undertaken, whilst the review, update and collection of evidence for the toolkit was still underway.

The final findings of the audit were received in June 2021. Where evidence required strengthening to underpin the Toolkit requirements, these actions and processes have been completed and development will continue. The Committee are asked to note that progress with some requirements had been impacted by Covid e.g. training figures, IAOs responses to audits etc.,. Some of the standards in the toolkit were a new requirement for the 2020/21 submission and some had been reworded, enhancing the level of evidence required

The DSPT submission was updated to reflect the findings of the audit. However, three areas where the audit recommendations couldn't be achieved prior to submission were added to the

NHS Improvement plan and the Toolkit was submitted as Standards Not Fully Met (Action plan in place).

It should be noted that since the action plan was agreed with NHSD on the premise that the core infrastructure projects would satisfy many of the requirements that weren't met at the time of submission, an issue has been raised by the projects that will impact on the delivery dates for these items.

Due to a global shortage of circuits and chips that are in the new network hardware required for us to complete our network installation and build there has been a subsequent delay to our delivery dates by up to six months which is beyond our direct control. This means that several of the actions will not be completed by the deadline of December 31<sup>st</sup> 2021. This will require the Trust to have some open discussions with NHS Digital ahead of this deadline to understand the impact of this and agree how this should be progressed. In the meantime, where mitigations are possible, these have been investigated and some funding from NHSD to support has been obtained, e.g. ensuring backups are stored offline and away from our core network. These are noted within Appendix 1 which provides the updates.

Appendix 1 shows the NHSD Improvement plan which was submitted with the DSP Toolkit for 2020-21, and the relevant updates which the committee are asked to note.

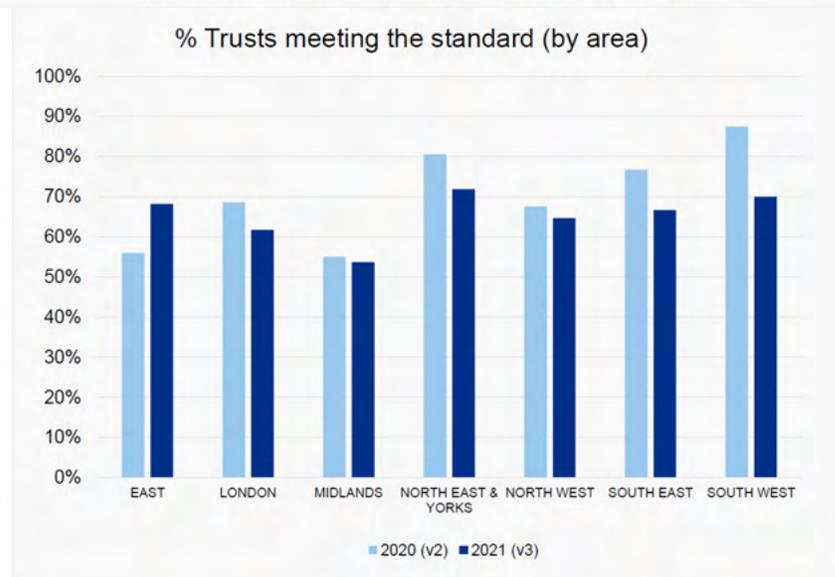
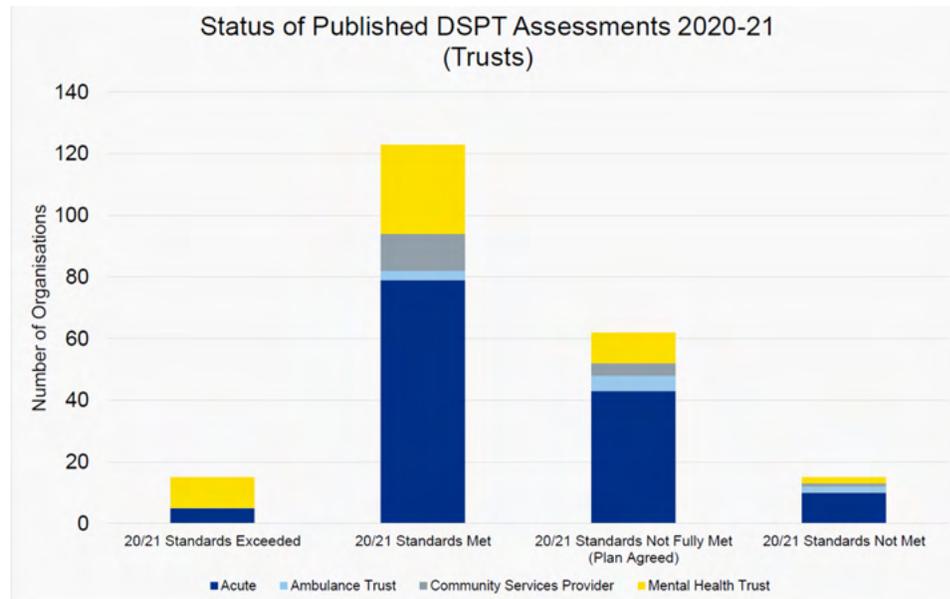
### **3 Summary of remaining standards not yet met**

The following table shows the standards from the plan that the Trust continues to work on.

<b>Risk of completion by deadline</b>	<b>Number of requirements</b>	
High Risk	2	
Medium Risk	3	
Low Risk	2	

### **4 National comparison of submissions**

Following the submission of the toolkit in June 2021, the national statistics for status by Trusts have been published. The graphs below demonstrates the spread of submission statuses for 2021.



## 5 Next steps

Trusts will be asked by NHSD for an update on the improvement plan in September 2021, with a final update due by December 2021. Organisations not completing their improvement plan will be amended from Standards Not Fully Met to Standards Not Met.

All NHS Trusts and Foundation Trusts are considered operators of essential services under Network and Information Systems (NIS) Regulations so a Trust may be issued with an Information Notice to require them to provide information or an Enforcement Notice requesting them to take specified steps as required under the Regulations.

The NIS Regulations provides legal measures to boost the overall level of security (both cyber and physical resilience) of network and information systems that are critical for the provision of

digital services and essential services (transport, energy, water, health, and digital infrastructure services).

The Regulations require organisations identified as 'operators of essential services' to take appropriate and proportionate measures to;

- manage risks posed to the security of the network and information systems on which their essential services rely;
- prevent and minimise the impact of incidents on the delivery of essential services; and
- report serious network and information incidents that impact on provision of the essential service.

The IT Department has submitted a funding request in September 2021 to NHS Digital Cyber Fund, to obtain either £250,000 in match funding towards our new firewall solutions or £92,000 of DSPT compliance monitoring and scoring software, that maintains network probes, to help identify issues outside of the Microsoft domain, that require intervention and remediation to achieve the new standards.

### **1.5 Recommendation**

The Committee are asked to note the steps being taken to meet the outstanding requirements, and approve the submission of the September 2021 updated improvement and development plan to NHS digital 2020/2021 DSP Toolkit.

**Meeting:** Trust Board Meeting in Public

**24 November 2021**

<b>Agenda item</b>	Patient experience and Involvement annual report
<b>Board Lead</b>	Chief Nurse
<b>Type name of Author</b>	Amarjit Kaur- Head of Patient Experience and Involvement
<b>Attachments</b>	Patient Experience and Involvement Annual Report
<b>Purpose</b>	Information
<b>Previously considered</b>	Q&CG 15 November 2021

### Executive Summary

Restrictions to visiting, changes to the hospital estate, and the move to remote appointments as a result of the pandemic, all impacted on patients experience of BHT. The patient experience team worked in partnership with the Trust Patient Experience Group to develop new ways to support patients. This included implementing virtual visits, the Letter to Loved one service, wayfinding volunteers and expanding our PALS and chaplaincy services.

BHT continued to collect patient feedback via the Friends and Family test allowing us to be responsive to patient views. Many trusts stopped after NHSE suspended national reporting. Staff attitude and behaviour was consistently the subject of the highest number of positive comments with waiting times the subject of the highest number of negative comments.

BHT performance in the CQC national survey programme on Children and Young People (CYP), Accident and Emergency (A&E) Maternity and Inpatients declined in 2020 in comparison to 2018/19 survey results. Patients continue to have very high levels of trust in doctors and nurses but patients not feeling involved in decisions about their care and treatment was a theme across all surveys.

There were 549 complaints in 2020/21. After falling at the start of the pandemic, there was a surge of complaints in Sept 20. The emergency department received the highest number of complaints, followed by gynaecology and neurology. Treatment & procedure was the subject with the highest number of complaints, followed by communication with the patient or carer.

Delays and cancellations were the subject of a surge in queries to our Patient Advice & Liaison Service over the pandemic period as patients.

Due to Covid restrictions the Trust was not able to carry out the usual range of patient involvement activity. However, the Trust's patient groups continued to meet virtually throughout the pandemic, helping to shape the Trust's response and ensuring excellent patient experience remained a priority.

The key areas where patients would like to see the trust improve are:

- Involving patients in decisions about their care and treatment
- Waiting times
- Delays and cancellations
- Discharge

The Quality and Clinical Governance Committee took assurance from this paper on 15 November 2021 noting the usefulness of regular updates to the Committee.

<b>Decision</b>	The Board is requested to note this paper			
<b>Relevant Strategic Priority</b>				
<b>Outstanding Care</b> <input checked="" type="checkbox"/>	<b>Healthy Communities</b> <input type="checkbox"/>	<b>Great Place to Work</b> <input type="checkbox"/>	<b>Net Zero</b> <input type="checkbox"/>	
<b>Implications / Impact</b>				
<b>Patient Safety</b>	Poor patient experience can be an indicator of safety concerns			
<b>Risk: link to Board Assurance Framework (BAF)/Risk Register</b>	Listening to the patient voice and a culture of quality improvement			
<b>Financial</b>	Potential litigation			
<b>Compliance</b> <small>Select an item.</small> <b>Person-centred Care</b>	Person centred care, safety, safeguarding, complaints			
<b>Partnership: consultation / communication</b>	We understand patient experience by listening to feedback from a variety of channels. We work in partnership with patients to improve services			
<b>Equality</b>	Working with key stakeholders in quality, safety and experience. 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.			
<b>Quality Impact Assessment [QIA] completion required?</b>	N/A			

# Patient Experience & Involvement Annual Report 2020-21



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Amarjit Kaur-Head of Patient Experience & Involvement

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# Summary

- Restrictions to visiting, changes to the hospital estate, and the move to remote appointments as a result of the Covid-19 pandemic, all impacted on patients experience of BHT, resulting in a decline in 2020 performance in comparison to 2018/19 national survey results. The patient experience team worked in partnership with the Trust Patient Experience Group to develop new ways to support patients. This included implementing virtual visits, the Letter to Loved one service, wayfinding volunteers and expanding our PALS and chaplaincy services.
- BHT continued to collect patient feedback via the Friends and Family test allowing us to be responsive to patient views. Many trusts stopped after NHSE suspended national reporting. Staff attitude and behaviour was consistently the subject of the highest number of positive comments with waiting times the subject of the highest number of negative comments
- BHT performance in the CQC national survey programme on Children and Young People (CYP), Accident and Emergency (A&E) Maternity and Inpatients declined in 2020 in comparison to 2018/19 survey results. Patients continue to have very high levels of trust in doctors and nurses but patients not feeling involved in decisions about their care and treatment was a theme across all surveys
- There were 549 complaints in 2020/21. After falling at the start of the pandemic, there was a surge of complaints in Sept 20. The emergency department received the highest number of complaints, followed by gynaecology and neurology. Treatment & procedure was the subject with the highest number of complaints, followed by communication with the patient or carer
- Delays and cancellations were the subject of a surge in queries to our Patient Advice & Liaison Service over the pandemic period as patients
- Due to Covid restrictions the Trust was not able to carry out the usual range of patient involvement activity. However, the Trust's patient groups continued to meet virtually throughout the pandemic, helping to shape the Trust's response and ensuring excellent patient experience remained a priority
- The key areas where patients would like to see the trust improve are:
  - Involving patients in decisions about their care and treatment
  - Waiting times
  - Delays and cancellations
  - Discharge

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# Supporting patients through the pandemic

Restrictions to visiting, changes to the hospital estate, and the move to remote appointments all impacted on patients experience of BHT. The patient experience team worked closely with across the organisation and in partnership with the Trust Patient Experience Group to develop new ways to support patients:

<b>Virtual visits</b>	During the first wave of the pandemic 52 iPads were secured and distributed to wards to enable relatives and friends to contact patients via video call. All ward iPads were later enabled to use Zoom and Skype for video calls. This initiative was recognised nationally with the Head of patient experience asked to speak at two national conferences on the subject and the BHT guide to virtual visits utilised by Trusts across the country
<b>Letter to a Loved One</b>	A dedicated email address <a href="mailto:bht.lettertoalovedone@nhs.net">bht.lettertoalovedone@nhs.net</a> was set up to allow friends and relatives to send a letter to patients in hospital. The letter and up to one colour photograph are printed out, put in an envelope and delivered to the ward with a special 'Letter to a loved one' sticker on it.
<b>Comfort packs</b>	The patient experience team secured charitable funding for comfort packs for inpatients. 2000 packs that included non-slip socks, toiletries, eye masks and ear plugs .
<b>Wayfinding volunteers</b>	A new wayfinding volunteer role was established to help patients and carers navigate the changes to the hospital estate. The patient experience team recruited and trained 11 volunteers who were then deployed at Wycombe and SMH.
<b>Staff volunteering scheme</b>	The patient experience team established a staff volunteering programme to alleviate the pressure on staff in wards and services by assisting with a range of tasks ranging from answering the phone, to collecting medication and supporting the patient experience through assisting with virtual visits and at mealtimes. In January 21 seventeen colleagues contributed 145 volunteer hours, the equivalent of 19 working days.
<b>Compassionate visiting policy</b>	AT BHT we recognise the importance of visitors to patient's wellbeing and recovery. In June 2020 we reintroduced visiting based on the 'Rule of one'. One visitor for one hour once a day. Exemptions to the policy applied for people with learning disability, dementia, communication issues such as being deaf or where English was not the first language.
<b>Remote appointments feedback review</b>	The urgent need to implement virtual appointments meant it was not possible to pre-test with patients. In May 2020, the patient experience team reviewed over 4000 Friends and Family test responses on virtual appointments to inform the development of the programme. The review is featured as an example of best practice on the NHS website <a href="#">NHS England » Using the Friends and Family Test to gain insight on the trust's response to the pandemic</a>
<b>PALS and Chaplaincy services</b>	The PALS service was extended to weekends with support from Bucks Council. The Chaplaincy service established a telephone support service for carers, friends and relatives.

# Listening to the patient voice

We understand the patient experience by listening to and involving patients and carers through a variety of channels, across the full spectrum of patient engagement



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# National Survey Programme

The CQC national survey programme is made up of the following surveys that all trusts are required to participate in: inpatient, maternity, A&E and children and young people. Though the surveys were not directly comparable to previous years as all surveys had a significant number of new questions, BHT performance in the Children and Young People (CYP), Accident and Emergency (A&E) Maternity and Inpatients surveys declined in 2020 in relation to other trusts. Patients continue to have very high levels of trust in doctors and nurses but patients not feeling involved in decisions about their care and treatment was a theme across all surveys



## CYP

2020: 27th out of 67 trusts surveyed by Picker-top 40%

2018- 7<sup>th</sup> out of 66 trusts surveyed by Picker –top 11%

## Maternity

2020- 48th out of 66 trusts surveyed by Picker-bottom 38%

2019- 16<sup>th</sup> out of 63 trusts, top 25%

## Inpatients

2020- 46th out of 75 trusts surveyed by Picker. Bottom 39%

2019-30<sup>th</sup> out of 74 trusts- top 40%

## A&E

2020-55th out of 66 trusts surveyed by Picker-bottom 17%

2018-48<sup>th</sup> out of 69 trusts for overall positive score- Bottom 30%

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# National Survey Programme

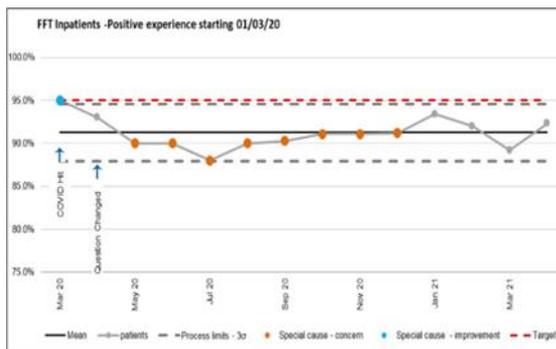
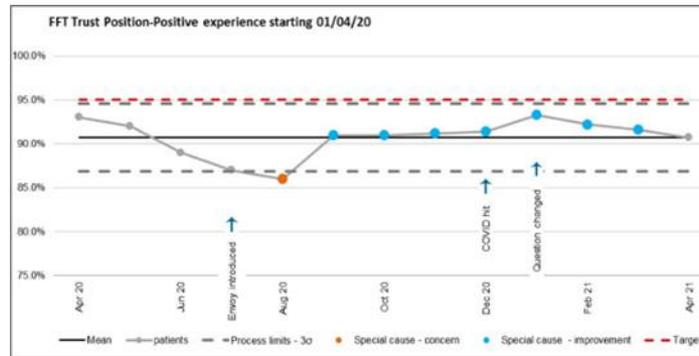
Survey	Good performance	Areas for improvement
CYP	<ul style="list-style-type: none"> <li>• Child had questions answered by staff</li> <li>• Parent given advice about caring for the child after they went home</li> <li>• Child could speak to staff about their worries</li> </ul>	<ul style="list-style-type: none"> <li>• Parent rated overnight facilities as good or very good</li> <li>• Parent felt that staff played with child</li> <li>• Parent felt staff agreed a plan with them for child's care</li> </ul>
Maternity	<ul style="list-style-type: none"> <li>• Felt midwives listened (antenatal)</li> <li>• Treated with respect and dignity (during labour and birth)</li> <li>• Had confidence and trust in midwives (post-natal)</li> </ul>	<ul style="list-style-type: none"> <li>• Involved in decisions about their care (antenatal)</li> <li>• Felt concerns were taken seriously (during labour and birth)</li> <li>• Given enough information about their own recovery (post-natal)</li> </ul>
Inpatients	<ul style="list-style-type: none"> <li>• Treated with dignity and respect overall</li> <li>• Had confidence and trust in the nurses and doctors</li> <li>• Staff helped control pain</li> </ul>	<ul style="list-style-type: none"> <li>• Was involved in decisions about care and treatment</li> <li>• Got enough to drink</li> <li>• Given enough notice when discharge would be</li> </ul>
A&E	<ul style="list-style-type: none"> <li>• Enough privacy when being examined or treated</li> <li>• Enough time to discuss condition or treatment with doctor/nurse</li> <li>• Staff discussed need for further health / social care after leaving A&amp;E</li> </ul>	<ul style="list-style-type: none"> <li>• Waited under four hours to be seen by a doctor/nurse</li> <li>• Involved in decisions about care and treatment</li> <li>• Staff helped control pain</li> </ul>

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# Friends and Family Test

Patients are sent a text after discharge or after a period of care asking them to rate their overall experience of their care. In April 2020 NHSE suspended national FFT reporting, many trusts stopped collecting FFT data. BHT continued with FFT, ensuring we continued to be responsive to patient feedback. Staff attitude and behaviour was consistently the theme of the highest number of positive comments from patients. Waiting time was the subject of most negative comments. Inpatient approval ratings fell during lockdowns when visiting was most restricted. Outpatient and community approval ratings remained high throughout the period, A&E approval ratings also declined during lockdown periods.

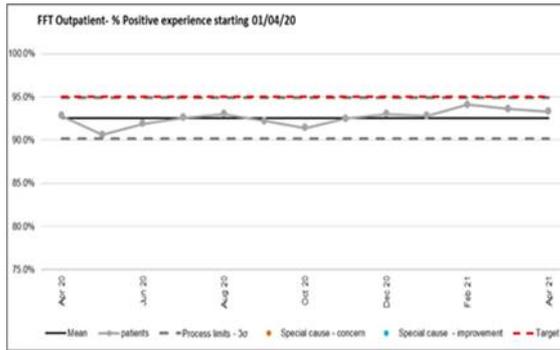


Top 10 Themes	
+ Positive	- Negative
1. Staff attitude 4116	1. Waiting time 654
2. Implementation of care 2725	2. Implementation of care 576
3. Waiting time 3128	3. Communication 486
4. Patient Mood/Feeling 2019	4. Patient Mood/Feeling 483
5. Clinical Treatment 1473	5. Clinical Treatment 460
6. Environment 1634	6. Staff attitude 441
7. Communication 1125	7. Environment 390
8. Staffing levels 761	8. Staffing levels 200
9. Admission 218	9. Admission 110
10. Catering 105	10. Catering 43

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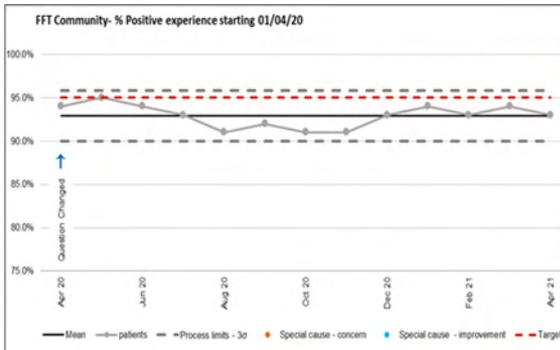
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# Friends & Family Test



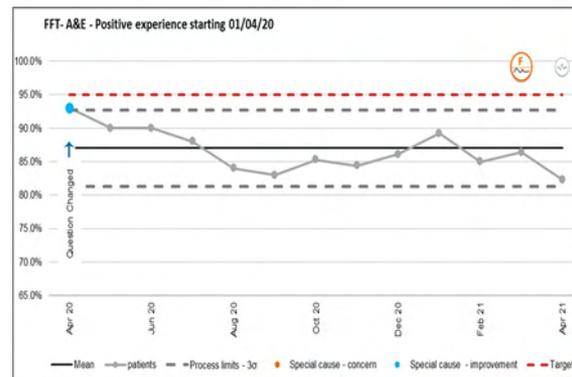
Top 10 Themes

+ Positive		- Negative	
1. Staff attitude	18254	1. Waiting time	1136
2. Implementation of care		2. Implementation of care	
3. Waiting time	7957 <sup>10894</sup>	3. Communication	930 <sup>931</sup>
4. Patient Mood/Feeling		4. Staff attitude	830
5. Clinical Treatment	7781	5. Clinical Treatment	815
6. Environment	5398 <sup>6985</sup>	6. Patient Mood/Feeling	811
7. Communication	4875	7. Environment	808
8. Staffing levels	1873	8. Admission	328
9. Admission	830	9. Staffing levels	285
10. Catering	257	10. Catering	54



Top 10 Themes

+ Positive		- Negative	
1. Implementation of care		1. Implementation of care	
2. Staff attitude	2035 <sup>4151</sup>	2. Communication	128 <sup>224</sup>
3. Communication	928	3. Clinical Treatment	118
4. Clinical Treatment	839	4. Staff attitude	88
5. Patient Mood/Feeling	820	5. Patient Mood/Feeling	86
6. Waiting time	523	6. Waiting time	73
7. Environment	448	7. Environment	55
8. Staffing levels	191	8. Staffing levels	29
9. Admission	87	9. Admission	16
10. Catering	19	10. Catering	7



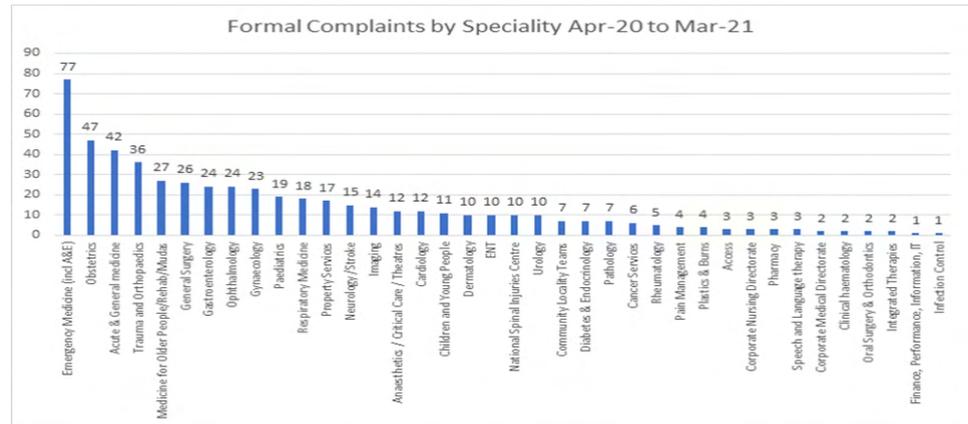
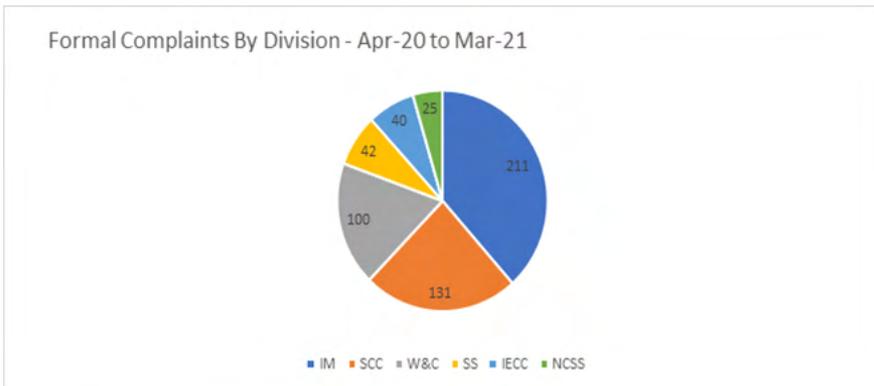
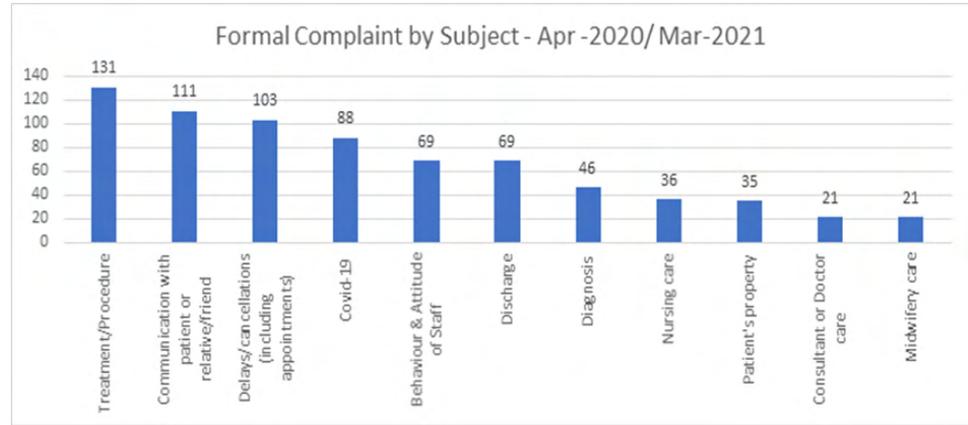
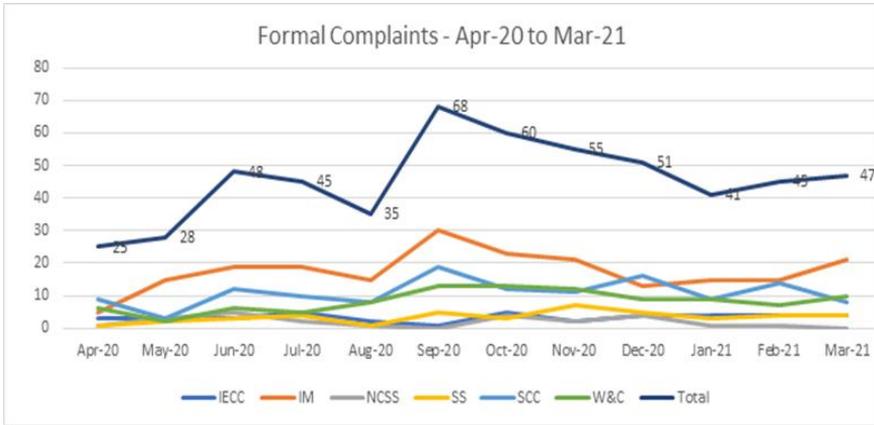
Top 10 Themes

+ Positive		- Negative	
1. Staff attitude	4116	1. Waiting time	654
2. Implementation of care		2. Implementation of care	
3. Waiting time	2725 <sup>3128</sup>	3. Communication	486 <sup>576</sup>
4. Patient Mood/Feeling		4. Patient Mood/Feeling	483
5. Clinical Treatment	2019	5. Clinical Treatment	460
6. Environment	1473 <sup>1634</sup>	6. Staff attitude	441
7. Communication	1125	7. Environment	390
8. Staffing levels	761	8. Staffing levels	200
9. Admission	218	9. Admission	110
10. Catering	105	10. Catering	43

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# Complaints

There were 549 complaints in 2020/21. After falling at the start of the pandemic, there was a surge of complaints in Sept 2020. Emergency Department (ED) received the highest number of complaints, followed by gynaecology and neurology. Treatment and procedure was the subject with the highest number of complaints.



