Buckinghamshire Healthcare NHS Trust

Buckinghamshire Healthcare NHS Trust
Annual Report
2015/16

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2. Our Trust

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

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