# Examples of improvements in response to complaints

<p><b>Women and children</b></p>	<ul style="list-style-type: none"> <li>• As a result of complaints relating to early pregnancy loss, an eLearning module on early pregnancy for staff has been set up and is being made mandatory. A&amp;E link nurse posts have been created to enable closer liaison with the bereavement midwives. Improved early pregnancy patient packs have also been developed.</li> <li>• Complaints were received where women complained about being left in triage, having contractions, for several hours, where they had less privacy due to there being other women present. This was exacerbated during the pandemic, as this meant partners could not be present during this time. As a result, all women are now admitted directly to a labour room for labour assessment and not seen in the triage area of labour ward. The guidelines have been updated to ensure that all women suspected of being in labour are admitted directly to a labour (or birth centre) room, which enables their birth partner to be present and be allows them greater opportunity for privacy and mobilisation. This has greatly improved their overall labour experience</li> </ul>
<p><b>Emergency department</b></p>	<ul style="list-style-type: none"> <li>• Following complaints all patients who are catheterized in the department receive their trial without catheter follow in the urology outpatients. Appointments are made by way of a secure email. Patients being sent home with a catheter are given a pack containing spare equipment and an advice sheet.</li> <li>• In response to complaints regarding cleanliness in ED, dedicated cleaners have been appointed from Sodexo to ensure that the Emergency department is thoroughly cleaned during the night.</li> </ul>

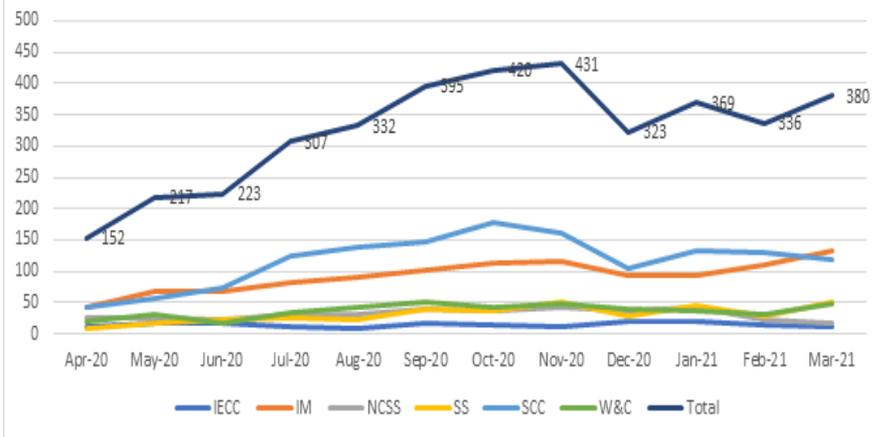
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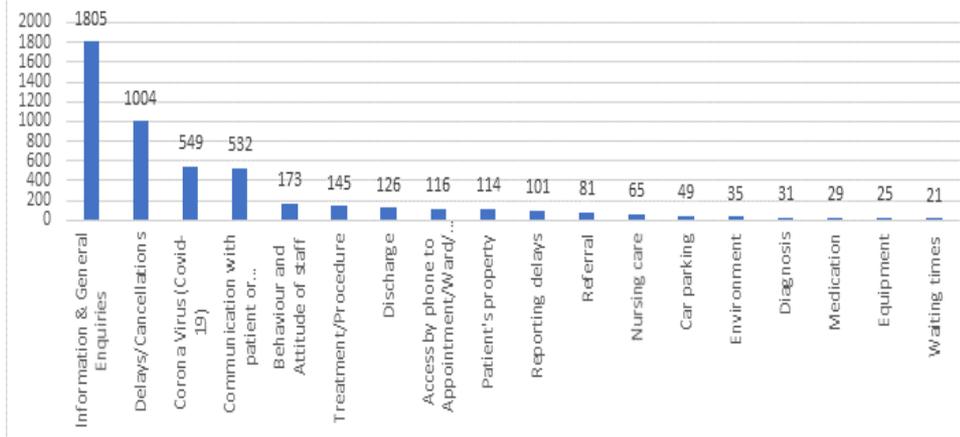
# Patient Advice & Liaison Service

Delays and cancellations was the highest subject area after general enquiries. The specialities that had the highest number of queries were trauma and orthopaedics and ED.

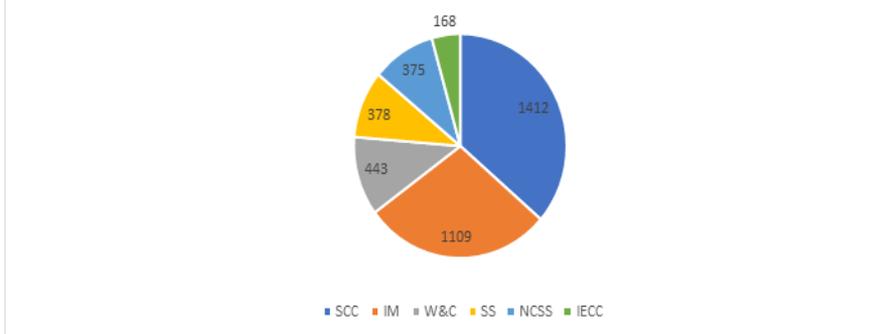
PALS Received Apr-20 to Mar-21



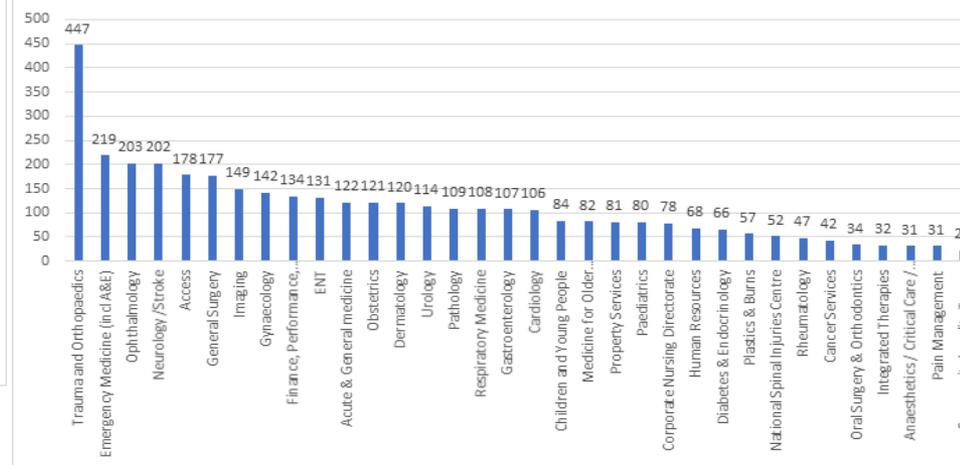
PALS - Subject



PALS - by Division



PALS - Speciality



# Compliments

Division	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
IECC	485	248	243	223	253	283	207	218	66	32	50	27
Women & Children	43	84	103	97	46	81	78	122	166	81	74	121
Integrated Medicine	18	26	24	22	74	28	44	19	23	95	153	137
Surgery	148	9	15	34	20	29	33	55	40	32	37	20
Specialist Services	106	62	46	46	35	40	71	73	419	161	187	196
Corporate/Non-Clinical Support Services		2	1		4	2	14	7			1	5
Grand Total	800	431	432	422	432	463	447	494	714	401	502	506

**Wycombe Adult Community Team:** Both Clare and Sharon went above and beyond their duties in caring for my wife during her day of need. Pedro has also been of great assistance during my wife's palliative care at home. Never have I seen or expected such care and tenderness. The district nurses are certainly a breed apart and I can only thank them from the depth of my heart which is currently breaking due to the loss of my wife. They are three of the most compassionate people I have met.

**General surgery, Stoke Mandeville Hospital:** I tripped on my sound booth door threshold 2 mins before I was about to be interviewed on BBC Radio about my new book. Fell awkwardly and sustained a proximal fracture to my right femur. Did the interview in agony, closed the fader and called 999! I was taken to SMH A&E where I was assessed right away and sent to ward 1. Mr Pollalis and Mr Aktseles performed full hip replacement on Saturday, the former coming in on his day off. What a great surgical team and the medical and nursing team on the ward are excellent."

**Endoscopy:** I would like to say thank you to Caroline Jenner in Endoscopy who went out of her way to help my mother and I find the correct place to be in the hospital. She could have just directed us to the main reception but she took the time to find out exactly where we needed to be. Caroline's help meant that the situation was far less stressful than would have been if we were left to sort ourselves out. I thanked her for her help at the time but wanted to formally express my thanks via an official channel

**Cardiac and Stroke Receiving Unit (CSRU), Ward 8 and MRI:** I was brought into Wycombe Hospital due to a stroke I was taken to the CSRU. I went for a head scan and later moved onto ward 8 where the staff were really nice and caring. Two of the nurses, one on ward 8 and the other on CSRU, were really helpful and friendly, I would go as far as saying a credit to your hospital. Once again it wasn't just these two it was everyone down to the porters, the lady serving breakfast and drinks and the people in the MRI room, the whole team made my stay with you more pleasant. Please pass my gratitude on to them as I think that during this difficult time they all do a fantastic job

**Breast Unit, Wycombe Hospital:** Have recently had my 12 year old daughter experience the service at the Breast Unit at WGH. From the appointment to the pre-op clinic to the surgery to the follow up, the care was incredible. My daughter felt well looked after and respected. Despite COVID, our teams are working hard every day. I was humbled and honoured to be with such caring and amazing people. Dr Fiona Tsang is a fantastic surgeon and a pleasure to have met. The nurses Gemma and Poppy were caring and kept us both at ease."

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# Chaplaincy Services

- Chaplaincy team continued to support patients, relatives and staff throughout the pandemic
- The chaplains provided religious support to patients nearing the end of life, conducted funeral services, memorial services, and naming and blessings for babies
- The chaplains were involved in TAERs (team after event reflections), as well as offered individual pastoral and spiritual support for staff
- A prayer and reflection booklet was developed and made available for staff including a multi-faith prayer resource for emergency situations when chaplains were not able to come alongside COVID19 patients
- Chaplaincy service established a telephone support service for carers, friends and relatives

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# Patient involvement and co-production

Due to Covid restrictions the Trust was not able to carry out the usual range of patient involvement activity. However, the Trust's patient groups continued to meet virtually throughout the pandemic, helping to shape the Trust's response and ensuring excellent patient experience remained a priority:

Group	Purpose and activity
<b>Patient Experience Group (PEG)</b>	<p>At the start of the pandemic, many Trusts suspended their patient experience group meetings. At BHT we moved immediately to meeting with PEG via Zoom, going from quarterly to weekly meetings. The group were instrumental in shaping the support package that was developed for patients. This included:</p> <ul style="list-style-type: none"> <li>• Virtual visits</li> <li>• Letter to a Loved one</li> <li>• Wayfinding volunteers</li> <li>• Family liaison officers</li> <li>• Comfort packages</li> </ul> <p>Following the first wave of the pandemic PEG representatives sat on all the recovery programme delivery groups, ensuring the patient voice was part of the conversation.</p> <p>In 2020/21 the PEG group also provided a sounding board to staff across the organisation on numerous initiatives and service improvements including:</p> <ul style="list-style-type: none"> <li>• The end of life strategy</li> <li>• Tested Trust's preferred video appointment platform</li> <li>• Home first-patient discharge pathway</li> <li>• Patient and carer experience strategy</li> </ul>
<b>NSIC patient forum</b>	<p>The NSIC Patient Forum set up in 2018 following engagement workshops involving 57 patients. The purpose of the group is to work with staff to oversee implementation of patient recommendations. This year the NSIC patient forum met with staff via virtual meetings and informed the NSIC transformation programme, including initiatives on patient flow and outpatient appointments</p>
<b>Maternity Voices Partnership</b>	<p>The Maternity Voices Partnership members work closely with the maternity team. This year year's activity includes:</p> <ul style="list-style-type: none"> <li>• Engagement with over 3000 service users and followers on social media</li> <li>• New electronic surveys launched, and detailed feedback received from over service users</li> <li>• Weekly meetings with Trust to stay up to date and provide service user voice in a fast moving/changing situation re COVID</li> <li>• Co-production of leaflets and patient communications</li> <li>• Produced general antenatal information videos for electronic distribution and co-produced antenatal education videos with clinical staff</li> <li>• Co designed new BHT Birth statistics infographic for sharing</li> <li>• Sharing of targeted health information for service users from a Black, Asian or other minority ethnic communities</li> <li>• Held online live sessions with health professionals including infant feeding, pelvic physio, and mental health team</li> <li>• Worked with Bucks New Uni developing new midwifery curriculum</li> <li>• Started new health inequalities project focused on hearing from our lesser heard voices - specifically our Black, Pakistani/Kashmiri, Romanian and Polish communities.</li> <li>• Secured funding to ensure sustainability of MVP in 21/22</li> </ul>

# Patient involvement and co-production

## Community Hub Stakeholder Group

The Trust Community Hub Stakeholder group (CHSG) meet bi-monthly. The purpose of stakeholder engagement 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 residents. The group:

- Provide a mechanism for feedback from communities back to BHT
- Are a forum where members can share analysed patient experience, make recommendations to the operational group on improvements to the delivery of the pilots and to inform the design and delivery of future community hubs across the county and track actions to ensure they have been taken into account
- Inform wider engagement opportunities and support communications and engagement activities within local communities
- In 2020/2021 the CHSG were fundamental in supporting the Trust communicate changes, which occurred due to COVID 19, to a much wider audience within the local communities they represent. The Trust kept the CHSG fully updated throughout the pandemic on how the Trust was reacting to the pandemic whilst ensuring essential and vital services remained open to the general public.

## Communications Advisory Panel

The Trust Communications Advisory Panel (CAP) met quarterly during 2020/2021. The Communications Advisory Panel aims to work with Buckinghamshire Healthcare NHS Trust to support improvements in patient and carer communications that go through the Trusts Communication Dept.

In 2020/2021 the CAP continued to meet online. This year their focus and support has been:

- New BHT Website – content, layout, functionality and how pages are laid out – following the patient journey
- Creation of new guidelines to help BHT staff write/create patient information leaflets
- CAP have scrutinised 59 patient information leaflets during COVID which is less than the usual flow of patient information leaflets because our workforce did not have the time to focus on these during this time.
- In addition to scrutinising patient information leaflets during this time, CAP were involved in responding to very short deadlines during COVID 19 when Trust policies, processes, visiting times, standard operating procedures, temporary signage (including PPE signage) any public facing communications needed to be looked at. The Communications team were reacting very quickly to demand, and CAP supported us with very demanding requirements that often only had hours before they needed to go to print

# Conclusions and plans

## Conclusions:

- Patients views of staff remained very positive throughout 2021-21 despite the enormous challenges presented by the pandemic. The Trust saw improvements in a number of areas including quality of food, staff not contradicting each other regarding care and treatment, new mothers receiving help and advice about feeding their baby, staff helping control pain in A&E, and parents being told what to do or who to contact if worried when home.
- The patient feedback highlights the following areas for improvement
  - Involving patients in decisions about their care and treatment
  - Waiting times
  - Delays and cancellations
  - Discharge

## Plans:

- Establish new Patient Experience Committee of staff, patient and third sector to oversee implementation of new patient experience improvement priorities included in Quality strategy
- Recruit and train patient partners representative of diversity of Bucks population
- Relaunch Envoy system for FFT with focus on using data for improvement
- Implement NICE guidelines on Shared Decision Making published June 2021

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**Meeting:** Trust Board Meeting in Public

**24 November 2021**

<b>Agenda item</b>	Infection Prevention and Control Annual Report, Infection Prevention and Control bi-monthly Report	
<b>Board Lead</b>	Karen Bonner Chief Nurse	
<b>Type name of Author</b>	Jo Shackleton Head of Nursing IPC	
<b>Attachments</b>	Infection Prevention and Control	
<b>Purpose</b>	Information	
<b>Previously considered</b>	EMC 9.11.2021 Q&CG 15.11.2021	

### Executive Summary

BHT Infection Prevention and Control monthly report key points include:

IPCT Staffing-Jo Shackleton Matron IPC has taken up the secondment to Head of Nursing IPC to cover maternity leave. The team is however reduced, and action will be taken in line with the existing business continuity plan. The Chief Nurses office will offer extra support to the team.

#### Compliance to IPC Policies:

**Hand Hygiene** It is well documented that hand hygiene reduces cross-contamination risks between staff, patients and visitors. Therefore, divisions continue to promote effective hand hygiene among their teams, coupled with the need for staff to be “bare below the elbow” (BBE).

**Personal Protective Equipment (PPE)** is essential to protect staff and patients. However, it does have limitations that stem from not wearing the necessary PPE items, items being used incorrectly and from being removed safely. Divisions continue to ensure the correct use of PPE that it is rigorously and consistently applied to avoid occupational exposure.

#### Outbreaks

There has been an Increase in reported Covid-19 outbreaks 4. Increase in the Incidence of Healthcare acquired Covid-19 –September 2021 = 7 (Probable = 4; Definite = 3) October 2021 = 7 (Probable = 1; Definite = 6) In response to the increase in the incidence of Covid-19 cases after admission, the IPCT has undertaken several contact tracing exercises to identify recent close contacts. Contacts are required to be isolated from inpatients for 14 days. Lead to increase in needs for Single room and closure of bays. It is recognised that this has been challenging, but it is an important part of the response of IPC to prevent outbreaks, healthcare-acquired infection and associated staff absence.

#### Incidents

- Endoscopy - The IPCT have been working with Endoscopy due to an incident declared due to contamination detected. Patients at risk of infection were traced and followed up by the Respiratory Team and informed of the exposure. It has been confirmed that to date there is no harm caused. Reassurance following the incident has been requested through the Infection Control Committee. The incident is being managed as an SI debrief meeting held 4.11.2021.

#### Mandatory Training

Compliance-October compliance is showing a decrease.

This paper was discussed at the Quality and Clinical Governance Committee on 15 November 2021. The Committee took assurance from the paper but requested benchmarking data from other Trusts. Work is ongoing to provide this.

<b>Decision</b>	The Board is requested to read for information on current challenges		
<b>Relevant Strategic Priority</b>			
<b>Outstanding Care</b> <input checked="" type="checkbox"/>	<b>Healthy Communities</b> <input checked="" type="checkbox"/>	<b>Great Place to Work</b> <input checked="" type="checkbox"/>	<b>Net Zero</b> <input type="checkbox"/>
<b>Implications / Impact</b>			
<b>Patient Safety</b>		Healthcare associated infection prevention is cornerstone of patient safety	
<b>Risk: link to Board Assurance Framework (BAF)/Risk Register</b>		BAF 1.8 inadequate infection prevention or control due to issues with estates 3.9 inadequate oversight of direct and indirect clinical harm caused by the pandemic 4.3 variations in organisational culture and behaviours	
<b>Financial</b>		Healthcare associated infections cause significant cost to the healthcare system and individual	
<b>Compliance</b> <small>Select an item.</small> <b>Safety</b>		Health and Social Care Act 2008 Care Quality Commission Guidance from Public Health England and NHSE/I CQC compliance	
<b>Partnership: consultation / communication</b>		Share with Clinical Commissioning Group and wider system	
<b>Equality</b>		No	
<b>Quality Impact Assessment [QIA] completion required?</b>		No	

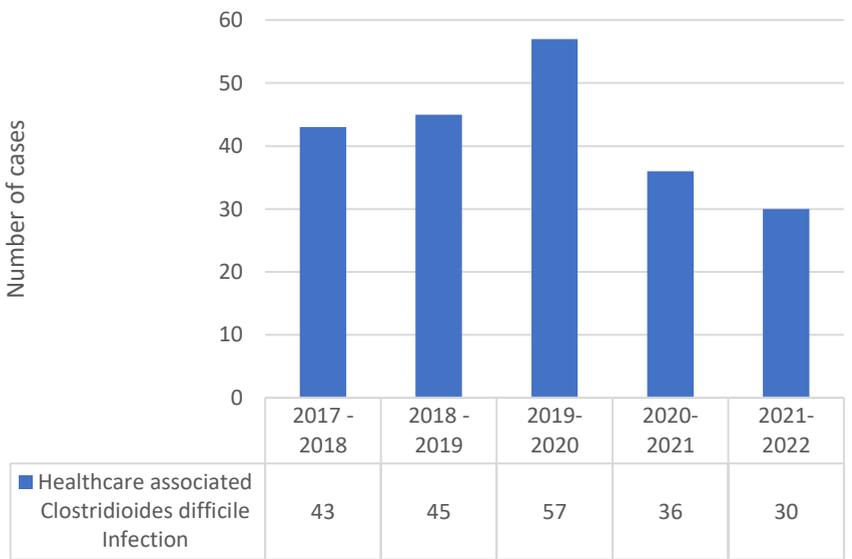
NB Please see report (power point attached)

## Infection Prevention Control at BHT: Key points from the IPC Report

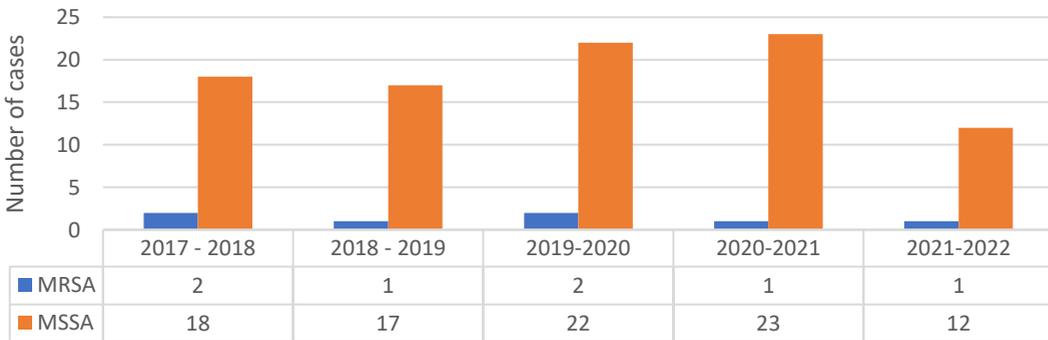
- **IPCT Staffing**-Best Wishes to Hannah Bysouth, Head Of Nursing Infection Prevention Control (IPC), who has now gone on Maternity leave. In addition, congratulations to Jo Shackleton, Matron Infection Prevention Control, who has been recruited to the Head of Nursing role and will take up the position from Nov 2021. It is to be noted that at this time the IPCT has reduced staff levels. Action will be taken in line with the existing business continuity plan.
- **Compliance to IPC Policies**- It is well documented that hand hygiene reduces cross-contamination risks between staff, patients and visitors. Therefore, divisions continue to promote effective hand hygiene among their teams, coupled with the need for staff to be “bare below the elbow” (BBE). Personal Protective Equipment (PPE) is essential to protect staff and patients. However, it does have limitations that stem from not wearing the necessary PPE items, items being used incorrectly and from being removed safely. Divisions continue to ensure the correct use of PPE that it is rigorously and consistently applied to avoid occupational exposure.
- **Outbreaks**-Increase in reported Covid-19 outbreaks 4. Increase in the Incidence of Healthcare acquired Covid-19 –September 2021 = 7 (Probable = 4; Definite = 3) October 2021 = 7 (Probable = 1; Definite = 6) In response to the increase in the incidence of Covid-19 cases after admission, the IPCT has undertaken several contact tracing exercises to identify recent close contacts. Contacts are required to be isolated from inpatients for 14 days. Lead to increase in needs for Single room and closure of bays. It is recognised that this has been challenging, but it is an important part of the response of IPC to prevent outbreaks, healthcare-acquired infection and associated staff absence.
- **Incidents**- Endoscopy - The IPCT have been working with Endoscopy due to an incident declared due to contamination detected. Patients at risk of infection were traced and followed up by the Respiratory Team and informed of the exposure. Reassurance following the incident has been requested through the Infection Control Committee. This is being managed as an SI debrief held 4.11.2021.
- **Mandatory Training Compliance**-October compliance is showing a decreased.

IPC Key Performance	Trust Total 2021/22	BHT Acquired Sept – Oct 21	Integrated Medicine Total 2021/22	Integrated Elderly and Community Care Total 2021/22	Surgery and Critical Care Total 2021/22	Women, Children and Sexual Health Total 2021/22	Specialist Services Total 2021/22
MRSA bacteraemia	1	0	1	0	0	0	0
MSSA Bacteraemia	12	4	6	1	2	0	3
Clostridioides difficile – hospital onset, healthcare associated	30	12	11	0	10	1	8
Clostridioides difficile – community onset, healthcare associated	5	0	0	0	0	0	0
Gram Negative Bloodstream Infections (GNBSI)	29	7	16	3	5	0	5
COVID-19 Trust acquired	16	14	10	4	0	0	2

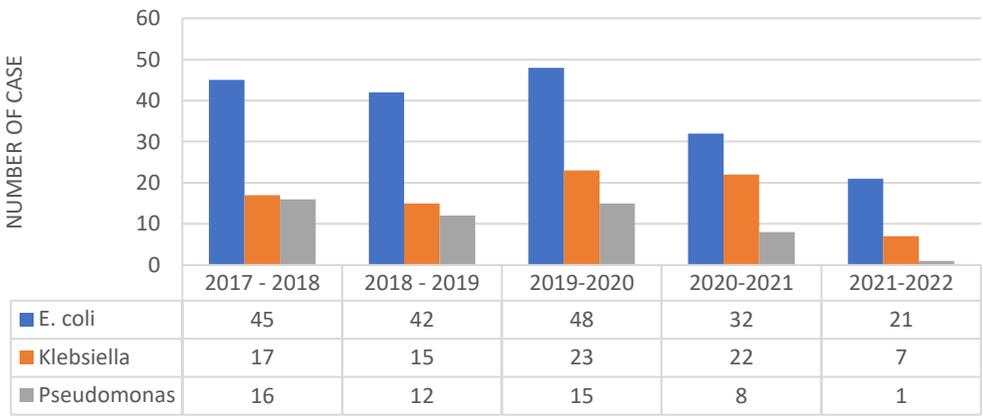
BHT Healthcare associated Clostridioides difficile Infection 2017-2022



BHT GRAM POSITIVE BLOODS STREAM INFECTION (GNBSI) 2017-2022



BHT GRAM NEGATIVE BLOODS STREAM INFECTION (GNBSI) 2017-2022



# Outbreaks and Period of Increased Incidence

## Actions taken in response to the outbreaks

- All outbreaks has been taken in line with Trust IPC Manual for Outbreak Management and Management of COVID-19
- increase in, assurance of hand hygiene and correct wearing and removal of PPE, and enhanced cleaning with an appropriate disinfectant.
- Staff were re-educated re Later flow device testing, PPE use and handwashing; additional measures taken to ensure non-clinical areas were COVID secure.

## Learning from COVID outbreaks

- Patient testing not in line with policy, challenges to patient placement due to lack of isolation facilities.
- Lateral flow device testing (and recording) among staff requires improvement.
- Challenges with agency staff not aware of Trust IPC requirements at Waterside. Poor compliance among medical staff with eye protection and a need for air purifiers identified.
- Increase in patient compliance to wearing mask whilst in cohort bays to mitigate the risk of possible exposure to the virus
- A review of the reuse of single use visor identified the need to dispose of visor after each session to mitigate the risk of possible exposure to the virus whilst cleaning the visor.

	Date declared	Number of patients positive	Number of staff positive	Bed days lost as of 28/10/21	Status
2A	29/9/21	15	3	60	Outbreak closed 27/10/21
Waterside	7/10/21	8	1	111 Calculated for 21 beds, IPC recommended reducing to 18	Last positive 13/10/21, ward reopened 28/10/21
St George's	19/10/21	2	3	49	Last case 19/10/21 ward re open 2nd Nov
Ward 4	26/10/21	5	0	0	Ward is open

## Bacteraemia Line Infections

### Aims & Ambitions

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

### Definitions to determine Avoidable / Unavoidable

#### Avoidable

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

#### Unavoidable

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

		Year Totals (excluding current month)	Current Month (sept cases)
Central Line	Avoidable	0	0
	Unavoidable	11	3
	Yet to be discussed	0	1 (? 2 more, awaiting final confirmation)
Peripheral Line		2	0
<b>Totals</b>		<b>13</b>	<b>4</b>
	Deemed not line infection	5	0

### Line Infection Meeting on 27<sup>th</sup> Sept (Non Datix cases for review) & 7<sup>th</sup> October 21 for August / September .

- 1 Discussed (non datix) 4 infections (Haem/onc) – All unavoidable (not counted in numbers)/ Learning below
- 2 Discussed August & Sept infections.

86 lines inserted in September = 3% infection rate

### Yearly Comparison Table

		18-19	19-20	20-21
Central Line	Avoidable	3	2	4
	Unavoidable	24	7	31
Peripheral Line		4	1	4
<b>Totals</b>		<b>31</b>	<b>10</b>	<b>39</b>

### Summary of outcome monitoring notes from meeting:

Cannulation knowledge & listening to patients, VIP charts, blood culture labelling & sampling. Site review pathway, ANTT , Hand hygiene upskilling, Weekend escalation

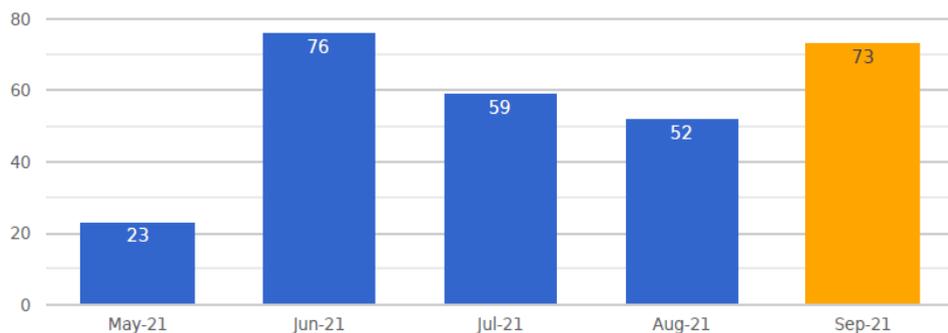
#### Actions:

Cannula education to be done at ward level with OPAT support.  
Discussion at Governance , Medical MDT, Site infection pathway for Oncology / Haem units to be developed by Band 6 nurses. Audits on peripheral cannulas / VIP scoring has been established.

## Sept 2021 – Hand hygiene and PPE

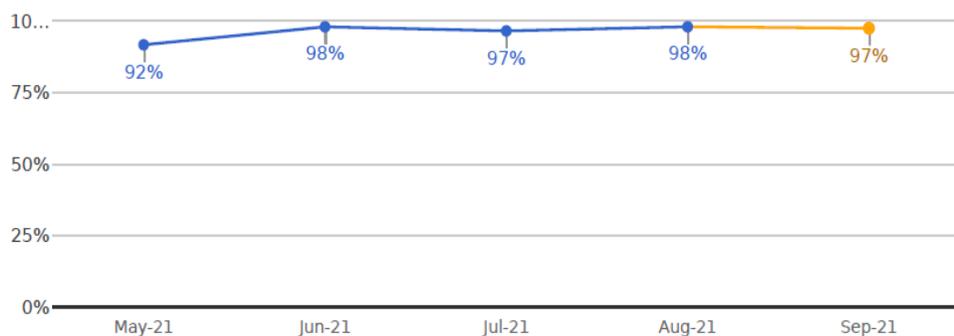
This month we have carried out 73 inspections across 55 areas – an average of 1.33 inspections per area.

Total monthly inspections (last 12 months)



The average score across the organisation this month was 97%.

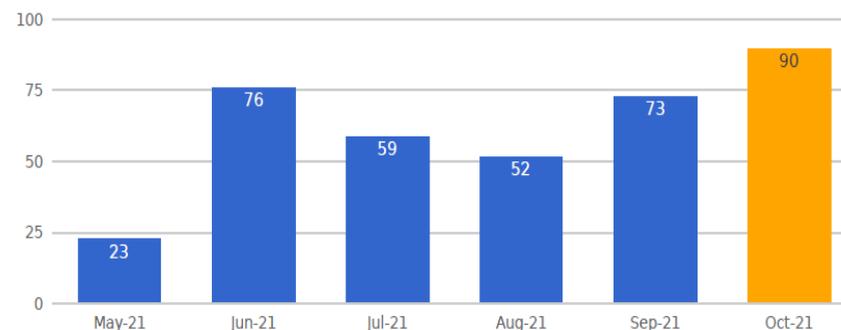
Average score (last 12 months)



## Oct 2021 – Hand hygiene and PPE

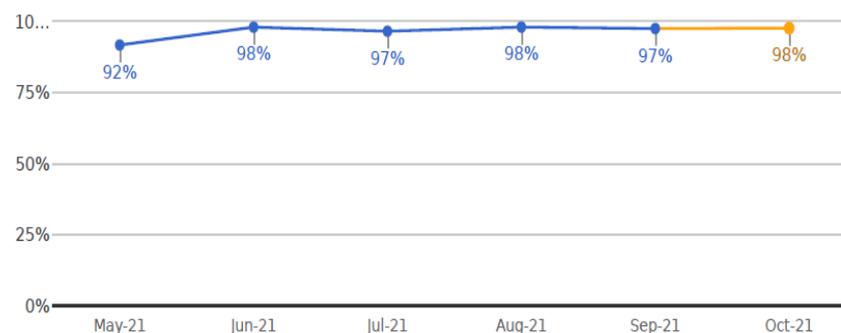
This month we have carried out 90 inspections across 51 areas – an average of 1.76 inspections per area.

Total monthly inspections (last 12 months)



The average score across the organisation this month was 98%.

Average score (last 12 months)



## 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	588	513	87%	144	103	72%	166	155	93%	247	230	93%	115	105	91%	115	106	92%	1375	1212	88%
IPC (Direct patient contact)	E-learning	140	115	82%	791	614	78%	941	762	81%	774	636	82%	827	729	88%	680	571	84%	4153	3427	83%
Hand Hygiene (Direct patient contact)	Face to face	156	133	85%	797	677	85%	943	833	88%	801	729	91%	832	773	93%	680	623	92%	4209	3768	90%

### Annual Track of Overall Totals 2021

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
No. of staff required to attend	10029		10033	10051	9650	8701	9737					
No. of staff who have attended	8462		8663	8661	8352	7538	8407					
Attendance %	84%		83%	86%	87%	87%	86%					

**Note:** Green = improved compliance    Red = compliance decreased    Blue = No Change  
**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

**24 November 2021**

<b>Agenda item</b>	National Inpatient Survey results-2020
<b>Board Lead</b>	Chief Nurse
<b>Type name of Author</b>	Amarjit Kaur - Head of Patient Experience and Involvement
<b>Attachments</b>	National inpatient survey results summary
<b>Purpose</b>	Information
<b>Previously considered</b>	Q&CG 15 November 2021

### Executive Summary

The 2020 inpatient survey sample was collected from people who were inpatients at BHT during the month of November 2020. The survey was put back from July due to the pandemic 84% of respondents rated their overall experience of BHT at 7/10 or higher, and 99% said they were treated with dignity and respect

As in previous years doctors and nurses were highly regarded with 99% of patients having trust and confidence in nurses and 98% in doctors

The Trust saw a significant rise in patients rating the food as good or quite good

There were improvements in some areas of discharge for example more patients reported staff discussing their needs for health and social care after discharge, while other areas such as being given enough notice of discharge saw a decline

Key areas where improvement is required include, patients feeling involved in decisions about their care and treatment, privacy when discussing their condition, and being able to sleep at night

Though the surveys are not directly comparable, as there was a significant number of new questions, overall, the Trust fell from the 40<sup>th</sup> percentile in 2019, to the 61<sup>st</sup> percentile of trusts surveyed by Picker in 2020

The 2021 survey sample will be collected from November inpatients

The Quality and Clinical Governance Committee took assurance from this paper on 15 November 2021.

<b>Decision</b>	The Board is requested to note this paper.
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### Relevant Strategic Priority

<b>Outstanding Care</b> <input checked="" type="checkbox"/>	<b>Healthy Communities</b> <input type="checkbox"/>	<b>Great Place to Work</b> <input type="checkbox"/>	<b>Net Zero</b> <input type="checkbox"/>
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### Implications / Impact

<b>Patient Safety</b>	Poor patient experience can be an indicator of safety concerns
<b>Risk: link to Board Assurance Framework (BAF)/Risk Register</b>	Listening to the patient voice and a culture of quality improvement
<b>Financial</b>	Potential litigation

<b>Compliance</b> <small>Select an item.</small> <b>Person-centred Care</b>	Person centred care, safety, safeguarding, complaints
<b>Partnership: consultation / communication</b>	We understand patient experience by listening to feedback from a variety of channels. We work in partnership with patients to improve services
<b>Equality</b>	Working with key stakeholders in quality, safety and experience. 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.
<b>Quality Impact Assessment [QIA] completion required?</b>	N/A

# National inpatient survey results 2020



Picker



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# Introduction

- The 2020 inpatient survey sample was collected from people who were inpatients at BHT during the month of November 2020. The survey was put back from July due to the pandemic
- 84% of respondents rated their overall experience of BHT at 7/10 or higher, and 99% said they were treated with dignity and respect
- As in previous years doctors and nurses were highly regarded with 99% of patients having trust and confidence in nurses and 98% in doctors
- The Trust saw a significant rise in patients rating the food as good or quite good
- There were improvements in some areas of discharge for example more patients reported staff discussing their needs for health and social care after discharge, while other areas such as being given enough notice of discharge saw a decline
- Key areas where improvement is required include, patients feeling involved in decisions about their care and treatment, and discharge planning and being able to sleep at night
- Though the surveys are not directly comparable, as there was a significant number of new questions, overall the Trust fell from the 40<sup>th</sup> percentile in 2019 ,to the 61<sup>st</sup> percentile of trusts surveyed by Picker in 2020
- The 2021 survey sample will be collected from November inpatients

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# Responses

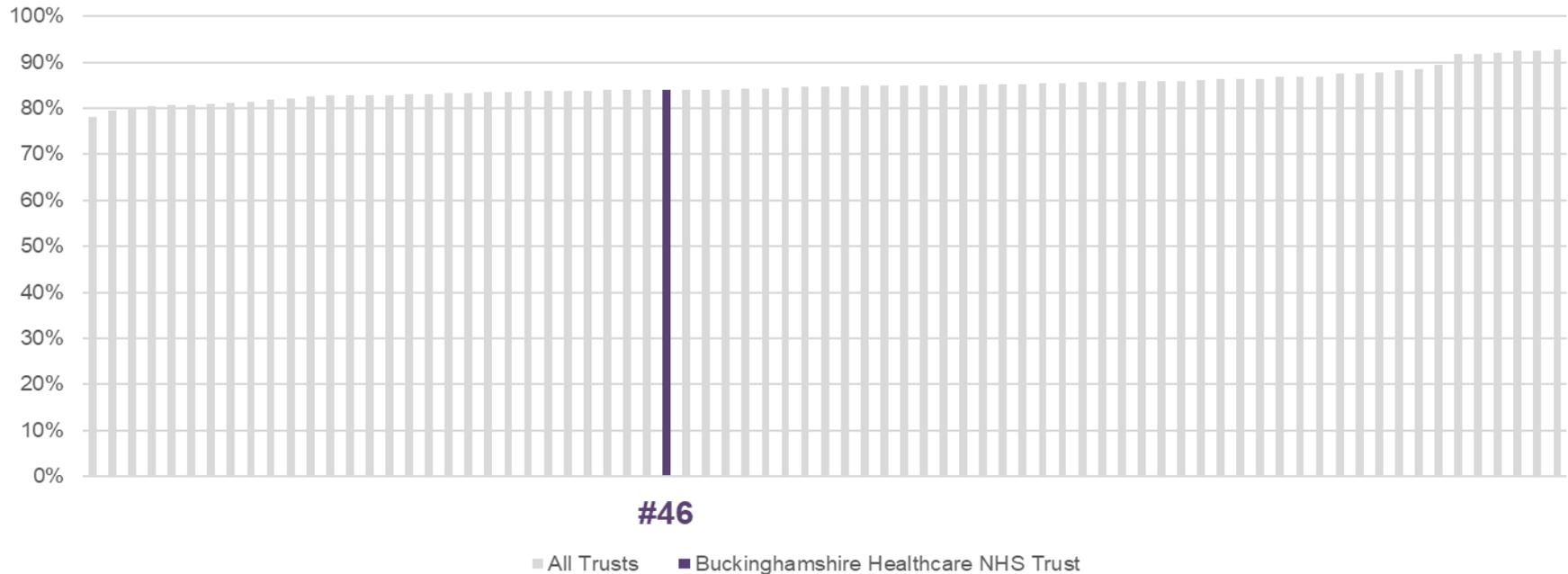
<b>1250</b> Invited to complete the survey	<b>1174</b> Eligible at the end of survey	<b>43%</b> Completed the survey (507)	<b>45%</b> Average response rate for similar organisations	<b>47%</b> Your previous response rate
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<p><b>84%</b> Q46. Rated overall experience as 7/10 or more</p> <p><b>99%</b> Q45. Treated with respect and dignity overall</p> <p><b>98%</b> Q16. Had confidence and trust in the doctors</p>	<p>Historical comparison*</p> <ul style="list-style-type: none"> <li><span style="color: green;">■</span> Significantly better</li> <li><span style="color: red;">■</span> Significantly worse</li> <li><span style="color: orange;">■</span> No significant difference</li> </ul>	<p>Comparison with average*</p> <ul style="list-style-type: none"> <li><span style="color: green;">■</span> Significantly better</li> <li><span style="color: red;">■</span> Significantly worse</li> <li><span style="color: orange;">■</span> No significant difference</li> </ul>
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# Average positive score ranking

Adult Inpatient Survey 2020: Overall Positive Score



- In 2020 the Trust was ranked **46<sup>th</sup> out of 75** Trusts surveyed by Picker
- In 2019 the Trust ranked **30<sup>th</sup> out of 74** Trusts surveyed by Picker
- This represents a **fall from the 40<sup>th</sup> to the 61<sup>st</sup>** percentile of trusts



Collaborate



Aspire



Respect



Enable

# National Inpatient survey results-2020

## Highlights

The Trust performed well in the following areas:

- 98% had confidence in doctors, 99% had confidence in nurses
- 99% said they had been treated with respect and dignity overall
- 97% reported that doctors and nurses included them in the conversation
- 95% said there were always or sometimes enough nurses on duty up from 91%
- 98% said that staff helped control pain

Areas of significant improvement:

- 63% said the food was very good or fairly good up from 51% to though still below national average of 70%
- 91% said they got enough help from staff to eat their meals up from 83%
- 85% reported that staff discussed need for further health or social care services after discharge up from 82%
- 83% reported that they got enough support from health or social care professionals after discharge up from 80%
- 86% were able to take their own medication when they wanted to up from 81%

## Areas for improvement in 2021/22

- Waiting for admission and for a bed on the ward
- Being able to sleep at night
- Having enough privacy when discussing condition
- Getting enough information on care or treatment
- Involvement in decisions about care and treatment
- Being involved in decisions about discharge and being given enough notice of discharge
- Being asked to give their views on quality of care during their stay

# Plans

- Picker facilitated an action planning workshop with staff in November
- The following areas for improvement were agreed:
  - Involvement in decisions about care and treatment
  - Discharge
  - Getting enough to drink
  - Noise at night
  - Privacy when discussing treatment
- These priorities will be supported by the patient experience team through QI projects and progress will be measured through the Perfect Ward patient survey

**Meeting:** Trust Board Meeting in Public

**24 November 2021**

<b>Agenda item</b>	Nursing & Midwifery Weekly Safe Staffing
<b>Board Lead</b>	Karen Bonner, Chief Nurse
<b>Type name of Author</b>	Jose Loreto Facultad, Associate Chief Nurse
<b>Attachments</b>	None
<b>Purpose</b>	Information
<b>Previously considered</b>	EMC 9.11.2021 Q&CG 15.11.2021

### Executive Summary

This briefing provides the committee to an overview of the Nursing and Midwifery safe staffing as is set out in line with the National Quality Board (NQB) Standards and Expectations for Safe Staffing published in 2016.

This report further covers the oversight of the Healthroster KPI compliance around workforce utilisation key indicators on safety, efficiency/affordability, and effectiveness in staff deployment. This also provides assurance that arrangements are in place to safely staff our services with the right number of Nurses and Midwives with the right skills, at the right time.

The twice daily safe staffing huddle monitors the risks in staffing levels with relevant mitigations and obtains assurance on safe staffing from both hospital and community settings to be able deliver safe care to our patients.

Maintaining safe staffing during the weekdays and weekends is equally challenging with the greatest challenge brought about by temporary staff cancelling their shifts and/or short-term/long term unplanned absences by our substantive workforce. There were occasions, which were escalated, where the organisational demand outstripped supply.

A divisional safe staffing weekend plan with the relevant risk rating and mitigation to maintain safe staffing has been introduced to help build staffing resilience over the weekend.

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

A proportion of clinical areas across the three hospital sites have a predominant reliance on temporary staffing (registered and unregistered nurses). This is brought about by unfunded posts to maintain safe staffing for areas creating capacity and/or escalation to meet increasing demand capacity to admit patients.

Senior leadership from the Chief Nurse Office (CNO) and at divisional level continue to provide visible and accessible focus and support to staff and colleagues.

This paper was considered at Quality and Clinical Governance Committee on 15 November 2021. The Committee took assurance from the paper, noting the improvements in weekend staffing planning in particular.

<b>Decision</b>	The Board is requested to note the report.
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<b>Relevant Strategic Priority</b>	
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Outstanding Care <input checked="" type="checkbox"/>	Healthy Communities <input checked="" type="checkbox"/>	Great Place to Work <input checked="" type="checkbox"/>	Net Zero <input type="checkbox"/>
<b>Implications / Impact</b>			
<b>Patient Safety</b>	Safe staffing levels are paramount and one of the key priorities in N&M workforce planning to deliver safe and effective patient care		
<b>Risk: link to Board Assurance Framework (BAF)/Risk Register</b>	Risk register CRR10 and BAF 1.0 both identifying inadequate staffing and over reliance on temporary staffing as a risk to staff wellbeing and safe care.		
<b>Financial</b>	Dependence on temporary staffing and at times high cost agency is a cost pressure		
<b>Compliance</b> <small>Select an item.</small> <b>Staffing</b>	National Quality Board (NQB) Standards and Expectations for Safe Staffing published in 2016. CQC Standards Staffing Regulations of the Health & Social Care Act: Safe Care and Treatment (12) Staffing (18)(1)		
<b>Partnership: consultation / communication</b>	N/A		
<b>Equality</b>	The Workforce Race Equality Standard (WRES) collecting data on race inequality revealed the disparities that exist for black, and minority ethnic staff compared to their white colleagues. The Trust is working to improve through the BHT people plan.		
<b>Quality Impact Assessment [QIA] completion required?</b>	N/A		

## 1. Introduction:

This document outlines our organisation's nursing & midwifery workforce approach to utilise effective staffing deployment and key measures to ensure the safest staffing levels are maintained proportionately as possible.

This will provide an overview of the Nursing and Midwifery safe staffing as is set out in line with the National Quality Board (NQB) Standards and Expectations for Safe Staffing published in 2016. The report further provides assurance that arrangements are in place to safely staff our services with the right number of Nurses and Midwives with the right skills, at the right time.

## 2. Key Highlights:

Table 1 outlines the key performance workforce indicators for Nursing & Midwifery mapped against Trust target with data comparison across the whole of Q2.

Key Performance Indicators	Target	July 2021 Performance	August 2021 Performance	September 2021 Performance	Context and Actions
Vacancy rate	10.0%	16.0%	15.3%	14.9%	There is a continuous downward trend in our overall vacancy rate. This is the lowest rate we had in comparison to previous months in the 12 month period. The staff in post only increased by 8 WTE in September however, international nursing recruitment continues to be strong and on tract in our recruitment strategy. The first cohort of nurses who were supported by Crew in their OSCE had their exam this October with a passing rate of 93% which is an excellent outcome compared to our previous cohorts supported locally averaging at 55% pass rate. A number of our international nurses currently awaiting NMC PIN. We should expect to see further reduction in RN vacancy rate in Q3. Ongoing work to reduce HSCW vacancy is also on tract. Our Trust was commended by NHSEI SE region for a very successful recruitment strategy for HCSW. We currently have the lowest HSCW vacancy rate of 6.8% in comparison to other organisations across the BOB ICS.
Annual turnover	12.0%	RN = 15.3% HCA = 13.4%	RN = 15.7% HCA = 14.3%	RN = 16.2% HCA = 14.8%	This is above Trust target with ongoing work from the Trust retention workstream to reduce this wherein the Associate Chief Nurse for Workforce is involved and engaged in the different initiatives to improve retention across the N&M workforce. A focussed approach to retention and staff well-being will be one of the key priorities when the new Nursing & Midwifery Council Committee will be set up in Q3.
Sickness rate	3.5%	4.2%	4.1%	4.7%	Unavailability of nursing and midwifery workforce related to sickness remain high and above trust target and is addressed within the individual Divisions and monitored through monthly Healthroster KPI exceptional reporting. It is expected that relevant Heads of Nursing will ensure this is further monitored through their monthly divisional performance meeting.
Bank Usage (monthly average)	No set target	5.6%	5.8%	7.6%	Our vacancy rate is driving the increase in bank & agency usage in all clinical areas. There are some short term sickness and unplanned absence such as isolating due to contact with symptomatic or COVID+ family members requiring same day request for temporary staffing cover to maintain safety. Our organisation demand for temporary staffing outstripped supply. However, our temporary staffing resourcing partner (NHSP) has consistently filled the required shifts at an average of 81% fill rate month on month in Q2.
Agency usage (monthly average)	No set target	5.5%	4.57%	4.98%	
Appraisal	80.0%	23.0%	25%	37%	Information taken directly from the Actus system where the staff appraisal records are uploaded and not directly linked to ESR. These are completed and signed appraisal records. The low figures accounts that, on the Actus system there are a number appraisals which are 'still in progress' status i.e. incomplete/not published; appraisal has commenced; awaiting to be signed, etc. These 'in progress' status accounts to an average of 25% which will bring the compliance between 60-65% month on month once completed. Managers need to be supported to ensure staff are having their appraisal and identify professional and career development plan which will have a positive impact to our retention rates.
Statutory Training Compliance	90%	89.5%	89.6%	89.6%	Compliance is slightly below trust target. Infection control training compliance only accounts an average of 84% overall as the topic of they lowest compliance. EDI training has the highest compliance averaging at 93.7%.

Table 1: Workforce Key Performance Indicators

### 3. Evidenced Based Workforce Planning

Having the right establishment, and the right staff in post, is essential to ensuring the safe and effective delivery of patient care. The Trusts commissioned an external specialist company to review staffing skill-mix and establishment to ensure we meet this expectation sets by the National Quality Board (NQB) Standards

and Expectations for Safe Staffing. The first audit was completed, and senior clinical leaders of each divisions are currently being invited to discuss the professional judgements to support the narratives of the data collected. The second audit is underway and due to be completed week ending 12 November 2021. The data collated during this second audit is as important as the first audit which will inform the overall recommendations when the final report is submitted to the Chief Nurse Office. Twice yearly establishments reviews and audits will be undertaken to meet the NQB standards and will be monitored through the newly formed Nursing & Midwifery Workforce Council.

#### 4. Weekly Safe Staffing

Safe Care® is used across all adult and children's inpatient areas to support the real time visibility of staffing levels across the Trust. The data collected highlights and supports decision making relating to the deployment and redistribution of staff to meet patient needs in other areas.

A twice daily safe staffing huddle monitors the risks in staffing levels with relevant mitigations and obtains assurance on safe staffing from both hospital and community settings to be able deliver safe care to our patients. A RAG risk rating on staffing levels was introduced in September 2021 in order to have clear understanding and assurance on the levels of staffing on the daily basis. The risk rating was based on the Trust Safe Staffing Escalation SOP with additional supporting narratives to guide senior clinicians in their decisions in identifying the level of risk in their staffing capacity for the day and implement appropriate mitigation to maintain safe staffing. The illustration below outlines the RAG risk rating used during the safe staffing huddle reporting.

**Risk RAG Rating:**

**Green** – staffing is safe, numbers are at optimum established numbers- would not require escalation as these constitute the levels expected through the agreed establishment

**Amber** – staffing is safe, numbers are on the safest minimum as per safe staffing escalation SOP and are vulnerable to any changes i.e. NHSP/Agency cancellation, unplanned absence, etc. This can also be if staffing that is below establishment however declared SAFE and mitigated and also vulnerable to any changes. Staff will prioritise their work and adjust their workload through the shift accordingly, with a continual review of any changes to the acuity and dependency which is update accordingly at each census period

**Red** – Staffing is unsafe, numbers below establishment and unable to mitigate. Necessary escalation and risk assessments were already been submitted up to requesting high-cost agency as necessary and escalation to the HoN/Lead already had happened prior to attending the safety huddle. At the safety huddle meeting, It would be very helpful if the divisional representative will be able to provide actions being taken forward to address the staffing shortage. However, I would expecting that the HoN/Lead of the department/clinical area with Red staffing level will attend the safety huddle. Further escalation will be highlighted at the Site Ops meeting and any bed capacity issues brought up at the safety huddle will be equally highlighted.

Table 2 below illustrates a snapshot of one of the weekday staffing status across all sites extrapolated from the daily staffing huddle reports. Areas declaring amber had mitigation in place to ensure we maintain the safety of the staff and patients during the shift. Safe staffing huddle recognises the service status in terms of beds and capacity to admit new patients however, the risk rating is specifically designed for safe staffing level only. Service bed capacity is escalated at the Site Operations meeting to ensure safe staffing is considered when operational decisions are made around additional capacity for the service to deliver on the day.

		Weekly Staffing Status 18-22 October 2021				
		18.10.21	19.10. 21	20.10.21	21.10.21	22.10.21
Divisions		RISK RATING				
Stoke Mandeville Hospital	Integrated Medicine	Green	Yellow	Green	Yellow	Yellow
	Surgery	Green	Yellow	Green	Green	Green
	IECC	Green	Green	Green	Green	Green
	Paediatrics	Green	Yellow	Green	Green	Green
	Specialist Services	Green	Green	Yellow	Yellow	Green
	Maternity	Yellow	Yellow	Green	Yellow	Yellow
	ITU (SMH/WH)	Green	Yellow	Green	Green	Green
RISK RATING						
Wycombe Hospital	Integrated Medicine	Green	Yellow	Green	Green	Green
	Surgery	Green	Yellow	Green	Green	Green
RISK RATING						
AH and Buckingham	Integrated Medicine	Green	Green	Green	Green	Green
	IECC	Green	Green	Green	Green	Green
	Buckingham CH	Green	Green	Green	Yellow	Green

Table 2: Extrapolated data: Safe Staffing huddle reports week commencing 18 October

#### 4.1 Weekend Staffing Plan

Weekend safe staffing plan form each division was introduced this month of October to ensure there is a centralised oversight of the staffing levels over the weekend and provides the organisation the assurance of safe staffing and/or appropriate mitigation is in place when necessary to be able to support staffing resilience during the weekend. The same risk RAG rating is used as above when planning for weekend staffing to maintain safety. See Appendix 1 for the Divisional Weekend Staffing Plan.

### 5. Healthroster KPI metrics

Efficient staffing deployment and/or workforce utilisation is key to having a safe and effective workforce in delivering safe care to patients. Historically the Healthroster metrics report is shared to a wider distribution list within the organisation without proper governance process on what is expected to do of the data. The information in the monthly report requires a level of scrutiny and assurance to ensure month on month reporting will demonstrate improvement compliance to the key metric indicators.

A new Healthroster KPI reporting template was introduced in September which captures the three main indicators of an efficient workforce planning and rostering (Safety; efficiency/affordability; and effectiveness). The monthly report which is generated a week after the roster is worked on and completed is shared to each division through the Matrons and Heads of Nursing who are expected to interrogate, validate, analyse the data and provide exceptional reporting narratives to either of the fully met or those

unmet KPIs. Unmet KPIs will be expected to have an action plan included in the exceptional reporting returns.

In September to October report, there was increase of 95 red flags (shown in Figure 1), the reasons identified are the increase the need to provide 1:1 care or patient enhanced care requirements and increase staffing unavailability which also reflected in the narratives in table 1 above. The use 1:1 as a red flag was only added earlier this year however, this category is not on the recommended red flag list by the NICE Guidance on Safe Staffing for Nursing in adult inpatient wards. Staff are encouraged to raise red flags where there may be concerns relating to safe staffing levels, which triggers a review by the Sister/Ward Manager/ Matron or Head of Nursing to resolve any immediate staffing concerns.

An action to review the use of 1:1 as a red flag category, use the category recommended by NICE and align practice with other organisations using Safe Care® and Safer Nursing Care Tool (SNCT).

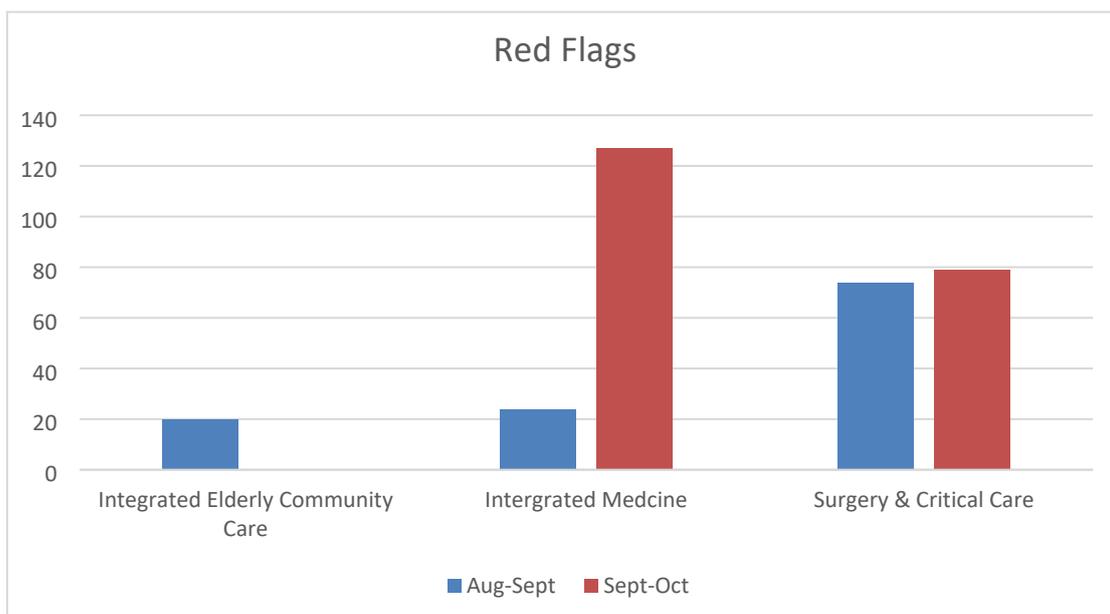
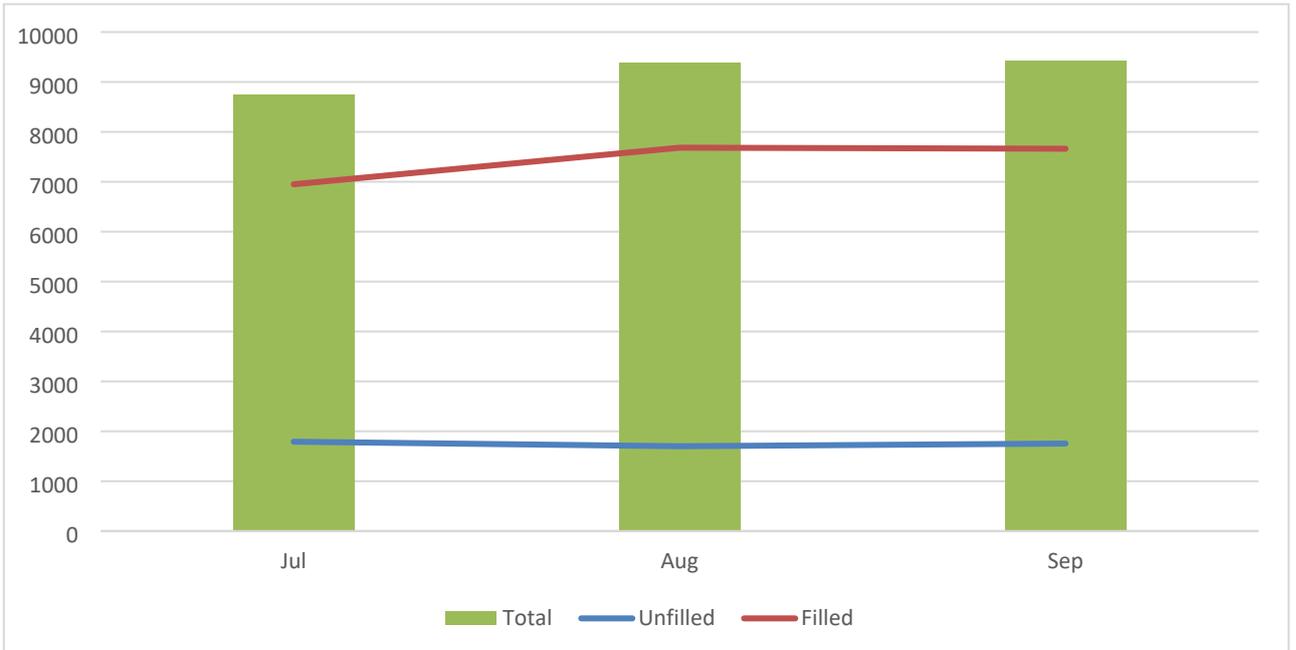


Figure 1: Red Flags by Divisions

- Having an efficient roster will support the measures taken to reduce bank and agency usage. However, the current nursing and midwifery workforce with a high number of vacancies will have a medium-term trajectory to reduce the use of bank and agency. A proportion of clinical areas across the three hospital sites predominantly rely on temporary staffing (registered and unregistered nurses) brought about by unfunded posts to maintain safe staffing for areas creating capacity and/or escalation to meet increasing demand capacity to admit patients. The demand of our organisation for temporary staffing outstripped the supply however, our temporary resourcing partner NHSP was able to fill the required shifts at an average 81% fill rate for this current quarter. Figure 2 below illustrates the total number of requested shifts in the past 3 months. The high volume of temporary staffing requests was attributed to vacancies, short term unplanned absence i.e., sickness, COVID 19 related absences, maternity cover and some long-term sickness absences.



**7. Conclusion:**

Recruitment for RNs locally and internationally continues to take place and we are doing very well in our international recruitment. HCSW recruitment is also in a very good position to which the organisation is commended by NHSEI SE region for having the lowest HCSW vacancies within the BOB ICS.

The Nursing & Midwifery Workforce Council which will provide senior leadership on all matters related to workforce governance with a focus on stabilising the workforce, reviewing new workforce models, reducing temporary staffing, and delivering on NQB guidance.

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

**8. Action required from the Board/Committee:**

For Committee information and assurance

Appendix 1:

Divisional Weekend Staffing Plan

All Heads of Nursing or delegate will be expected to complete this template for the Wednesday Staffing Safety Huddle meeting. This must include planned vs actual, the plans to mitigate gaps, the ceiling of escalation i.e. backfilling RN with RNA/Unreg B4/HCA, usual process of completing the risk assessment and request for high cost agency if deemed necessary. Any plan to move staff within and/or across Divisions must include specifics i.e. 1 RN from x ward to another.

This will be reviewed at the Friday morning Staffing Safety Huddle, this plan must include instructions for the Clinical Site Management Team (CSMT) and Senior Duty oncall if you plan to move staff between wards to mitigate staffing shortages over the weekend.

This must be sent electronically to Jose Facultad, Karen Gollop and Alison Mackie on a Friday and this will be submitted to the CSMT and Senior Duty on call to support staffing resilience over the weekend. This template must be adapted to cover BH weekends until Tuesday morning as required.

Risk RAG Rating:

Green – staffing is safe, numbers are at optimum established numbers- would not require escalation as these constitute the levels expected through the agreed establishment

Amber – staffing is safe, numbers are on the safest minimum as per safe staffing escalation SOP and are vulnerable to any changes i.e. NHSP/Agency cancellation, unplanned absence, etc. This can also be if staffing that is below establishment however declared SAFE and mitigated and also vulnerable to any changes. Staff will prioritise their work and adjust their workload through the shift accordingly, with a continual review of any changes to the acuity and dependency which is update accordingly at each census period

Red – Staffing is unsafe, numbers below establishment and unable to mitigate. Necessary escalation and risk assessments were already been submitted up to requesting high-cost agency as necessary and escalation to the HoN/Lead already had happened prior to attending the safety huddle. At the safety huddle meeting, it would be very helpful if the divisional representative will be able to provide actions being taken forward to address the staffing shortage. However, I would expecting that the HoN/Lead of the department/clinical area with Red staffing level will attend the safety huddle. Further escalation will be highlighted at the Site Ops meeting and any bed capacity issues brought up at the safety huddle will be equally highlighted.

Division:						Weekend Commencing:											
WARD/AREA NAME:		RNs* Established numbers on shift	RN Actual Nos	NA Actual Nos	Name & Band of Nurse in Charge of Shift	WARD/AREA NAME:		RNs* Established numbers on shift	RN Actual Nos	NA Actual Nos	Name & Band of Nurse in Charge of Shift	WARD/AREA NAME:		RNs* Established numbers on shift	RN Actual Nos	NA Actual Nos	Name & Band of Nurse in Charge of Shift
Actions & Mitigations						Actions & Mitigations						Actions & Mitigations					
Friday - Date:	Day					Friday - Date:	Day					Friday - Date:	Day				
	Night						Night						Night				
Saturday - Date:	Day					Saturday - Date:	Day					Saturday - Date:	Day				
	Night						Night						Night				
Sunday - Date:	Day					Sunday - Date:	Day					Sunday - Date:	Day				
	Night						Night						Night				
Monday - Date:	Day					Monday - Date:	Day					Monday - Date:	Day				
	Night						Night						Night				

**Meeting:** Trust Board Meeting in Public

**24 November 2021**

<b>Agenda item</b>	Quarter 2 Maternity Safety Report 21/22
<b>Board Lead</b>	Karen Bonner Chief Nurse
<b>Type name of Author</b>	Heidi Beddall Director of Midwifery
<b>Attachments</b>	Appendix 1-3
<b>Purpose</b>	Information
<b>Previously considered</b>	Divisional Quality 04/11/21 EMC 09/11/21 QCG 15/11/2021

### Executive Summary

The current midwifery vacancy remained high during this quarter peaking at 22.4% beginning of October. A reduction to at least 13.75% is expected by year end. The impact of midwifery staffing shortages in this quarter are:

- Increased internal escalation process used
- Increased use of temporary staffing (particularly nurses); on call staff including community midwives and midwifery managers.
- Delayed induction of labour
- Temporary suspensions of home birth services

Due to the ongoing midwifery vacancy in the Wycombe community midwives' team, the planned "on demand" model for Wycombe birth centre, due to commence 1<sup>st</sup> December cannot be fully staffed and will compromise the home birth service and internal escalation process. The safest option is to continue to provide antenatal and postnatal care at Wycombe birth centre but not restore intrapartum care.

BHT maternity have been selected to take part in the next part of the 'understanding safety culture' project with the Maternity Neonatal Safety Improvement Programme as 1 of 4 case studies

There were 3 reportable PMRT cases in Quarter 2 and 1 closed in Quarter 2. Families are involved in all case investigations/reviews. Term admissions to neonatal unit and pre term births remain below target.

**Ockenden report** - Feedback on the Ockenden evidence submission was received on 27<sup>th</sup> October. BHT were assessed as non-compliant with 74 actions out of 122. Of the 74 areas of non-compliance:

- 42 have been requested for reassessment as evidence was submitted
- 11 have evidence available for submission
- 21 require action

**NHSE eight point action plan for maternity and neonatal services** - Assurance paper submitted to Trust exec in September. Further progress with actions made (see Appendix 1 for current compliance)

**NHSR Early Notification Scheme Qualifying Incidents-** There were no qualifying incidents in this quarter.

The national team have published new guidance on implementing continuity of carer as the default model of care. Local maternity and neonatal system plans for implementation of continuity of carer need to be developed by the revised date of January 31<sup>st</sup> 2022.

CQC engagement day with maternity 20<sup>th</sup> October – no immediate concerns raised

The Chief Midwifery officer for England has written to Trust boards to arrange maternity safety meetings with executive teams.

This paper was discussed at the Quality and Clinical Governance Committee on 15 November 2021. The Committee took assurance from the paper, noting the national midwifery staffing challenges and the number of workstreams in place to address this.

<b>Decision</b>	The Board is requested to note this paper.			
<b>Relevant Strategic Priority</b>				
<b>Outstanding Care</b> <input checked="" type="checkbox"/>	<b>Health Communities</b> <input checked="" type="checkbox"/>	<b>Great Place to Work</b> <input checked="" type="checkbox"/>	<b>Net Zero</b> <input type="checkbox"/>	
<b>Implications / Impact</b>				
<b>Patient Safety</b>	Assurance of and progress with patient safety work streams including any issues or challenges			
<b>Risk: link to Board Assurance Framework (BAF)/ Risk Register</b>	CRR 10 BAF 1.1 Culture of quality improvement An organisation that learns Listening to the patient voice			
<b>Financial</b>	Delivery of safety actions of maternity incentive scheme (CNST) Workforce funding from NHSE/I to meet Ockenden recommendations			
<b>Compliance CQC Standards</b> <small>Select CQC standard from list.</small>	Safe Effective Well led Responsive			
<b>Partnership: consultation / communication</b>	Acute paediatrics- neonatal services Quality Improvement team Recruitment team Local Maternity System			
<b>Equality</b>	It is essential to have an increased focus on reducing health inequalities for BAME women. Maternal and neonatal outcomes are significantly worse for these families compared to white counterparts.			
<b>Quality Impact Assessment [QIA] completion required?</b>	No			

**See Separate Paper**

Title	Maternity Safety Quarterly Report Quarter 2 2021/22
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### Midwifery Staffing

The current midwifery vacancy remained high during this quarter peaking at 22.4% beginning of October. A reduction to at least 13.75% is expected by year end. The vacancy gap widened due to the additional 9.5wte posts funded by the Ockenden bid in addition to leavers.

Maternity are working closely with the people directorate to increase recruitment and retention opportunities, including the recruitment of extra admin and support staff to optimise midwifery time.

The impact of midwifery staffing shortages in this quarter are:

- Increased internal escalation process used
- Increased use of temporary staffing (particularly nurses); on call staff including community midwives and midwifery managers.
- Delayed induction of labour
- Temporary suspensions of home birth services

Midwifery staffing remains on the divisional risk register as a 20.

Key mitigations include the internal escalation process and use of on call staff to support peaks of activity and maintain home birth services. This ensures women have 3 options for place of birth as much as possible and receive 1:1 care in labour.

Due to the ongoing midwifery vacancy in the Wycombe community midwives team, the planned “on demand” model for Wycombe birth centre, due to commence 1<sup>st</sup> December cannot be fully staffed and will compromise the home birth service and internal escalation process.

The safest option is to continue to provide antenatal and postnatal care at Wycombe birth centre but not restore intrapartum care. An executive discussion and decision is needed; a separate paper submitted to EMC 09/11/21.

### Maternity/Neonatal Safety Improvement Programme (MatNeoSIP)

Further to maternity being asked to participate in an ‘understanding safety culture’ project with the Maternity Neonatal Safety Improvement Programme, BHT maternity have been selected to take part in the next part of the project as 1 of 4 case studies This is aimed at identifying what ‘good’ looks like and how this can be implemented more consistently and widely across the country.

### Quarterly Perinatal Mortality Review Tool (PMRT)

There were 3 reportable PMRT cases in Quarter 2 and 1 closed in Quarter 2. Families are involved in all case investigations/reviews. The cause of death was a cord incident – narrowing of cord insertion. Fetal growth restriction was a factor but not due to placental cause and therefore not preventable or predictable.

Issues identified in the closed case:

- Mother did not have a kleihauer test post birth as the lab do not undertake them for rhesus positive women; this may have helped determine if cause of death was a fetal maternal haemorrhage
- There was a delay in being seen in maternity triage

The case summary list is available on request.



**National Recommendations and Action Plans 2021/22*****The Avoiding Term Admissions to Neonatal Units Action Plan***

There are no actions due for Quarter 1. A progress report is awaited from neonates. Admission rates remain below the target of 5%.

***Ockenden report***

Feedback on the Ockenden evidence submission was received on 27<sup>th</sup> October. BHT were assessed as non-compliant with 69 actions out of 122. A review of the submission has been undertaken by the Director of Midwifery and lead Midwife for clinical governance and quality. In line with the request of the regional chief midwife, a submission of suggested revisions submitted on 6<sup>th</sup> November following executive sign off.

Of the 74 areas of non-compliance:

- 42 have been requested for reassessment as evidence was submitted
- 11 have evidence available for submission
- 21 require action

This has been discussed at the maternity external and assurance meeting (02/11/21) and action owners identified. The tracking and monitoring of areas of non-compliance will be via the LMNS. Deadlines have not been clarified by the regional teams yet.

***NHSE eight point action plan for maternity and neonatal services***

Assurance paper submitted to Trust exec in September. Further progress with actions made (see Appendix 1 for current compliance)

**Maternity and Neonatal Safety Champions**

Meeting held 28<sup>th</sup> October 2021 (see Appendix 2)

**NHSR Early Notification Scheme Qualifying Incidents**

There were no qualifying incidents in this quarter. Enquiry made to NHSR regarding one case that does not meet criteria but as it did not meet HSIB criteria it is being clarified if they would like to be notified. The case was a baby that went for cooling at the tertiary centre. The mother presented with reduced movements and immediate delivery was initiated due to an abnormal fetal heart pattern. Both mother and baby tested positive for COVID 19.

**NHSR Maternity Incentive Scheme (CNST)– risk assessment and progress tracking**

Confirmation of reimbursement from NHSR awaited.  
Year 4 standards published; action plan in development.

**Continuity of Carer**

As referenced in the Quarter 1 21/22 maternity safety report, midwifery staffing posed a risk to the planned Autumn launch of community based continuity of carer teams. The teams have not been launched as the vacancies in community midwifery have not been filled.

In response to feedback that the deliverables related to continuity of carer are not aligned with current capacity and staffing of maternity services across the country, the national team have published new guidance on implementing continuity of carer as the default model of care. The guidance accounts for the required staffing levels needed for implementation and includes toolkits for workforce modelling. Local maternity and neonatal system plans for implementation of continuity of carer need to be developed by the revised date of January 31<sup>st</sup> 2022.

### **Preterm birth**

There is an ongoing national focus on reducing preterm births, ensuring mothers in extreme preterm labour are given Magnesium Sulphate (Mgso4) for neonatal neuro protection and transferred to level 3 neonatal unit as required.

Incidence of women with a singleton pregnancy giving birth (liveborn and stillborn) as a % of all singleton births in this quarter:

- a) In the late second trimester (from 16+0 to 23+6 weeks) = 0% (YTD)
- b) Preterm (from 24+0 to 36+6 weeks) = 5.2% (YTD)

Overall preterm birth rate = 5.8%. Target <6%

Mgso4 administration 100% compliant

Correct place of birth: 100% compliant

### **Fetal growth restriction**

#### **Prevention of fetal growth restriction**

Aspirin assessment is continued at booking.

Smoking at booking rates: 7.11%

Smoking at time of birth also 6.61% (target 6%).

Fetal growth restriction was a contributory factor in the one PMRT case closed between January and March 2021 not placental causation therefore not predictable or preventable.

#### **Audits:**

There are no outstanding audits for maternity as per Trust audit schedule.

### **Maternity dashboard**

The maternity dashboard (See Appendix 3) has been updated:

- in line with the NHSE/I perinatal quality surveillance model
- to follow national recommendations to include Robson groups
- to ensure Board have sight of KPI's for the antenatal and newborn screening pathways that are submitted externally to Public Health England
- incorporate the Healthy Child programme KPI's
- include midwifery led care and continuity of carer performance and quality metrics

#### **AOB:**

- A new South East mutual aid document has been published due to the increasing capacity, activity and staffing issues across maternity services. This is being incorporated into the Trust capacity in maternity guideline.
- National increase in the number of pregnant women critically ill with COVID 19. Maternity are working in partners across the ICP in line with national recommendations to promote vaccination.
- CQC engagement day with maternity 20<sup>th</sup> October – a presentation was delivered by the division (available on request) and staff focus groups were held. Staff feedback positively about the focus groups and the joined up multidisciplinary approach to the presentation was commented on by the CQC. The new engagement process does not include a feedback session from the CQC but they will if there are immediate concerns. No immediate concerns were raised.
- The Chief Midwifery officer for England has written to Trust boards to arrange maternity safety meetings with executive teams to:

- discuss maternity safety, highlight key maternity safety messages and share learning and best practice
- discuss maternity safety assurance processes
- re-introduce the refreshed National Maternity Self-Assessment tool that supports early identification of issues requiring improvement

Appendix 1			
Action for local response	BHT compliance	Evidence	Outstanding actions
Care of pregnant women who test positive for COVID 19	Fully met	IP +C guidelines in place. SOP for partner access/visiting and national COVID 10 sit rep. submissions SOP for neonatal COVID 19 admission pathways. RCOG COVID 19 in pregnancy guideline in use.	
Covid 19 vaccination for pregnant women	Partially met	All staff email communication to advise vaccination and provide information at every contact. All staff email communication and electronic shared folders of up to date COVID 19 information. Trust vaccination leads agreement to support maternity with vaccination to pregnant people. Active involvement and co design with maternity voices partnership throughout pandemic and ongoing. Cascaded message from Chief Midwifery office from vaccination team to primary care. Health visitors using 28 week check and five universal health reviews to promote vaccination.	Engagement with local pharmacies to promote vaccination.
COVID 19 vaccination – increase uptake in maternity workforce	Partially met	High uptake in vaccination by staff >90%	OH + W to identify who has not been vaccinated – line managers to have supportive conversation with staff member.
Workforce – maternity disciplinary team	Fully Met	Self isolating or shielding staff allocated to non clinical or virtual working. OH+W guideline on returning to work if staff member had contact with COVID 19. Additional support in place for student and newly qualified midwives. Retire and return midwives supported to return to work. No redeployment of staff from maternity	
Maternity transformation programme workstreams and other initiatives/assurance/reporting	Fully Met	Shielding staff supporting delivery. Additional staff fixed term contracts being discussed with divisional accountant in relation to vacancy and maternity incentive scheme reimbursement. November Update: Transformation programmes continued in line with revised national guidance eg maternity incentive scheme, continuity of carer	
Charities – support from non-NHS organisations	Not for local response		
Working with other services	Partially Met	Regional mutual aid document developed. Twice weekly regional sit rep on staffing, activity and service provision No redeployment of maternity staff Paediatric critical surge plan written. <b>November update:</b> HoM shared mutual aid document with relevant stakeholders. Mutual aid process integrated into practice at BHT; guideline will be updated once revised version published.	HoM to update local business continuity plans and capacity in maternity guideline with version 2 of the South East mutual aid document.
Communication	Not for local response		

## Appendix 2

**Agenda**  
**Maternity and Neonatal Safety Champions Bi**  
**Monthly Meeting**  
**28<sup>th</sup> October Via MS Teams**

**Present: Karen Bonner, Aparna Reddy, Sanjay Salgia, Gaynor Tyler, Heidi Beddall**

<b>1</b>	<p><b>Staffing</b></p> <p><b>Neonate Unit</b></p> <p>Have successfully recruited 4x band 5 international nurses all with neonatal experience, aiming to be able to start work in Jan/Feb 22.</p> <p>Two nurses recruited into band 6 posts.</p> <p>0.77 WTE vacancy remaining at band 6.</p> <p>In the interim relying heavily on bank and agency staff to fill gaps in the roster through Nov and Dec. due to vacancies, maternity leave and long term sick leave.</p> <p>Working with the Network and use of the workforce calculator to explore the possibility of additional funding through NHS long term plan and Neonatal Critical Care review to fill gaps in the workforce as additional funding available for 2022-23.</p> <p><b>Maternity</b></p> <p>Midwifery vacancy remains high, working closely with people directorate to recruit. New starters commenced end of October and international nurses recruited. Safety being maintained but an increase in the last quarter of:</p> <ul style="list-style-type: none"> <li>• Use of internal escalation process</li> <li>• Use of temporary staffing (particularly nurses); on call staff including community midwives and midwifery managers.</li> <li>• Delayed induction of labour</li> <li>• Temporary suspensions of home birth services</li> </ul> <p><b>Safety issue:</b></p> <ul style="list-style-type: none"> <li>• Mutual aid has not been available when sought by maternity and neonates</li> <li>• Midwifery staffing remains on the divisional risk register as a 20.</li> </ul>	
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	<p>Key mitigations include the internal escalation process and use of on call staff to support peaks of activity and maintain home birth services. This ensures women have 3 options for place of birth as much as possible and receive 1:1 care in labour.</p> <p>Due the ongoing midwifery vacancy in the Wycombe community midwives team, the planned “on demand “model for Wycombe birth centre, due to commence 1<sup>st</sup> December cannot be fully staffed and will compromise the home birth service and internal escalation process.</p> <p>The safest option is to continue to provide antenatal and postnatal care at Wycombe birth centre but not restore intrapartum care. An executive discussion and decision is needed.</p>	
<b>2</b>	<p><b>Training</b></p> <p>Year 4 maternity incentive scheme standards revised – face to face training not required to be face to face from end of September.</p> <p><b>Safety issue:</b> Medical attendance at safeguarding level 3 training</p> <p><b>Neonatal Unit</b></p> <p>Face to face nurse mandatory training sessions recommenced in September.</p> <p><b>Safety issue:</b> Mandatory training in October needed to be suspended halfway through the day due to clinical demands within paediatrics.</p>	
<b>3</b>	<p><b>Mat Neo Safety Collaborative:</b></p> <p>The following projects continue and have all been registered with the Trust QI team.</p> <ul style="list-style-type: none"> <li>• Early expression of breastmilk</li> <li>• Optimal cord clamping</li> <li>• Thermal care</li> </ul>	
<b>4</b>	<p><b>Perinatal dashboards</b> NNAP Q3 report</p>	
<b>5</b>	<p><b>Patient Safety and Quality Improvement</b></p> <ul style="list-style-type: none"> <li>• Newborn pulse oximetry screening</li> <li>• Enhanced maternal care pathway launched</li> </ul> <p>Quality week in November – plans in progress with divisional QI lead to showcase current local and regional projects</p>	
<b>6</b>	<p><b>Regional/National Reports and Publications</b></p> <p>TV and W 2020 Annual Report attached.</p>	

	Feedback on Ockenden evidence submission received 27 <sup>th</sup> October – review and gap analysis in progress, due completion on 1 <sup>st</sup> November for sharing with divisional team, EMC approval and submission to regional chief midwife.	
<b>7</b>	<b>Update from board level safety champion – staff feedback sessions</b> Last session – issues raised IT on Rothschild ward and staffing.  Need to commence and action tracker and for walkabouts to commence as part of Ockenden evidence.	
<b>8</b>	<b>Achievements</b> Director of Midwifery commenced in post	
<b>9</b>	<b>AOB</b> NNU continues to be running at >80% capacity, causing a delay in repatriating neonates from JRH and increasing the need for antenatal transfers of potential preterm deliveries.  Network ATAIN task and finish group.  Regional mutual aid guideline published for maternity and neonatal services due to revised in November due to feedback.  CQC TMA engagement day with maternity held 20 <sup>th</sup> October  Increasing cases of critically unwell women with COVID 19 nationally	
	<b>Date of next meeting</b>	

### Appendix 3



Maternity  
Dashboard 2021-2022

**Meeting:** Trust Board Meeting in Public

**24 November 2021**

<b>Agenda item</b>	Mortality Report – Annual report	
<b>Board Lead</b>	Mr Andrew McLaren, Chief Medical Officer	
<b>Type name of author</b>	Dr Mitra Shahidi	Consultant Respiratory Physician and Associate Medical Director for Patient Safety and Quality
	Mandy Chetland	Head of Medical Quality
	Robert Douce	Head of Consultancy, Dr Foster
	Dr Justin Mandeville	Consultant in Intensive Care Medicine and Anaesthesia
<b>Attachments</b>	None	
<b>Purpose</b>	Assurance	
<b>Previously considered</b>	EMC, Quality & Clinical Governance Oct 2021	

## Executive Summary

### HSMR

Our HSMR has been increasing since September 2019, when it became “higher than expected from June 2020 onwards. An investigation identified 3.5k records had not been uploaded and were subsequently resent for the October and November 2020. Data could not be resubmitted for the periods prior to October. Our HSMR from October 2020 onwards is now “as expected”.

### Covid analysis

The most frequently recorded comorbidity was hypertension which accounted for 31% of patients with COVID-19 and diagnosis coding. The next most prevalent conditions were chronic endocrine conditions (mostly consisting of patients with diabetes), chronic respiratory diseases and chronic heart diseases: 25%, 18% and 17% of all COVID-19 positive cases respectively.

Understandably, the group with the highest mortality rate (84%), was palliative care.

The next highest mortality rates at the trust (from groups of size >25 patients) were chronic kidney disease (41%), cancers of the blood and bone marrow (40%) and chronic heart disease (38%).

The distribution of deaths by condition was similar at the trust compared to nationally for all conditions (4% difference or less).

## ICNARC

Bucks average ICU patient mean age was significantly higher than the mean for the region. 8 years higher than MK, and 2 years higher than the mean.

ICU survivors appeared to remain on ICU for less time, but this is partly because we transferred the more stable, weaning patients to Wycombe. Those who died had a similar duration of stay to elsewhere in the region, suggesting we didn't withdraw high-level care sooner than elsewhere did.

A very high proportion of patients were ventilated. Patients were on higher amounts of oxygen than any other centre at the time of admission to ICU, suggesting they came to ICU later than they did at other trusts.

This paper was considered at the Quality and Clinical Governance Committee on 20 October 2021. The reasons for high HSMR and rectification issues related to the coding file transmission were noted. Lessons learned with management of COVID-19 patients were discussed including the benefits of earlier ICU admission. It was noted that, overall, BHT performed well.

<b>Decision</b>		For assurance	
<b>Relevant Strategic Priority</b>			
<b>Outstanding Care</b> <input checked="" type="checkbox"/>	<b>Health Communities</b> <input type="checkbox"/>	<b>Great Place to Work</b> <input type="checkbox"/>	<b>Net Zero</b> <input type="checkbox"/>
<b>Implications / Impact</b>			
<b>Patient Safety</b>	Monitoring and investigating/auditing our mortality to ensure we are providing the safe care and identifying any learning if a lapse in care is identified.		
<b>Risk: link to Board Assurance Framework (BAF)/Risk Register</b>	The Trust's mortality rates are indicators of how well we care for our patients and may impact negatively on the Trust's reputation.		
<b>Financial</b>	No financial implications.		
<b>Compliance</b> Select an item. Select CQC standard from list.	The standard for HSMR is 100.0.		
<b>Partnership: consultation / communication</b>	Collaboration with all divisions and the Dr Foster analyst at the Mortality Reduction Group Meeting as well as when investigating/auditing specific diagnoses.		
<b>Equality</b>	Mortality data does not discriminate against protected characteristics but can identify inequalities if mortality is higher in a		

	particular group of people ie., age, gender, ethnicity, etc.
<b>Quality Impact Assessment [QIA] completion required?</b>	Not required for this paper.

# Mortality Report

## 1 Introduction

This report provides an update on:

- Mortality Review Group
- HSMR
- Covid 19 Analysis
- ICNARC

## 2 Mortality Review Group (MRG)

MRG continued to meet during the pandemic and had a good representation from Medical, Nursing and Coding teams. The members of MRG continue to have an effective working relationship with Dr Foster.

During the last 12 months, there has been a focus on data quality to improve our HSMR. Areas of improvement are:

### Coding

Medical Records and Coding worked on a joint improvement goal to reduce the number of 'missing' notes so that coding could be completed from notes and not discharge summaries, therefore improving the depth of coding.

Outcomes were:

- Coding Team backdated coding of notes previously coded just from discharge summary
- Scanning is now done in order of date of discharge and not from date of arrival of the notes in Medical Records; a target which drives improved efficiency across the system.
- Ward clerks in Florence Nightingale and Cancer Day Unit now code admissions to the unit as non-elective and not as routine elective admissions.
- Medical Records and Coding continue to work in close collaboration, monitoring progress and addressing issues as they arise.

### Uncoded admissions

Working with Dr Foster to understand why our HSMR had been rising from August 2020, it was identified that the data sent from the Trust's BI Team relating to uncoded data differed from the information received by Dr Foster. For example, according to Coding dept records there were only 44 uncoded admissions between January-December 2020, however the Dr Foster data showed 735 uncoded between January-March 2020.

The BI team identified 5 of the 82 submitted files had fallen through a processing gap. The files were submitted but failed due to technical issues in the transfer and failed to load. The email notifications highlighting this error were received but not actioned.

An investigation identified 3.5k records had not been uploaded and were subsequently resent.

Two essential changes in data processing routines have been made as a result of this error.

- The returned emails and their status content are now recorded against the outbound file information held in our SQL data. This means that any file that is not confirmed or any file that fails will be easily identified and rectified within the submission timeframes.
- The complicated process of analysing the post reconciliation data and comparing that to our submissions has been simplified during this exercise and will now form part of the monthly data quality checks.

These two routines will ensure that this type of processing failure is easily identified and actioned in a realistic timeframe and should avoid similar issues in the future.

Following the outcome of the investigation, the missing data has subsequently been identified by the Information team and re-submitted to SUS. Dr Foster has reprocessed the data to correct the anomalies.

The original Dr. Foster HSMR Reports from March 2021 (diagram 1a) shows a higher HSMR during the period where the data issues occurred than the most recent report (August 2021 – diagram 1b).

The figures can be summarised in the table below (table 1). These have been taken from the graphs shown in diagrams 1a and 1b to enable a comparison of the HSMR rolling 12-month figure by month be demonstrated where overlapping data exists.

Date Range	Before Fix	Post Fix	Difference
May 19 to Apr 20	105	104.5	0.5
June 19 to May 20	106	105	1
July 19 to Jun 20	109	108	1
Aug 19 to Jul 20	110	108	2
Sep 19 to Aug 20	111	108.5	2.5
Oct 19 to Sep 20	110	107	3
Nov 19 to Oct 20	106.5	102.5	4
Dec 19 to Nov 20	105	100.5	4.5
Jan 20 to Dec 20	104	98	6

Table 1 – HSMR 12 month rolling figures extracted from graphs for information, Dr. Foster, March 2021 and August 2021 reports

#### Diagnoses - HSMR | Mortality (in-hospital) | Jan 2020 - Dec 2020 | Trend (rolling 12 months)

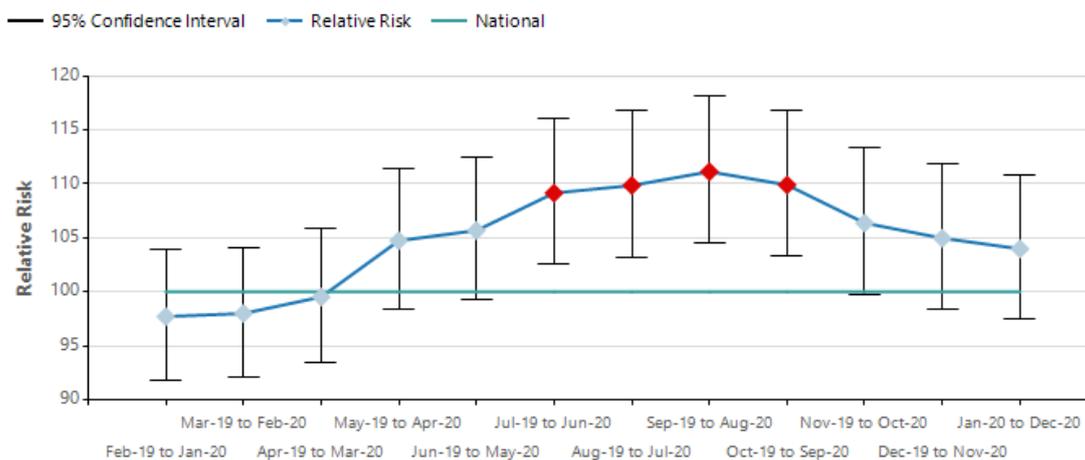


Diagram 1a – HSMR 12 month rolling trend, Dr. Foster, March 2021 report

The chart below shows that the HSMR scores over the same period of time are reduced and the trend has improved significantly over the subsequent months.

Diagnoses - HSMR | Mortality (in-hospital) | Apr 2020 - Mar 2021 | Trend (rolling 12 months)

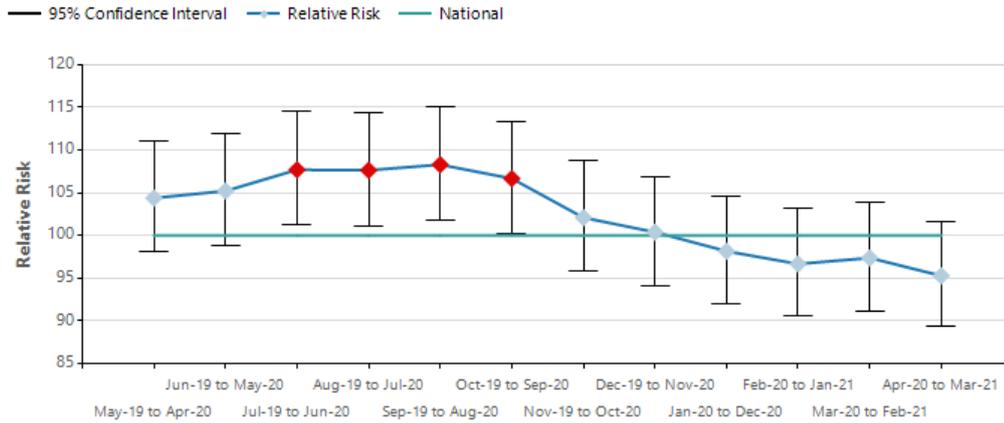


Diagram 1b – HSMR 12 month rolling trend, Dr. Foster, August 2021 report

Deep Dives

Coding and clinical deep dives of alerting diagnosis continued. The following reviews were undertaken in the last 12 months and no lapses of care were identified. All coding errors were corrected and if learning was identified, this is shared within the team.

- Acute Bronchitis
- Cancer of brain and nervous system
- Cancer of bronchus, lung
- Cancer of head and neck
- Cancer of the rectum and anus
- Cancer of thyroid
- Diverticulosis and diverticulitis
- Gastritis and duodenitis
- GU congenital anomalies
- Hepatitis
- Residual Codes (uncoded)
- Secondary malignancies
- Septicaemia

3 HSMR

An update and review of our HSMR has been provided by Dr Foster for this report.

The HSMR rolling 12 month trend shows four of the data periods with an HSMR that is banded as statistically ‘higher than expected’ (figure 1).

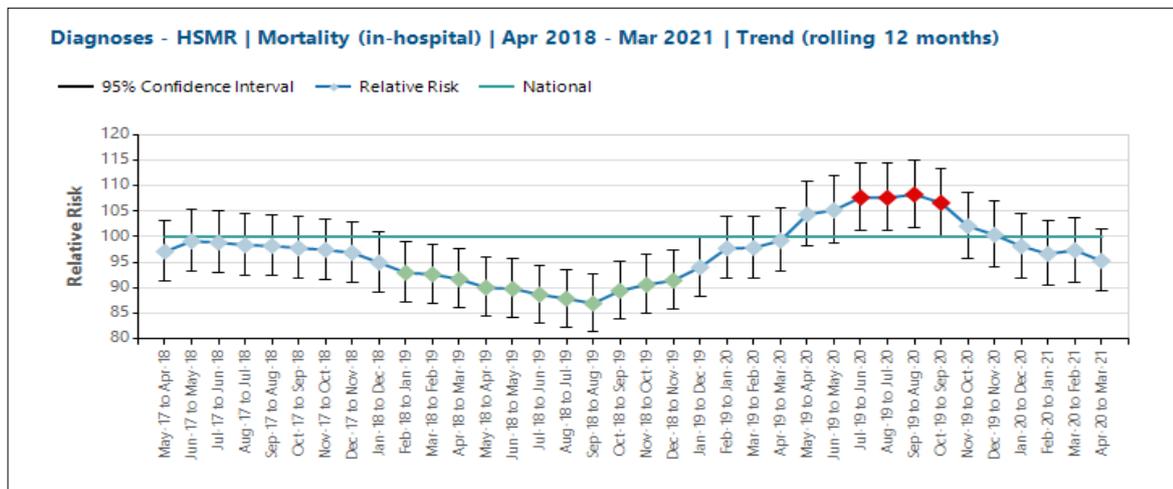


Figure 1 – HSMR Trend (rolling 12 months)

HSMR doesn't include any patients with a primary diagnosis of Covid-19 instead these patients are housed within the 'viral infections' diagnosis group that forms part of our SMR (all diagnosis). It is however important to note that patients with a Covid-19 code in a secondary position will be included in the HSMR basket (for the last available 12 months this represents 2.1% of admissions within the HSMR basket at Buckinghamshire Healthcare NHS Trust).

The following chart provides comparative trends showing the rolling 12-month HSMR vs HSMR (excluding Covid-19) to highlight the impact of this cohort of patients within the HSMR metric (figure 2).

- If super-spells with a secondary Covid-19 diagnosis are excluded from the rolling HSMR trend there are no 12 months periods with a relative risk banded as 'statistically higher' than expected and the last three periods are banded as statistically 'lower than expected'.

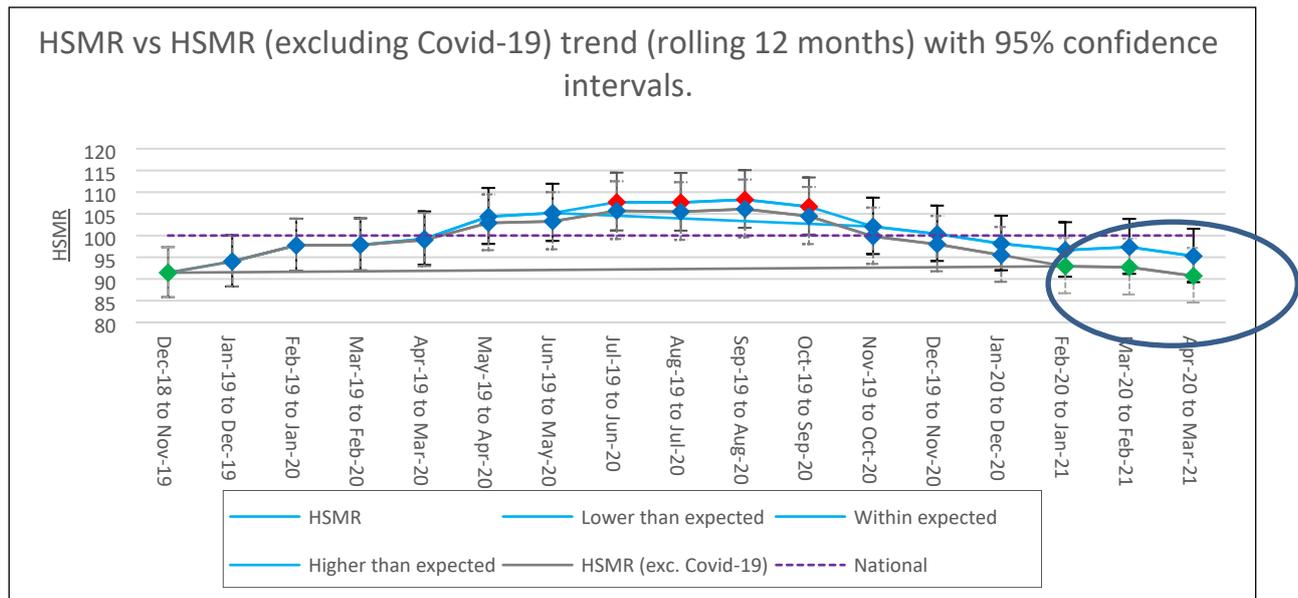


Figure 2 – HSMR vs HSMR (excluding Covid-19) Trend (rolling 12 months)

The volume (super-spells) of patients with secondary Covid-19 codes in the HSMR basket is most significant during the last three 12-month periods (figure 3):

- Feb-20 to Jan-21, 405 super-spells with a secondary Covid-19 diagnosis
- Mar-20 to Feb-21, 505 super-spells with a secondary Covid-19 diagnosis
- Apr-20 to Mar-21, 563 super-spells with a secondary Covid-19 diagnosis

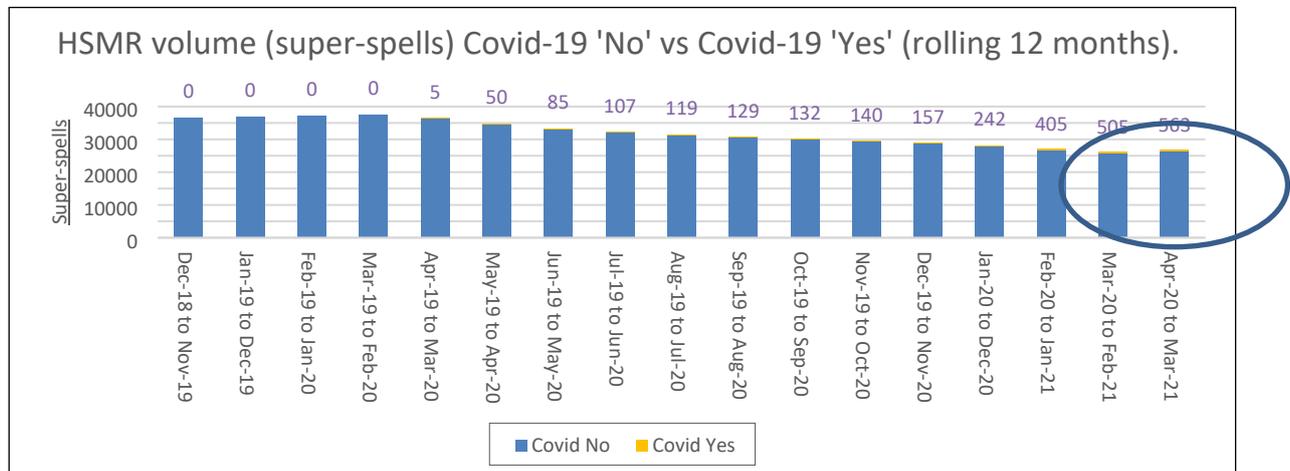
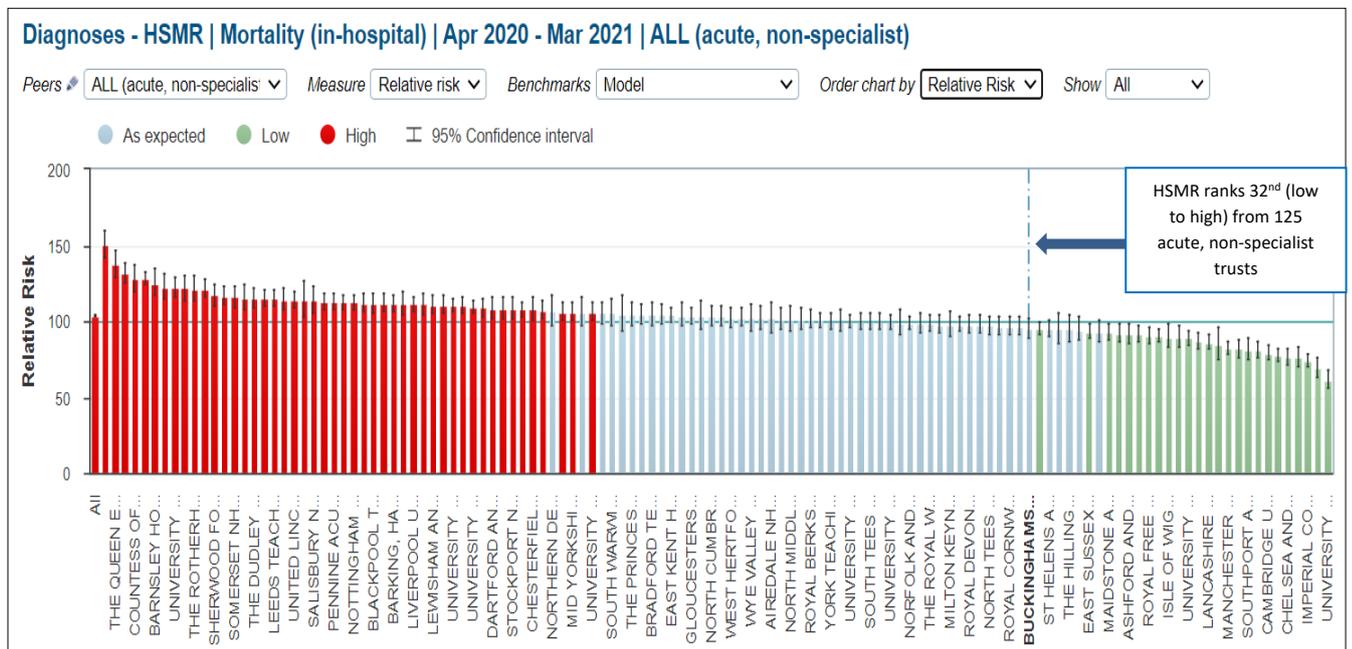
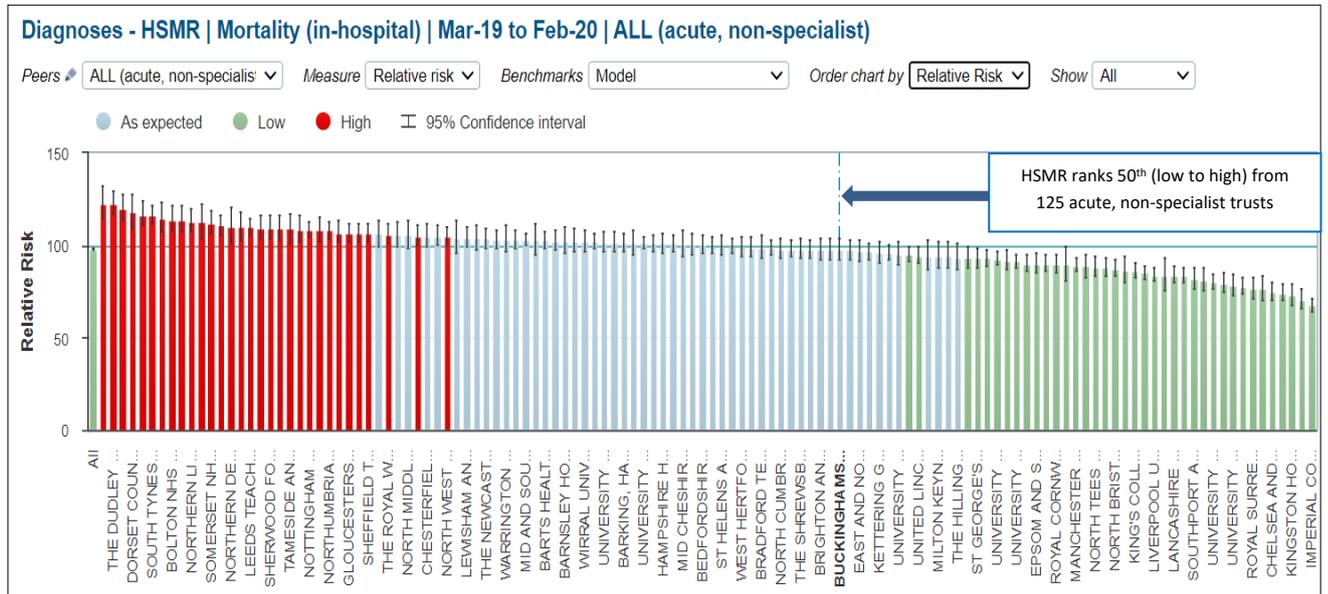


Figure 3 - HSMR volume (super-spells) Covid-19 'No' vs Covid-19 'Yes' (rolling 12 months).

The charts below show HSMR rank vs national peers (acute, non-specialist) prior to the pandemic (Mar-19 to Feb-20) and the latest data period (Apr-20 to Mar-21).

If HSMR values are ranked nationally (acute, non-specialist trusts) the Trusts HSMR position is currently better than the last pre-pandemic 12-month period. This may reflect the growing number of low Covid-19 months post second peak in Jan-21, the data quality improvements recently initiated and the re-submission of data via the SUS portal.



Crude mortality within the HSMR basket peaks at 5.7% in Apr-20 during the first wave of the pandemic and then peaks at 4.6% during the second wave in Jan-21.

April-20 (1382 super-spells) and May-20 (1667 super-spells) have the lowest volumes within the HSMR basket during this period (figure 4).

The number of super-spells (denominator) fell and our crude rate increased due to the increase in mortality (numerator) associated with Covid-19.

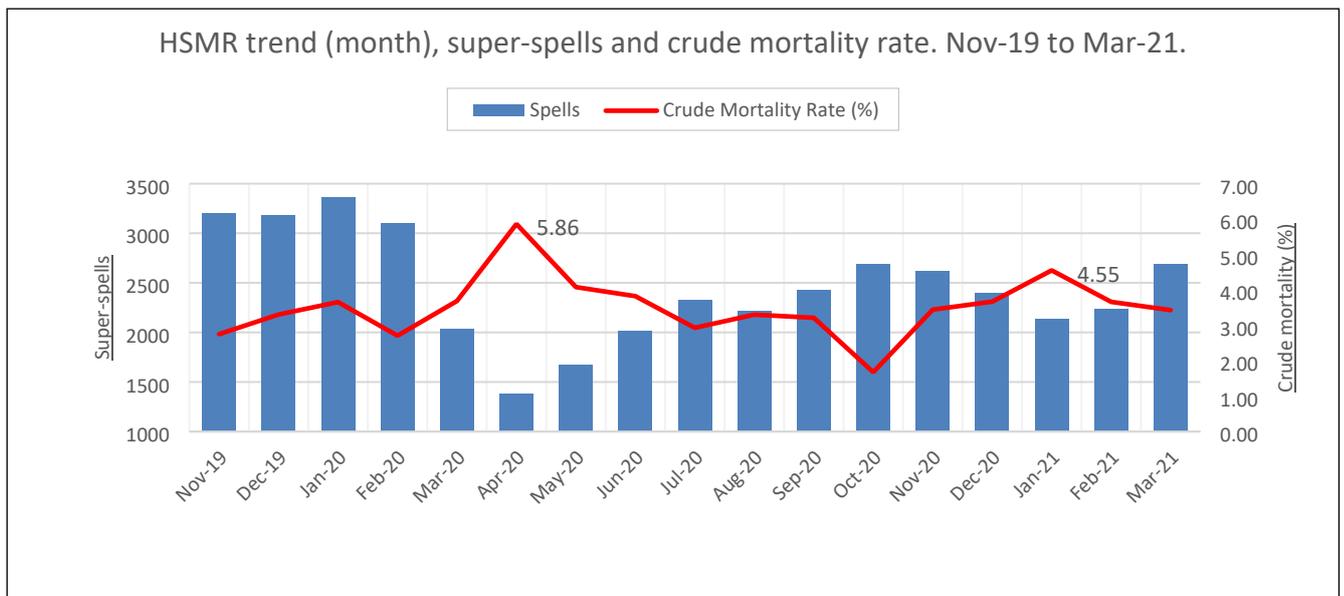


Figure 4 – HSMR Trend (month) Nov-19 to Mar-21

#### 4 COVID-19 Analysis

Dr Foster were commissioned to provide a detailed data analysis to identify potential risk factors leading to a hospital admission due to COVID-19 and the subsequent risk of having to be treated in critical care or risk of mortality. The analysis received so far is below:

The second wave of COVID-19 begins earlier (mid-October) and the January peak is much more significant with nearly 30% of all super-spells in this month having a primary or secondary Covid-19 diagnosis compared with 12% nationally (acute, non-specialist trusts) (figure 5).

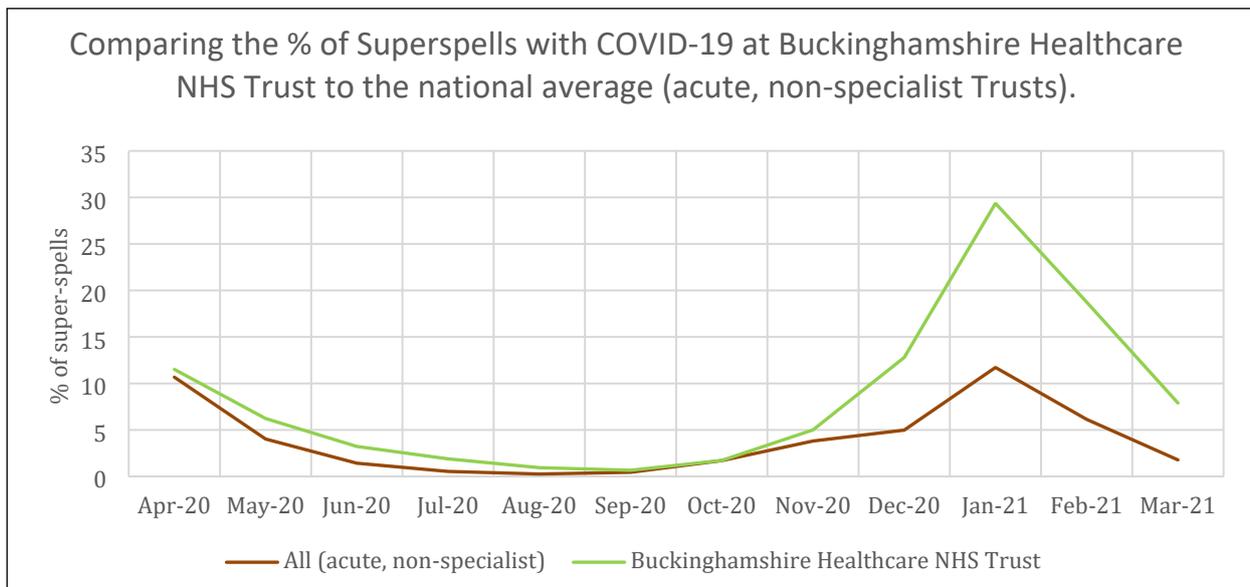


Figure 5 – Proportion of Super-spells (all diagnosis) with Covid-19 vs National (trend month). Apr-20 to Mar-21.

## Weekly trend of the number of Covid-19 patients

### Inclusion criteria

- Admitted patients who tested positive for COVID-19 (defined by the presence of U071 coded in the last episode of spell or a positive test within 2 weeks of the admission).

### Summary

- There is a recent rise in cases at the trust as part of the third wave however, this rise is not reflected in hospital deaths. Since the last refresh there have been 41 more cases recorded and 1 more death.
- The mortality rate for all Covid-19 positive patients admitted to the Trust is 23% (CI:21.16%24.91%). Split by first and second wave the crude mortality rates were 31% and 21% respectively.

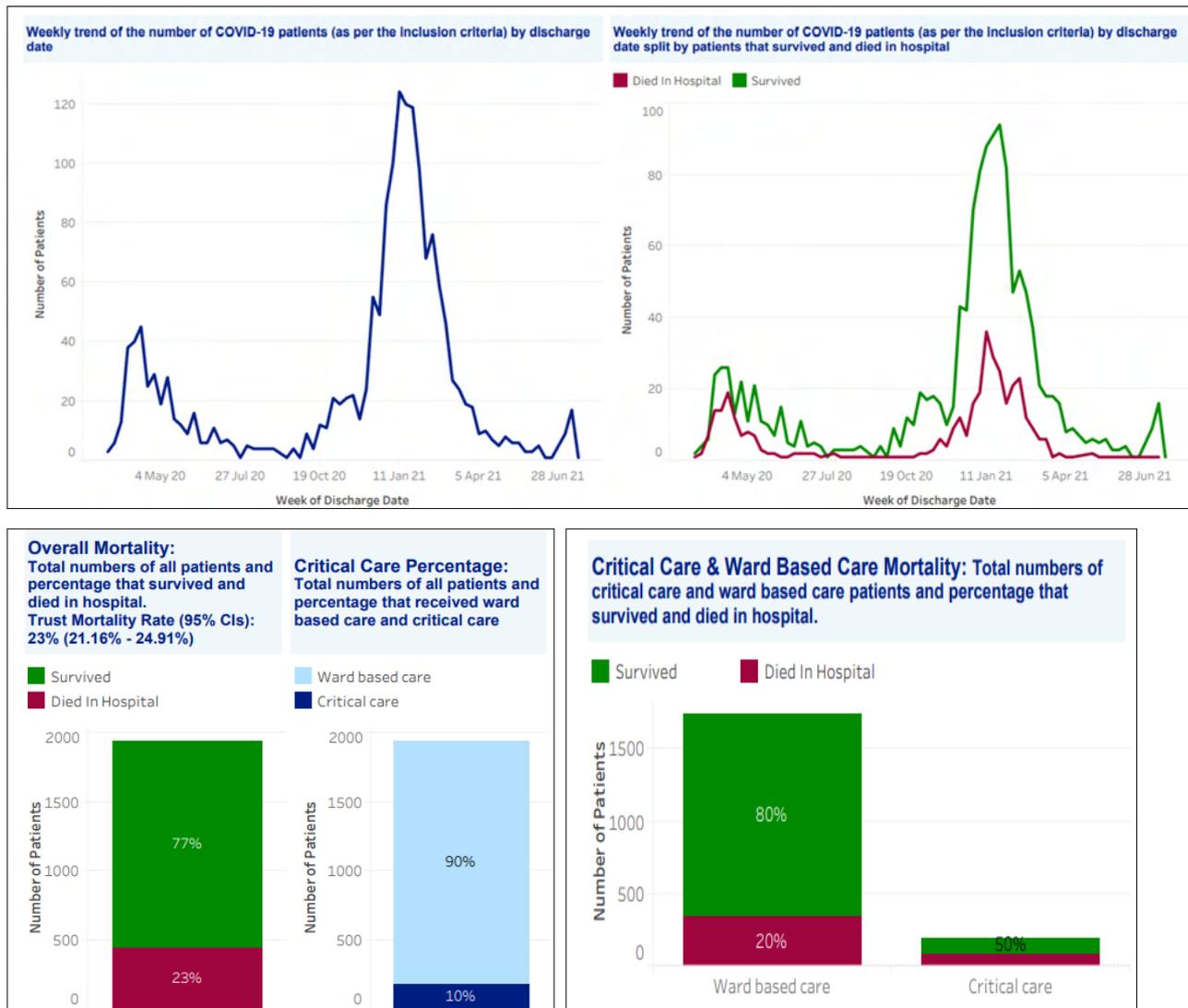
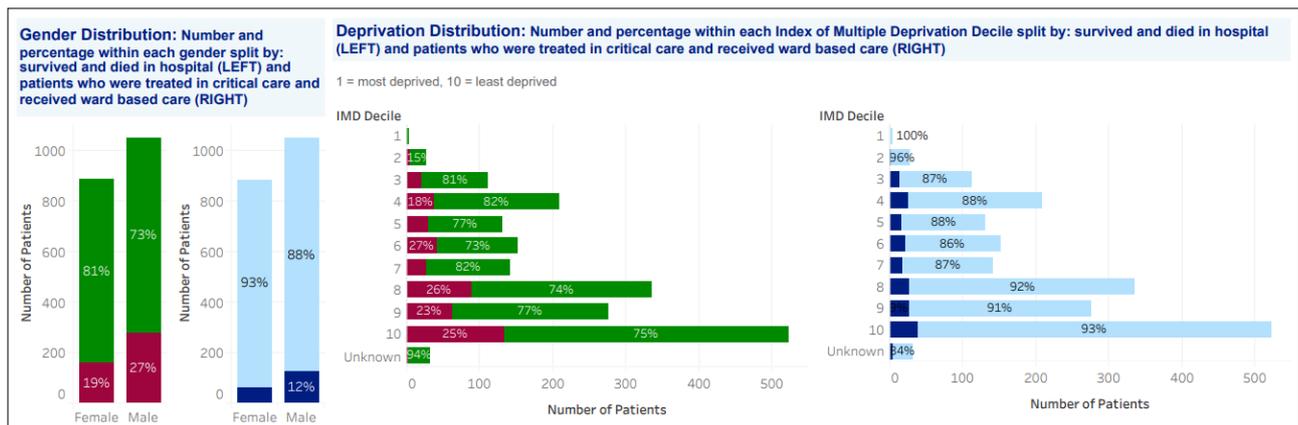
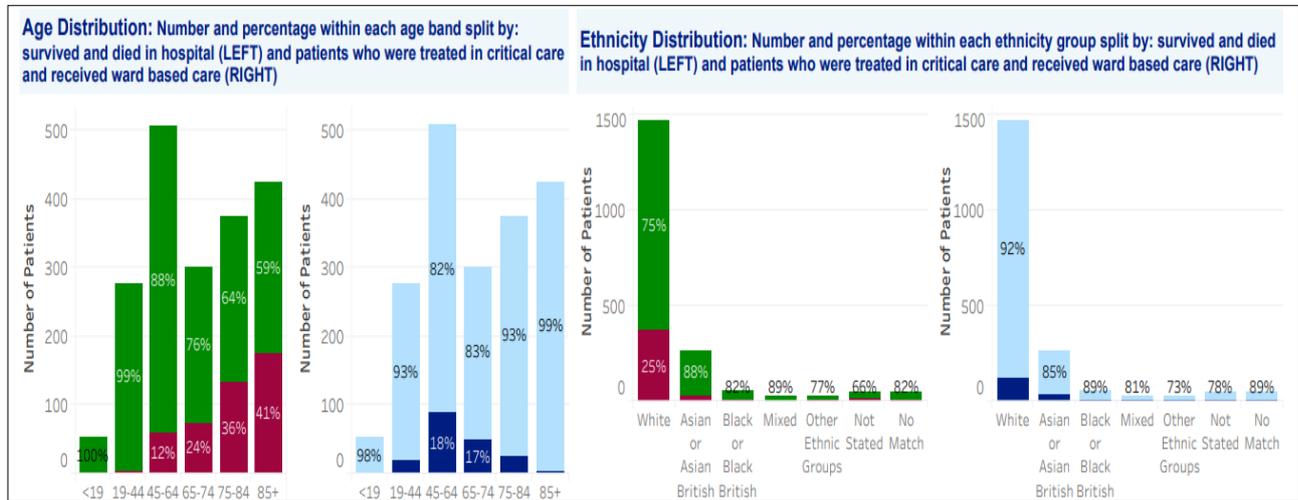


Figure 6 – Weekly trend of the number of Covid-19 patients.

## Patient Demographics and National Comparison.

- The mortality rate increased with each increasing age group up to 41% in the 85+ group.
- The mortality rate for males (27%) was significantly higher than that for females (19%).
- The proportion of in hospital deaths that were male was 4% greater at the trust (63%) compared to nationally (59%).
- Most patients were in the white ethnicity group in which the mortality rate was 25%. The next largest ethnicity group was Asian or Asian British where the mortality rate was 12%.

- There was a smaller proportion of BAME and ethnicity unknown in hospital deaths at the trust (17%) compared to nationally (21%).
- The population at the trust was skewed towards the lesser deprived IMD Deciles-with 27% of all patients in the cohort, in the least deprived decile. The group with the highest crude mortality rate (27%) was IMD Decile 6.



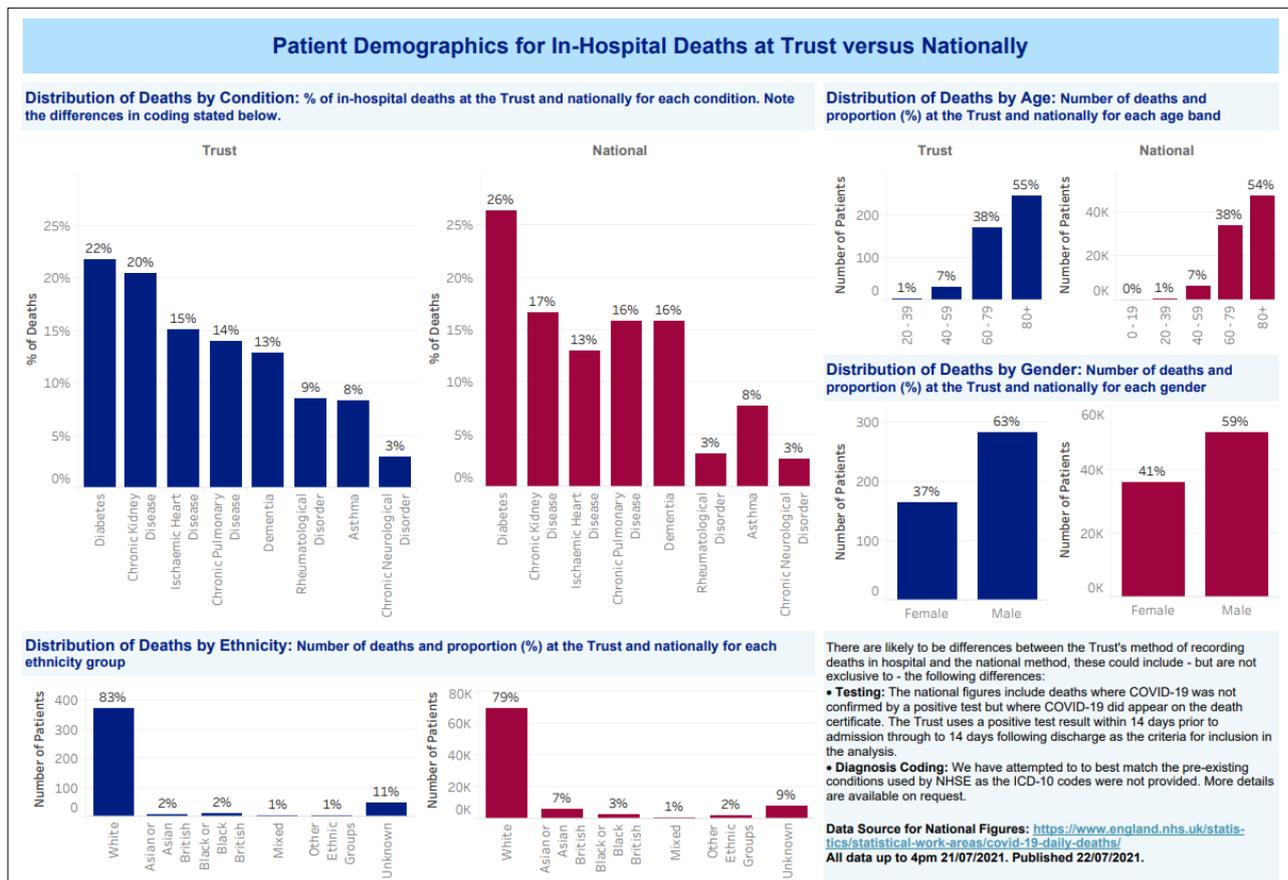


Figure 7 – Patient Demographics and National Comparison.

### Comorbidities and National Comparison

- The most frequently recorded comorbidity was hypertension which accounted for 31% of patients with COVID-19 and diagnosis coding. The next most prevalent conditions were chronic endocrine conditions (mostly consisting of patients with diabetes), chronic respiratory diseases and chronic heart diseases: 25%, 18% and 17% of all COVID-19 positive cases respectively.
- Understandably, the group with the highest mortality rate (84%), was palliative care. 214 out of 446 deaths (48%) were accounted for by patients who were recorded as palliative care. NB: These patients may have received specialist palliative care for the first time during the course of the admission. The greater the count of diagnosis groups, the higher the mortality rate at the trust.
- The next highest mortality rates at the trust (from groups of size >25 patients) were chronic kidney disease (41%), cancers of the blood and bone marrow (40%) and chronic heart disease (38%).
- The distribution of deaths by condition was similar at the trust compared to nationally for all conditions (4% difference or less) except for rheumatological disorders where the trust had a greater proportion: 9% compared to 3% at the trust. Analysis suggests that this may be due to the slightly higher than average number of CXovid-19 deaths in the 80+ age group.

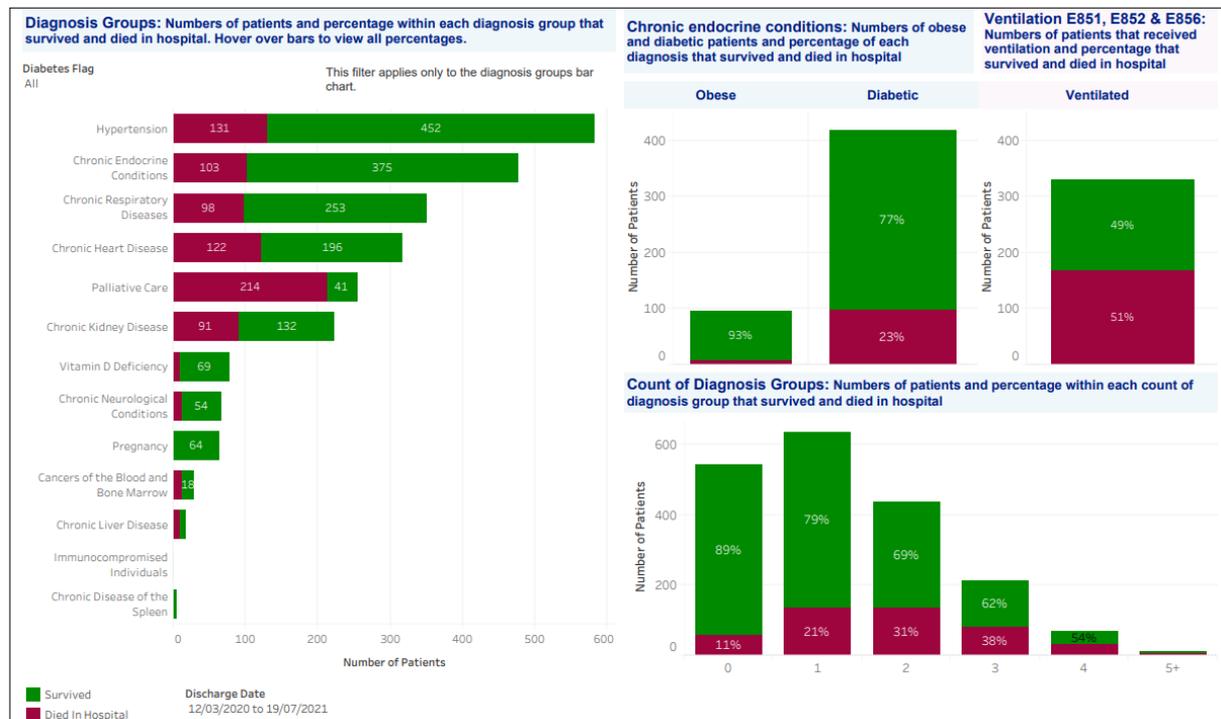


Figure 8 – Comorbidities and National Comparison

## Overall Mortality & Ventilation Breakdown. First Wave vs. Second Wave.

### Inclusion criteria

- In previous analyses ventilation codes have been based on the final episode in the spell only however changes have been made from the 4th refresh onwards to reflect ventilation codes across all episodes within the spell.

### Hierarchy

- Patients are split into the 4 ventilation groups using a hierarchy so that patients are only counted once across the groups. This means that if a patient had an invasive ventilation code then that will trump use of any other ventilation codes that were additionally used. Next we look for CPAP which will trump the use of non-invasive ventilation and so on.

### Summary

- 17% of patients (n=329) were recorded as having received ventilation and of those that did, 51% died in-hospital.
- The proportion of patients that received invasive ventilation in the first wave; 10%, was double the proportion that received invasive ventilation in the second wave; 5%.
- There was a higher proportion of patients in the second wave recorded as receiving oxygen therapy– other specified; 18%, compared to the first wave; 11%.
- The mortality rate in the non-invasive ventilation group was much greater in the first wave (56%) compared to the second wave (27%).
- The mortality rate in the invasive ventilation group was much greater in the second wave (73%) compared to the first wave (51%).



Figure 9 – Overall Mortality & Ventilation Breakdown. First Wave vs. Second Wave.

## Testing and Healthcare Associated COVID

- The majority of patients received a positive test result early on in their admission although the result date was not recorded for 295 patients.
- 17% of all patients fell into either the 'probable healthcare associated COVID 'or' definite healthcare associated COVID groups.

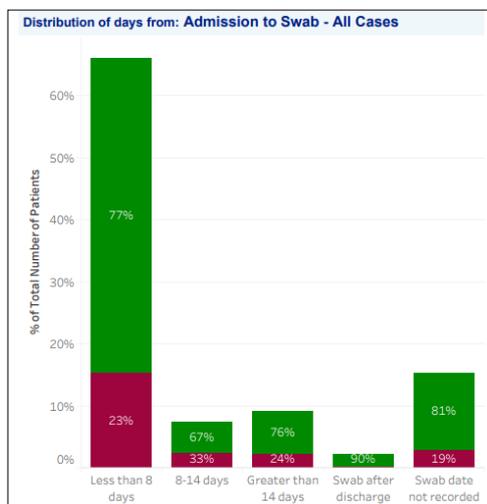


Figure 10 – Testing and Healthcare Associated COVID

## 5 ICNARC

ICU COVID-19 Second Wave Mortality and ICNARC data - October 2020 to June 7, 2021.

Patients were taken to ICU when it was felt that the chance of needing invasive ventilation soon was high, or when it was felt that ICU could offer an environment for optimised non-invasive ventilation, for example in patients having trouble with tolerating the mask. The difficulty in predicting the right time to come to ICU meant that some were admitted but then didn't need invasive ventilation, but some were brought late and had a hurried intubation (the

procedure during which the patient is put on the ventilator) on arrival or even on the ward prior to admission. Patients whom had multiple comorbidities which meant a low likelihood of surviving invasive intubation were kept on the Respiratory Unit for ward-based care.

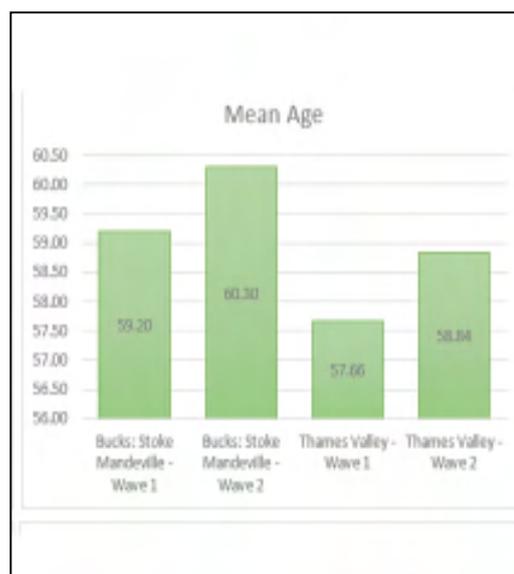
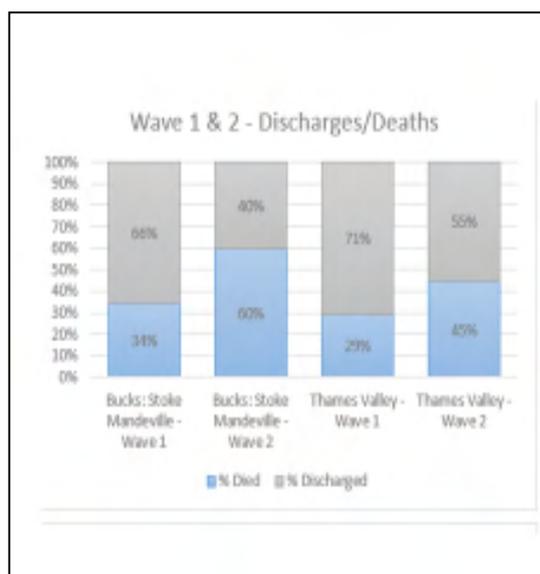
It should be noted there is inherent difficulty comparing data from different units due to different set-up of ward/HDU/ICU facilities. Trigger for admission varied across units and other units were able to do a bigger proportion of their non-invasive (tight mask) ventilation on the ICU or a high-dependency unit. If we had been more stringent about age and co-morbidities when considering ICU admissions, we could potentially have taken patients earlier, however there was no evidence to support this approach, would have been ethically challenging and not in line with the BHT Pandemic Ethics Framework.

Several patients who were weaning and stable were moved to Wycombe from Stoke. This explains the short duration for survivors at Stoke and longer duration for survivors at Wycombe. Where numbers don't add up it's because there were patients still in the ICU at the time of data collection (figure 11).

COVID-19 wave 2					
Unit	No. Pts	Discharged	Died	Duration (Days)	
				Survivors	Non. Surv
Bucks: Stoke Mandeville	105	42 (40%)	62(59%)	7	13
Bucks: Wycombe	26	14 (54%)	11 (42%)	37	19
Thames Valley	711	388 (54%)	313 (44%)	16	14

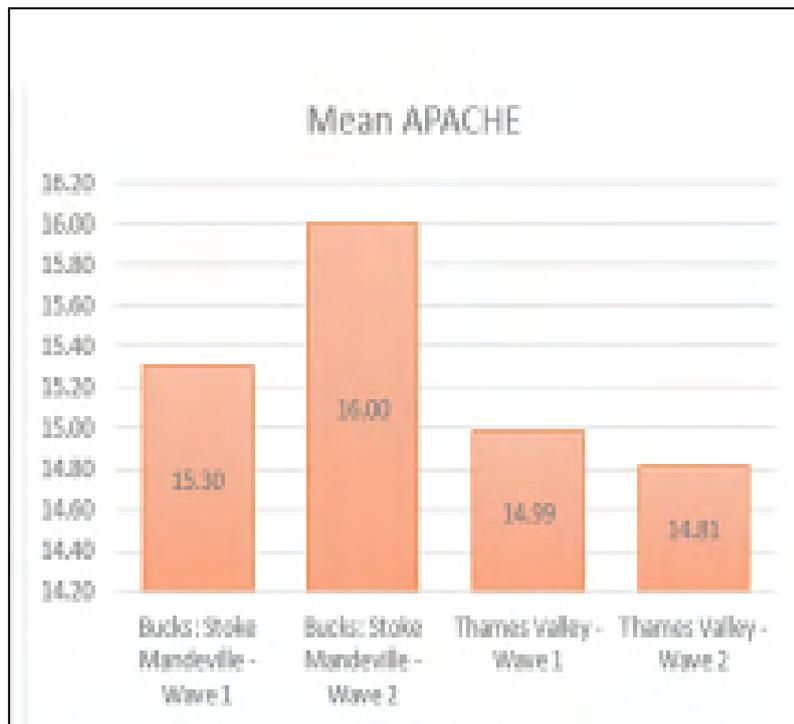
Figure 11

On average, patients in Bucks ICUs were older than the rest of the region. Given the very large increase in mortality between the ages of 55 and 65yrs this difference is significant. (figure 12a below).



Also patients in Bucks ICUs were on average more unwell than the rest of the region as judged by a higher APACHE score. Without COVID, an APACHE score of 14 suggests a mortality rate of around 15% where a score of 16 this is closer to 30%.

Figure 12b



Many of the patients at Wycombe started at Stoke Mandeville and were transferred for capacity reasons. This meant that they were a group more likely to survive (figure 13).

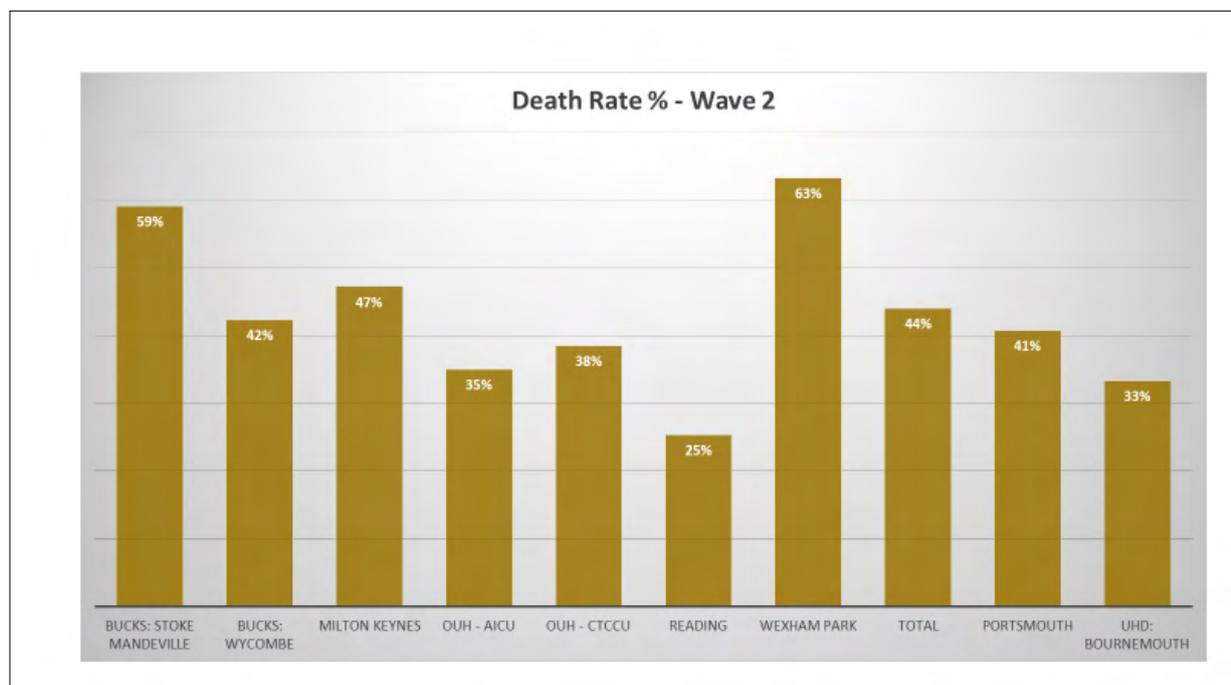


Figure 13

Figure 14 shows crude mortality as a percentage. A very high proportion of patients were ventilated. Patients were on higher amounts of oxygen than any other centre at the time of admission to ICU, suggesting they came to ICU later than they did at other trusts.

Wave 2	Adv. Resp. Support	Adv. Cardio Supp.	Renal Support	< 13.3 kPa	13.3-26.6 kPa	> 26.7 kPa
<b>Bucks: Stoke Mandeville</b>	<b>73%</b>	<b>26%</b>	<b>27%</b>	<b>73%</b>	<b>20%</b>	<b>6%</b>
<b>Bucks: Wycombe</b>	<b>92%</b>	<b>23%</b>	<b>23%</b>	<b>69%</b>	<b>19%</b>	<b>12%</b>
Milton Keynes	67%	15%	11%	64%	25%	6%
OUH - AICU	78%	41%	24%	49%	42%	6%
OUH - CTCCU	77%	43%	37%	48%	37%	9%
Reading (lowest mortality)	<b>51%</b>	73%	16%	<b>41%</b>	46%	12%
Wexham Park	88%	40%	35%	56%	42%	1%
Thames Valley and Wessex Total	60%	26%	18%	48%	39%	8%

Figure 14

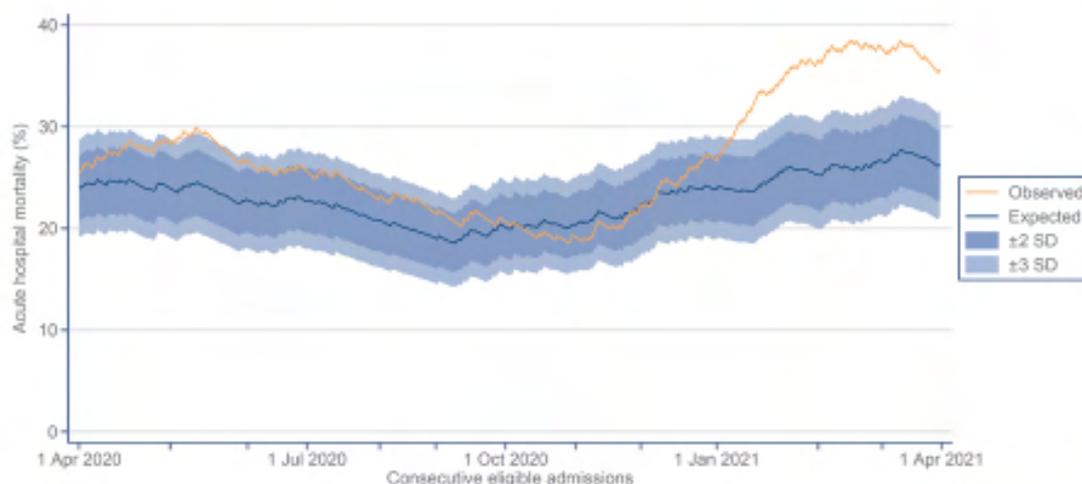
ICU survivors appeared to remain on ICU for less time, but this is partly because we transferred the more stable, weaning patients to Wycombe. Those who died had a similar duration of stay to elsewhere in the region, suggesting we didn't withdraw high-level care sooner than elsewhere did (figure 15).

Wave 2	Number	Died	Length of stay		BMI >30	Mean APACHE	Mean Age
			Survivors	Non-Survivors			
SMH	105	62	7	13	50%	16	60
JR AICU	123	43	14	15	48%	15	58
MK	72	34	7	12	63%	14	53
Thames Valley	711	313	16	14	48%	15	59

Figure 15

Figure 16 is an EWMA plot so it is likely this curve will come back towards the upper end of the +2SD zone in due course. This is partly due to patients surviving beyond the date of this data collection and partly due to the nature of EWMA which is designed to magnify recent trends. ICNARC scores predict death in COVID-19 poorly meaning that standardizing mortality using this score is problematic.

### Risk-adjusted acute hospital mortality (EWMA plot)



#### Explanation

- The Exponentially Weighted Moving Average (EWMA) plot shows the trends in observed and expected acute hospital mortality in your unit for the time period of the report
- Expected acute hospital mortality is calculated from the ICNARC<sub>2019-2021</sub> model
- The plots are updated after each consecutive eligible admission and points are 'exponentially weighted' – giving a larger weighting to the most recent admissions to smooth the appearance of the lines
- The blue shaded areas of the plot represent 2 and 3 standard deviations (SD) above and below the expected line
- If the observed line is above the blue shaded areas, this means the observed acute hospital mortality is significantly higher than expected
- If the observed line is below the blue shaded areas, this means the observed acute hospital mortality is significantly lower than expected

Date of report: 27/05/2021

15

©ICNARC 2021

Figure 16

#### Summary

- Bucks average ICU patient mean age was significantly higher than the mean for the region. 8 years higher than MK, and 2 years higher than the mean.
- Bucks ICUs took patients later, when they were more unwell, both in terms of hypoxia and systemic upset, than other centres.

#### Learning

Would earlier admission to ICU have improved outcomes? Potentially, optimised NIV on ICU could have prevented the need for mechanical ventilation. This would potentially allow greater ability to optimise masks, maximise attention to patient positioning/proning, allow more frequent and complex observations to be taken and to spot deterioration sooner. This would have required more nursing staff

Split-site ICU meant more ambulance transfers of very unwell patients than other trusts. Whilst we tried to transfer only the most stable patients, a 30 minute journey in an ambulance on a ventilator represents risk. It also takes trained staff away from the ICU for several hours.

## 6 Next Steps

### ICNARC

When ICU capacity allows, patients with COVID-19 should be considered for ICU admission at an earlier stage in their illness to facilitate optimised respiratory support and closer observation.

## **HSMR**

There is currently an internal audit on HSMR coding which is being undertaken by RSM to provide assurance on:

Documented policies and procedures/guidance is in place relating to mortality indicator coding which are in line with the Clinical Coding Guidance.

- How staff awareness is raised e.g. through the sharing of pamphlets to ensure accurate coding.
- Whether processes have been established to ensure that mortality coding is taking place in a timely and effective manner.
- The depth of coding, and whether the underlying cause of this is multiple comorbidities or errors/discrepancies in the coding process.
- The processes in place, including only Senior Clinicians coding those that can have the biggest impact on the HSMR to help ensure accurate coding.
- Whether the clinical and coding teams are liaising to ensure that coding is accurate.
- The completion of data quality audits to review the quality and robustness of coding data. Where weaknesses are identified action plans are put in place to rectify these.
- Whether deep dives are undertaken on all deaths to ensure correct coding, including input from the Medical Examiner Team.
- The monitoring and review of cases by the Mortality Review Group to ensure accurate coding. We will attend a meeting to assess the functioning of this forum.
- Whether there is appropriate reporting and scrutiny of HSMR metrics throughout the Trust, including scrutiny of the timeliness and accuracy of coding.

The following limitations apply to the scope of our work:

- We will not confirm the accuracy and appropriateness of mortality coding, only that effective processes are in place to ensure this.
- Our testing will be on a sample basis only.
- The results of our work are reliant on the quality and completeness of the information provided to us.

## **7 Action required from the Board/Committee**

For assurance

**Meeting:** Trust Board Meeting in Public

**24 November 2021**

<b>Agenda item</b>	BHT Non-Covid Harm
<b>Board Lead</b>	Mr Andrew McLaren, Chief Medical Officer
<b>Type name of Author</b>	Dr Syed Hasan
<b>Report attached</b>	Report attached – Harms Paper for Board
<b>Purpose</b>	Assurance
<b>Previously considered</b>	EMC August 2021, Quality & Clinical Governance October 2021

### Executive Summary

Patients are waiting for a longer period for elective procedures, diagnostics & clinic appointments. A process is in place to keep track of these patients and ensure that they do not come to harm.

There is a System-wide Harms Group monitoring and mitigating the risk of harm. BHT works very closely with this group.

Patients on waiting lists are being actively classified according to Royal College of Surgeons criteria, arrangements are in place to get their procedures done at the earliest and a Hidden Harm Report prepared.

Measures put in place to identify non-Covid harm through our Datix system are reported and show evidence of harm.

This paper was discussed at Quality and Clinical Governance Committee on 20 October 2021. The Committee took assurance from the paper and, through discussion, noted a potential harm to children and young people due to a lack of access to children's services. This will be included in ongoing discussions with the CCG.

<b>Decision</b>	The Board is requested to take consider, take assurance from and approve this plan to mitigate and monitor non-Covid Clinical Harm Risk
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### Relevant Strategic Priority

<b>Outstanding Care</b> <input checked="" type="checkbox"/>	<b>Healthy Communities</b> <input checked="" type="checkbox"/>	<b>Great Place to Work</b> <input type="checkbox"/>	<b>Net Zero</b> <input type="checkbox"/>
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### Implications / Impact

<b>Patient Safety</b>	Make sure that patients do not come to harm while on the waiting list.
<b>Risk: link to Board Assurance Framework (BAF)/Risk Register</b>	To keep sight of evidence of harm and prioritise resources according to needs.
<b>Financial</b>	Will require additional resources to build capacity for this work
<b>Compliance NHS Regulation</b> <small>Select CQC standard from list.</small>	Compliance with NHSEI guidance.
<b>Partnership: consultation / communication</b>	CCG, ICP, Public Health

<b>Equality</b>	When reviewing non-Covid harm we remain mindful of risk that disadvantaged groups may be disproportionately affected and incorporate this into our thinking about how Recovery takes place
<b>Quality Impact Assessment [QIA] completion required?</b>	No

## 1 Introduction/Position

Covid-19 has led to delays in pathways creating risk of harm particularly Waiting List Patients:

There are patients waiting for:

- Elective procedures
- Diagnostics
- Clinic reviews

## 2 Problem

While these patients are on the waiting lists there is a risk they may come to harm. Hidden harms Review has shown that disease has progressed including cancer and there have been other adverse consequences.

## 3 Possibilities

Patients on elective list are being categorised according to a Royal College of Surgeons criteria and capacity is being built to do the procedures for them at the earliest. Patients waiting for diagnostics are also being categorised. Patients waiting for clinic appointments have been written to.

At the same time group has been set up to monitor and report on harms and a first Hidden Harms Report has been done.

## 4 Proposal, conclusions recommendations and next steps.

Harms Group will continue its work. Harms Audit will be repeated in 3 months. Identified risks will be managed via the DOC. SDUs will be supported to come up with mitigations for their pathways. Report Back to EMC in 6 months.

## 5 Action required from the Board/Committee

- 5.1 The Board is requested to consider, take assurance from and approve this plan.

## **BHT Non Covid-19 Harm**

Covid-19 has put a strain on almost all clinical pathways. Delays in pathways creates risk of harm. In this report, we will:

1. Identify areas of risk of harm
2. Quantify the harm and identify where the maximum risk is.
3. Measures being put in place to prevent harm

### **Waiting List Patients:**

There are patients who are waiting for:

- Elective procedures
- Diagnostics
- OP reviews

### **Elective Waiting List:**

Royal College of Surgeons (July 2020) developed “P” Categories for these patients.

<b>Code</b>	<b>Description</b>
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 whose condition is more stable.

These are included in IPR & reported to EMC, F&BP & Trust Board.

Any delay in P1 beyond 72 hours are escalated

P2s are reviewed at APMG and list allocation adjusted to ensure early surgery

After P1 & P2, anyone waiting over 104 weeks is booked.

Delayed patients on the admitted waiting list received communication in January 2021

Delayed patients on the non-admitted waiting list received communication in April 2021

Clinical Contact: Clinicians contacted patients waiting for elective procedure for more than 90 weeks (around 4 months ago). Approximately 100 (mostly orthopaedic) patients were contacted.

Up to date information re: P:

Row Labels	Count of Clinical P Category	% categorised	
		Total	
P2	635		
P3	2000		
P4	4317		
(blank)			
Grand Total	6952	7138	97.39%

In a significant number of cases patients chose to delay (P5: delay because of Covid-19 related causes like concern about coming to hospital & P6: reasons other than Covid-19).

Decision to offer this group 3/52 and a choice of two dates. If not taken up they will be discharged back to their GP. P5 & P6 over 99 weeks have been cleared now.

List on Medway is updated every night based on risk matrix.

### Waiters for Diagnostics:

D categories. Same as P categories.

To date we only intend to submit Endoscopy modality and only those on an active diagnostic waiting list (not surveillance) – 1367 are categorised.

365 D2s

1002 D3s

D1	Under 72 hours. Usually inpatients
D2	2 WW. e.g. Biopsy of lumps
D3	Routine (e.g. OGD)
D4	Surveillance

### Bucks ICP Non-Covid Clinical Harms Steering Group:

Multi-disciplinary clinical harms group. Aim is to take a system-wide oversight of non-covid clinical harms and make recommendations. Have found gaps in the system and been able to link right people up to close these gaps. (Substance Misuse is an example; group discussion problem solved and connected the right people).

Attended by colleagues from HPFT, BHT OHFT, Primary Care, and other ICP partners such as Public Health. Looking at themes from harms and making recommendations to the overarching Bucks Delivery Board around areas of focus.

Had presentations from an AI company: use of AI could be helpful in terms of priority setting for those on the waiting list. This has been raised with NHSE/I. waiting to hear back from surgeons.

No integrated way across system to monitor harms proactively, and the Group made a recommendation to procure and develop a system harms/risk management system that all agencies could use. Also explored existing internal systems but has not got very far due to other factors (Covid being one of them). Looked at the possibility of using Graphnet but other priorities have taken precedent.

Need to:

- Look at an ICS integrated Risk Management System that all partners can utilise.
- Explore use of AI to proactively map population and identify priority areas of focus with our limited challenged resources.

### **NHSEI Questions - Review of Harms**

Earlier in the year NHSEI undertook a regional Harms Review project.

This review's first phase included a mappings exercise to understand processes / SOPs used by providers.

For this they asked following questions from providers in BOB.

In phase two, this will be used to complete a regional analysis, aiming to share successes across the region.

#### **Is the CHR used a systemwide process, utilised by all providers or provider specific?**

BHT activity is based on NHSE advice/Royal College Standards and agreed with the Recovery Board for the Bucks ICP. The principles should be the same as those applied nationally, but our precise processes may differ, we have not liaised with peers.

#### **When were CHRs commenced?**

At the start of the pandemic when elective surgery was paused all 7000 patients on the elective waiting list were reviewed and categorised for urgency.

#### **Which pathways does the CHRs cover?**

Any and all pathways for elective treatment

#### **Has prioritisation of pathways for CHRs been established, if so how, using which guidance?**

There are patients who are waiting for:

- Elective procedures
- Diagnostics
- OP reviews

All pathways are addressed equally. Prioritisation of individual response is based on the impact identified by the harm reviews.

#### **Does the CHRs cover all settings, i.e. inpatient, outpatient, diagnostics?**

In-patients, patients awaiting elective procedures and diagnostics. Not included are patients awaiting Outpatient clinic appointments.

**Where waits are high, are cohorts sampled for CHR?**

Data on services with large numbers of breaches is covered in Harm Review Group – there has been no random sampling to date

**Are CHRs proactive and/or reactive?**

Proactive.

**How are CHRs monitored, what is the governance in place?**

Harm review process has been developed within the Divisional teams and overseen by the Divisional Operations Committee. Harms are reviewed in the Quality and Patient Safety Group. Process overall overseen by CMO with quarterly reports to EMC

System level assurance via the Bucks Clinical Harms Steering Group. All reviews identifying Moderate or Major impact are discussed and where applicable subject to further investigation such as SI Process.

**What have been the challenges for systems/providers and successes with regards to implementation CHRs?**

Finding time to complete harm reviews of a suitable depth – especially once elective treatment was suspended because of Covid

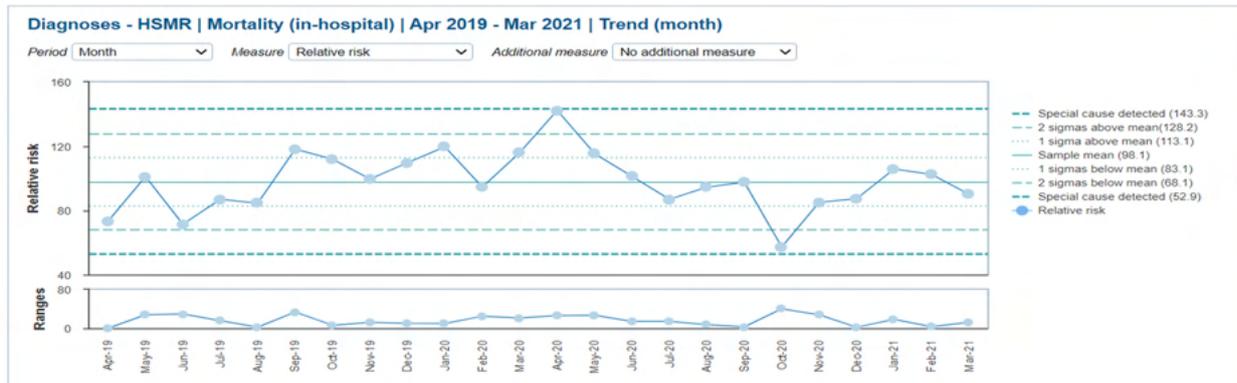
**Have any process/issues/training been implemented as a result of the CHR process?**

Letters to be sent regularly to patients on waiting list

## In Hospital Mortality

Using Dr Foster data analysis, since April 2020 when the HSMR peaked, it has settled into a more reasonable position hovering around 100 and more recently dropping to 95 (see graph A below):

Graph A



### Contributors to the HSMR:

1. Coding – a lot of work has gone into coding over the years and in this last year it came to light that there has been a problem with data transfer, which was impacting negatively on the HSMR. This has been resolved and resulted in a marked reduction in the HSMR as a result. Ongoing work is continuing to refine our coding and once the Trust gets fully electronic with inpatient clinical noting, this will help with more accurate recording of HRGs and comorbidities, impacting on the finances and the HSMR together. Coding Florence Nightingale admissions as non-elective has also had a positive impact on the HSMR.
2. Numbers of admissions (superspells) – during the first 2 peaks of Covid, non-Covid admissions reduced markedly as people were wary of coming into hospital. Over the last year this has picked up again (see graph B below) but not quite at the pre-Covid levels.

Graph B



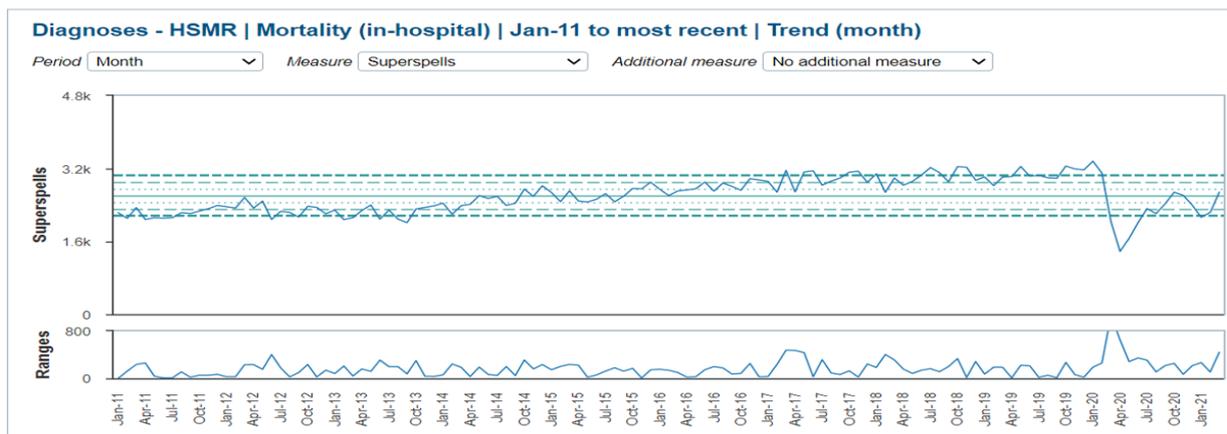
- Crude mortality (expressed as a percentage of total superspells) has remained higher than at pre Covid levels – shown in Graph C below.  
This is a reflection of a reduction of total spells with only the most acute patients being admitted and having a higher likelihood of death.

Graph C



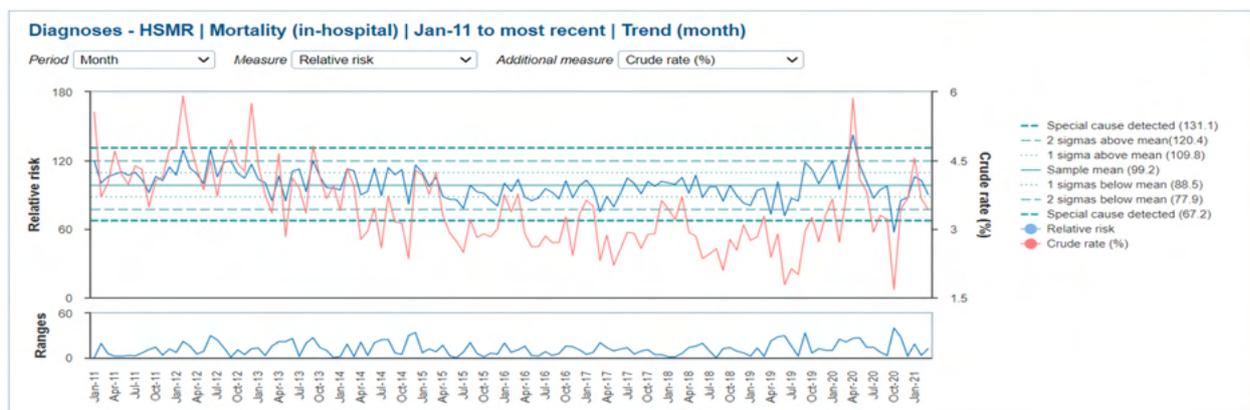
**Further graphs with longer time spells for interest**

Graph D - Trust activity – number of superspells (admissions) from Jan 2011 to date



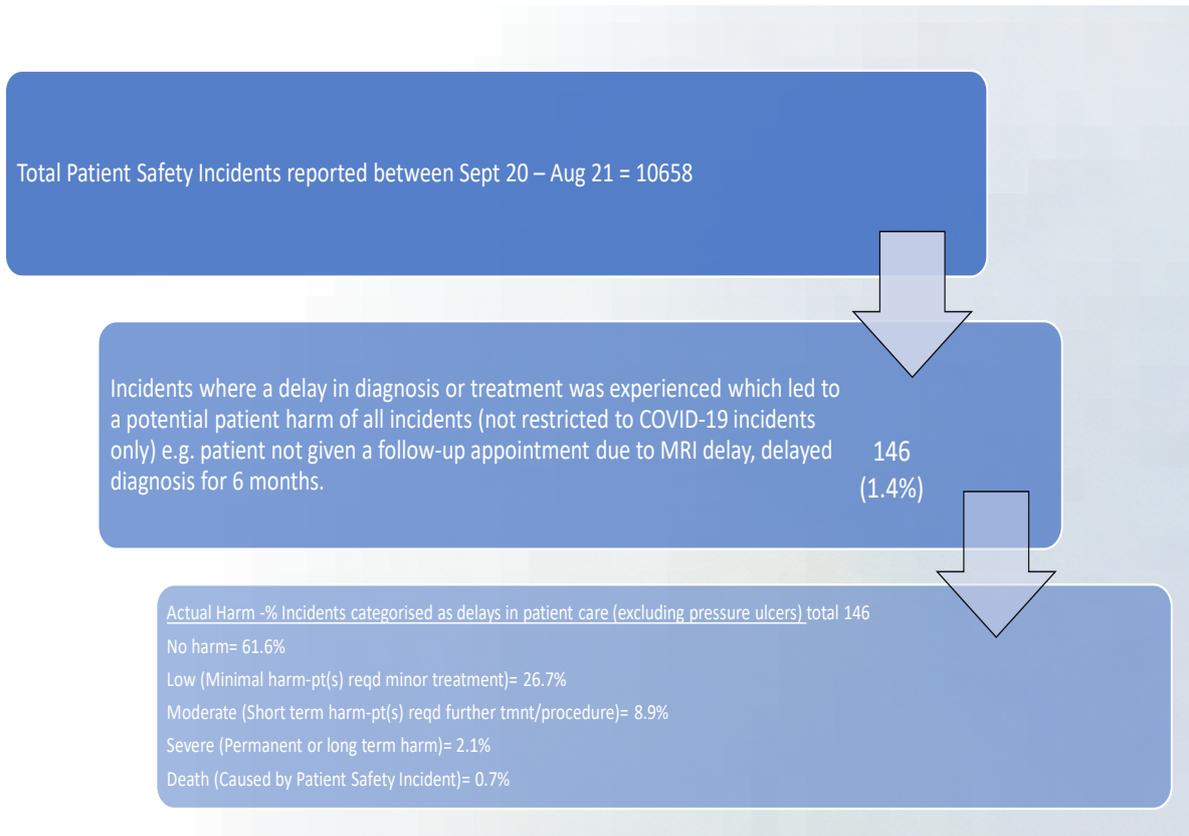
Note the significant drop in activity in April 20 which resulted in a large upswing of the crude rate and HSMR (seen on Graph E)

Graph E - Crude death rate (red line - % of total superspells) and HSMR (blue line)

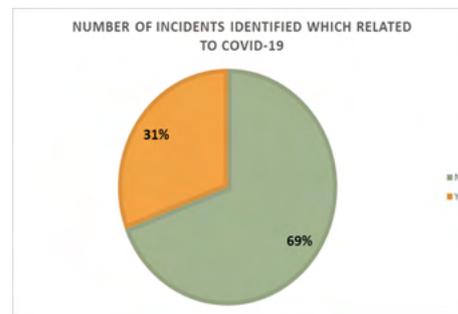
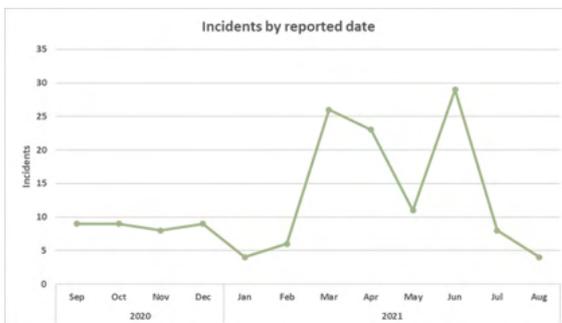


## Hidden harm report : Incidents where a delay in diagnosis or treatment was experienced which led to a potential patient harm

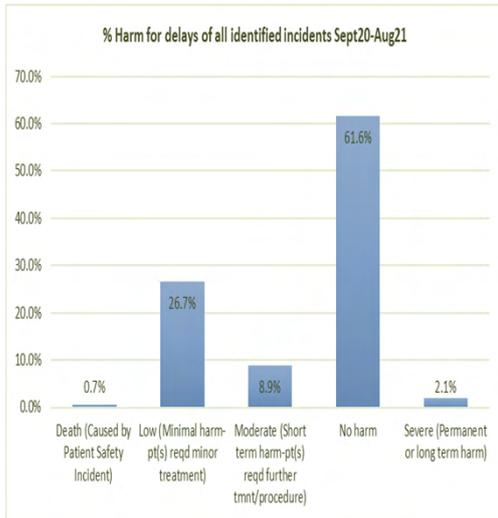
Data Source: Patient Safety Team  
Date: August 2021



Incidents where a delay in diagnosis or treatment was experienced which led to a potential patient harm of all incidents are reported on below. Total identified = 146.



Actual Harm	No harm (near miss)	Low (Minimal harm-pt(s) reqd minor treatment)	Moderate (Short term harm-pt(s) reqd further tmnt/procedure)	Severe (Permanent or long term harm)	Death (Caused by Patient Safety Incident)
Division of Corporate/Non Clinical Support Services	0	6	0	0	0
Division of Integrated Elderly & Community Care	8	1	0	1	0
Division of Integrated Medicine	19	13	2	0	1
Division of Specialist Services	8	4	1	0	0
Division of Surgery & Critical Care	33	13	10	2	0
Division of Women, Children & Sexual Health Services	22	2	0	0	0
<b>Grand Total</b>	<b>90</b>	<b>39</b>	<b>13</b>	<b>3</b>	<b>1</b>



Category Of Incident	% Incidents
Delay To Receive Appointment	22.6%
Procedure Delayed Due To No Covid Swab Results Availa	11.0%
Lost To Follow-Up-Other	11.0%
Antenatal Booking Lost	7.5%
Delay To Receive Community Services	6.8%
Lost To Follow-Up-Cancer	5.5%
Delayed Diagnosis-Cancer	5.5%
Delayed Treatment	4.1%
No Follow-Up Requested	3.4%
Delayed Diagnostic Results-Cancer	3.4%
Admin Error And Not Added To Waiting List	2.7%
Delayed Treatment Due To Diagnostic Error	2.1%
Delayed Diagnosis Due To Scan Results Not Actioned	1.4%
Delayed Treatment Due To External Factors	1.4%
Delay To Follow-Up- Cancer	1.4%
Delayed Procedure Due To Reduced Theatre Capacity	1.4%
Delay To Treatment-Cancer	1.4%
Delayed Referral To Health Visiting	0.7%
Delayed Treatment-Antenatal	0.7%
Delay To Receive Appointment-Cancer	0.7%
Delayed Diagnostic Results	0.7%
Delayed Diagnosis Due To Diagnostic Error	0.7%
Delay To Receive Appointment-Stroke	0.7%
Missed Diagnosis-#Nof	0.7%
Delayed Procedure-Cancer	0.7%
Delayed Salt Referral	0.7%
Delayed Treatment Due To Lack Of Clinic Space	0.7%
Delayed Procedure	0.7%
<b>Total Incidents Related To Long Wait/Delay</b>	<b>100.00%</b>

Confidential Case Study 1:

Mass noted on patients hand and referred by GP. Seen in clinic and MRI ordered however follow-up clinic appointment delayed due to Clinic cancelled due to pandemic and patient lost to follow-up.

Resulted in a delayed cancer diagnosis. Patient long term outcome unlikely to have been affected however this caused distress to the patient and family.

Total delay was 29 weeks

Harm rating = Moderate

Confidential Case Study 2:

Patient had past history of bowel cancer and was on the surveillance pathway requiring annual scans. The 2020 surveillance colonoscopy was delayed due to Covid-19.

When the colonoscopy was performed a large Caecal cancer was discovered which required the patient to have urgent hemicolectomy performed.

Total delay was 31 weeks

Harm rating = Moderate

Confidential Case Study 3:

Patient had steroid implant performed to eye. No follow-up appointment was made resulting in the dislocation of the implant due to inflammation. The procedure was required to be repeated.

The total delay was 5 weeks

Harm rating = Severe

**Going Forward:**

Non-Covid harm is going to be with us for some time. We need to make sure that we have plans in place with clear oversight and governance structure.

This initial report is highlights the ongoing risk in our waiting list and processes and needs further refinement and review in Divisional and Trust governance meetings. This report will be created every 3 months

This will be discussed at the DOC & cascaded to SDUs for specific actions.



**Meeting:** Trust Board Meeting in Public

**24 November 2021**

<b>Agenda item</b>	Use of the Trust Seal
<b>Board Lead</b>	Chief Executive Officer
<b>Type name of Author</b>	Elisabeth Jones, Senior Board Administrator
<b>Attachments</b>	N/A
<b>Purpose</b>	Information
<b>Previously considered</b>	None

### Executive Summary

The Board is asked to note the use of the Trust seal in accordance with Standing Orders (Sealing of Documents)

<b>Decision</b>	The Board is asked to note the information			
<b>Relevant Strategic Priority</b>				
<b>Outstanding Care</b> <input checked="" type="checkbox"/>	<b>Healthy Communities</b> <input checked="" type="checkbox"/>	<b>Great Place to Work</b> <input checked="" type="checkbox"/>	<b>Net Zero</b> <input type="checkbox"/>	
<b>Implications / Impact</b>				
<b>Patient Safety</b>	The use of the Trust Seal does not have an impact on patient safety			
<b>Risk: link to Board Assurance Framework (BAF)/Risk Register</b>	There are no relevant risks relating to the Trust Seal on the CRR or BAF			
<b>Financial</b>	The Trust Seal is used in accordance with the Trust Standing Financial Instructions and Standing Orders			
<b>Compliance</b> <small>Select an item. Select CQC standard from list.</small>	Meets the requirements of the Trust Standing Orders			
<b>Partnership: consultation / communication</b>	Not required			
<b>Equality</b>	The use of the Trust Seal does not affect Equality			
<b>Quality Impact Assessment [QIA] completion required?</b>	Not required			

## 1 Introduction

There have been 2 occasions since the last report to the Trust Board which has required the use of the official Trust seal:

No	Date of Sealing	Details
108	18 May 2021	Buckinghamshire Council and Buckinghamshire Healthcare Trust Lease of Land at former Bucks Sports and Social Club Lower Road, Aylesbury Bucks for staff parking  Signed by Chief Nurse and Director of Finance
109	22 July 2021	Engrossment Leases in respect of:  i) The land formerly comprising huts 1 and ii) Huts 3 and 4 at Paraplegic Sports Centre adjacent to Stoke Mandeville Hospital.  Underlease between the British Wheelchair Sports Foundation Limited and Buckinghamshire Healthcare NHS Trust.  Signed by Chief Nurse and Chief Operating Officer
110	30 September 2021	JCT Agreement Design and Build contract. This covers the second MRI Roof to be completed by end of November 2021.  Signed by Commercial Director and Director of Finance
111	11 October 2021	Lease of Office Outlet site, Queen Alexandra Road, High Wycombe (Staples Car Park) for duration of 12 months.  Signed by Commercial Director and Director of Strategy.
112	29 October 2021	Marlow Hospital – Marlow Medical Group Lease relating to ground floor annex premises, Marlow Community Hospital, Victoria Road, Marlow SL7 1DQ. Between Buckinghamshire Healthcare NHS Trust and Fedbucks Ltd.  Signed by Commercial Director and Director of Strategy.

In accordance with the Trusts Standing Orders:

### **8.5.2. Sealing of Documents**

*Where it is necessary that a document shall be sealed, the seal shall be affixed in the presence of two senior managers duly authorised by the Chief Executive, and not also from the originating department, and shall be attested by them.*

## 2 Action required from Trust Board

The Board is asked to note the use of the Trust seal in accordance with Standing Orders (Sealing of Documents).

**Meeting:** Trust Board Meeting in Public

**24 November 2021**

<b>Agenda item</b>	Board Attendance Record
<b>Board Lead</b>	Trust Board Business Manager
<b>Type name of Author</b>	Senior Board Administrator
<b>Attachments</b>	None
<b>Purpose</b>	Information
<b>Previously considered</b>	N/A

### Executive Summary

To keep the Board informed of the attendance of Board members at Board Meetings and Board Sub-Committees.

<b>Decision</b>	The Board is requested to note the contents of the report.
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### Relevant Strategic Priority

<b>Outstanding Care</b> <input checked="" type="checkbox"/>	<b>Healthy Communities</b> <input checked="" type="checkbox"/>	<b>Great Place to Work</b> <input checked="" type="checkbox"/>	<b>Net Zero</b> <input checked="" type="checkbox"/>
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### Implications / Impact

<b>Patient Safety</b>	Patient safety concerns are discussed by all members of the Board
<b>Risk: link to Board Assurance Framework (BAF)/Risk Register</b>	Board risks are discussed by all members of the Board
<b>Financial</b>	Financial information is presented and discussed by all Board members
<b>Compliance</b> <small>Select an item. Select CQC standard from list.</small>	Compliance information and concerns are presented when appropriate and discussed by all Board members
<b>Partnership: consultation / communication</b>	Not required
<b>Equality</b>	Equality, Diversity and Inclusion information and compliance is identified in all Board reports and discussed by members of the Board
<b>Quality Impact Assessment [QIA] completion required?</b>	Not required

Board Attendance Record: September to November 2021

	Strategic Workforce Committee		Finance and Business Performance Committee			Quality & Clinical Governance Committee			Organ & Tissue Donation Committee	Charitable Funds Committee	Audit Committee		Trust Board	
	13 Sep	8 Nov	21 Sep	19 Oct	16 Nov	22 Sep	20 Oct	15 Nov	2 Nov	No Meeting	2 Sep	4 Nov	29 Sept	27 Oct
Hattie Llewelyn-Davies Trust Chair *	✓	✓	✓	✓	x	✓	x	x					✓	✓
Neil Macdonald, Chief Executive Officer *			✓	x	✓	x	✓	x					✓	✓
Dipti Amin NED*						✓	✓	✓	✓		x	✓	✓	✓
Karen Bonner Chief Nurse *	✓	✓				✓	✓	✓			✓		✓	✓
Gavin MacDonald Interim Chief Operating Officer*				x	✓			x	x					✓
Nicola Gilham NED*			✓	x	✓						✓	✓	✓	✓
Mo Girach Associate NED						x	x	✓					x	x

	Strategic Workforce Committee		Finance and Business Performance Committee			Quality & Clinical Governance Committee			Organ & Tissue Donation Committee	Charitable Funds Committee	Audit Committee		Trust Board	
	13 Sep	8 Nov	21 Sep	19 Oct	16 Nov	22 Sep	20 Oct	15 Nov	2 Nov	No Meeting	2 Sep	4 Nov	29 Sept	27 Oct
Adrian Hayter Associate NED						✓	x	x					✓	x
Rajiv Jaitly NED *			✓	✓	✓						✓	✓	✓	✓
Barry Jenkins Director of Finance*			✓	✓	✓						✓	x	✓	✓
Mark Johnson Board Affiliate	x	✓											✓	✓
John Lisle NED *			✓	✓	✓						✓	✓	✓	✓
Andrew McLaren Chief Medical Officer *			x	✓	✓	x	✓	✓	✓				✓	✓
Bridget O'Kelly Chief People Officer	✓	✓			✓								✓	✓
Tom Roche NED*	✓	✓	x	✓	✓						✓	✓	✓	✓
Sandra Silva Board Affiliate	✓	✓				x	x	✓					✓	x

	Strategic Workforce Committee		Finance and Business Performance Committee			Quality & Clinical Governance Committee			Organ & Tissue Donation Committee	Charitable Funds Committee	Audit Committee		Trust Board	
	13 Sep	8 Nov	21 Sep	19 Oct	16 Nov	22 Sep	20 Oct	15 Nov	2 Nov	No Meeting	2 Sep	4 Nov	29 Sept	27 Oct
David Williams Director of Strategy & Business Development			x	✓	✓						✓		✓	✓
Ali Williams Commercial Director			✓	x	✓								✓	✓

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

**24 November 2021**

<b>Agenda item</b>	Private Board Summary Report 29 September 2021		
<b>Board Lead</b>	Trust Board Business Manager		
<b>Type name of Author</b>	Senior Board Administrator		
<b>Attachments</b>	None		
<b>Purpose</b>	Information		
<b>Previously considered</b>	N/A		

### Executive Summary

The purpose of this report is to provide a summary of matters discussed at the Board in private on the 29 September 2021 and 27 October 2021. The matters considered at these sessions of the Board were as follows:

- Place and System Briefing
- Serious Incidents Report
- Learning from People Practices
- Health Education England Contract
- Finance Report
- Long Term Financial Plan
- External Auditors Report (Value for Money)
- Amersham CDH Letter of Agreement
- Aerated Concrete Report
- Survey Report on Wycombe Tower
- SCAS Contract Extension
- Dermatology at Amersham Business Case
- Variation of Contract UTC model
- Safe Medical Staffing Business Case
- Chair Recruitment
- Recovery and next steps

<b>Decision</b>	The Board is requested to note the contents of the report.
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### Relevant Strategic Priority

<b>Outstanding Care</b> ☒	<b>Healthy Communities</b> ☒	<b>Great Place to Work</b> ☒	<b>Net Zero</b> ☒
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### Implications / Impact

<b>Patient Safety</b>	Aspects of patient safety were considered at relevant points in the meeting
<b>Risk: link to Board Assurance Framework (BAF)/Risk Register</b>	Any relevant risk was highlighted within the reports and during the discussion
<b>Financial</b>	Where finance had an impact, it was highlighted and discussed as appropriate

<b>Compliance</b> Select an item. Select CQC standard from list.	Compliance with legislation and CQC standards were highlighted when required or relevant
<b>Partnership: consultation / communication</b>	N/A
<b>Equality</b>	Any equality issues were highlighted and discussed as required.
<b>Quality Impact Assessment [QIA] completion required?</b>	N/A

## Acronym 'Buster'

- A&E - Accident and Emergency
- AD - Associate Director
- ADT - Admission, Discharge and Transfer
- AfC - Agenda for Change
- AGM - Annual General Meeting
- AHP - Allied Health Professional
- AIS – Accessible Information Standard
- AKI - Acute Kidney Injury
- AMR - Antimicrobial Resistance
- ANP - Advanced Nurse Practitioner

## **B**

- BBE - Bare Below Elbow
- BHT – Buckinghamshire Healthcare Trust
- BME - Black and Minority Ethnic
- BMA - British Medical Association
- BMI - Body Mass Index
- BOB – Buckinghamshire, Oxfordshire, Berkshire West
- BPPC – Better Payment Practice Code

## **C**

- CAMHS - Child and Adolescent Mental Health Services
- CAS - Central Alert System
- CCG - Clinical Commissioning Group
- CCU - Coronary Care Unit
- Cdif / C.Diff - Clostridium Difficile
- CEA - Clinical Excellence Awards
- CEO - Chief Executive Officer
- CHD - Coronary Heart Disease
- CIO - Chief Information Officer
- CIP - Cost Improvement Plan
- CQC - Care Quality Commission
- CQUIN - Commissioning for Quality and Innovation
- CRL – Capital Resource Limit
- CSU - Commissioning Support Unit
- CT - Computerised Tomography
- CTG - Cardiotocography

## **D**

- DBS - Disclosure Barring Service
- DGH - District General Hospital
- DH / DoH - Department of Health
- DIPC - Director of Infection Prevention and Control
- DNA - Did Not Attend
- DNACPR - Do Not Attempt Cardiopulmonary Resuscitation
- DNAR - Do Not Attempt Resuscitation
- DNR - Do Not Resuscitate
- DOH – Department of Health
- DoLS - Deprivation of Liberty Safeguards
- DPA - Data Protection Act
- DSU - Day Surgery Unit
- DVT - Deep Vein Thrombosis

## **E**

- E&D - Equality and Diversity
- EBITDA - Earnings Before Interest, Taxes, Depreciation and Amortization
- ECG - Electrocardiogram
- ED - Emergency Department
- EDD - Estimated Date of Discharge
- EIA - Equality Impact Assessment
- EIS – Elective Incentive Scheme
- ENT - Ear, Nose and Throat
- EOLC - End of Life Care
- EPR - Electronic Patient Record
- EPRR - Emergency Preparedness, Resilience and Response
- ESD - Early Supported Discharge
- ESR - Electronic Staff Record

## **F**

- FBC - Full Business Case
- FFT - Friends and Family Test
- FOI - Freedom of Information
- FTE - Full Time Equivalent

## **G**

- GI - Gastrointestinal
- GMC - General Medical Council
- GP - General Practitioner
- GRE – Glycopeptide Resistant Enterococci

## **H**

- HAI - Hospital Acquired Infection
- HASU - Hyper Acute Stroke Unit
- HCA - Health Care Assistant
- HCAI - Healthcare-Associated Infection
- HDU - High Dependency Unit
- HEE – Health Education England
- HETV - Health Education Thames Valley
- HMRC – Her Majesty’s Revenue and Customs

- HSE - Health and Safety Executive
- HSLI – Health System Led Investment
- HSMR – Hospital-level Standardised Mortality Ratio
- HWB - Health and Wellbeing Board

## I

- ICS – Integrated Care System

## M

- I&E - Income and Expenditure
- IC - Information Commissioner
- ICP - Integrated Care Pathway
- ICU - Intensive Care Unit
- IG - Information Governance
- IGT / IGTK - Information Governance Toolkit
- IM&T - Information Management and Technology
- IPR - Individual Performance Review
- ITU - Intensive Therapy Unit / Critical Care Unit
- IV - Intravenous

## J

- JAG - Joint Advisory Group

## K

- KPI - Key Performance Indicator

## L

- LA - Local Authority
- LCFS - Local Counter Fraud Specialist
- LD - Learning Disability
- LHRP - Local Health Resilience Partnership
- LiA - Listening into Action
- LOS / LoS - Length of Stay
- LUCADA - Lung Cancer Audit Data

## M

- M&M - Morbidity and Mortality
- MDT - Multi-Disciplinary Team
- MIU - Minor Injuries Unit
- MRI - Magnetic Resonance Imaging
- MRSA - Meticillin-Resistant Staphylococcus Aureus

## N

- NBOCAP - National Bowel Cancer Audit Programme
- NCASP - National Clinical Audit Support Programme
- NED - Non-Executive Director

- NHS – National Health Service
- NHSE – National Health Service England
- NHSE/I – National Health Service England & Improvement
- NHSI – National Health Service Improvement
- NHSLA - NHS Litigation Authority
- NICE - National Institute for Health and Care Excellence
- NICU - Neonatal Intensive Care Unit
- NMC - Nursing and Midwifery Council
- NNU - Neonatal Unit
- NOGCA - National Oesophago-Gastric Cancer Audit
- NRLS - National Reporting and Learning System / Service

## O

- O&G - Obstetrics and Gynaecology
- OBC - Outline Business Case
- ODP - Operating Department Practitioner
- OHD - Occupational Health Department
- OOH - Out of Hours
- OP - Outpatient
- OPD - Outpatient Department
- OT - Occupational Therapist/Therapy
- OUH - Oxford University Hospital

## P

- PACS - Picture Archiving and Communications System / Primary and Acute Care System
- PALS - Patient Advice and Liaison Service
- PAS - Patient Administration System
- PBR - Payment by Results
- PBR Excluded – Items not covered under the PBR tariff
- PDC - Public Dividend Capital
- PDD - Predicted Date of Discharge
- PE - Pulmonary Embolism
- PFI - Private Finance Initiative
- PHE - Public Health England
- PICC - Peripherally Inserted Central Catheters
- PID - Patient / Person Identifiable Data
- PID - Project Initiation Document
- PLACE - Patient-Led Assessments of the Care Environment
- PMO - Programme Management Office
- PPE - Personal Protective Equipment
- PP – Private Patients
- PPI - Patient and Public Involvement
- PSED - Public Sector Equality Duty

## Q

- QA - Quality Assurance
- QI - Quality Indicator
- QIP - Quality Improvement Plan
- QIPP - Quality, Innovation, Productivity and Prevention
- QIA - Quality Impact Assessment
- QOF - Quality and Outcomes Framework

## R

- RAG - Red Amber Green
- RCA - Root Cause Analysis

- RCN - Royal College of Nursing
- RCP - Royal College of Physicians
- RCS - Royal College of Surgeons
- RIDDOR - Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
- RTT - Referral to Treatment

## **S**

- SAU - Surgical Assessment Unit
- SCAS / SCAmb - South Central Ambulance Service
- SHMI - Summary Hospital-level Mortality Indicator
- SI - Serious Incident
- SIRI - Serious Incident Requiring Investigation
- SIRO – Senior Information Risk Owner
- SID - Senior Independent Director
- SLA - Service Level Agreement
- SLR - Service-Line Reporting
- SLT / SaLT - Speech and Language Therapy
- SMR - Standardised Mortality Ratio
- SoS - Secretary of State
- SSI(S) - Surgical Site Infections (Surveillance)
- SNAP - Sentinel Stroke National Audit Programme
- STF – Strategic Transformation Fund
- STP - Sustainability and Transformation Plan
- SUI - Serious Untoward Incident

## **T**

- TIA - Transient Ischaemic Attack
- TNA - Training Needs Analysis
- TPN - Total Parenteral Nutrition
- TTA - To Take Away
- TTO - To Take Out
- TUPE - Transfer of Undertakings (Protection of Employment) Regulations 1981

## **U**

- UGI - Upper Gastrointestinal
- UTI - Urinary Tract Infection

## **V**

- VfM - Value for Money
- VSM - Very Senior Manager
- VTE - Venous Thromboembolism

## **W**

- WHO - World Health Organization
- WTE - Whole Time Equivalent

## **Y**

- YTD - Year to Date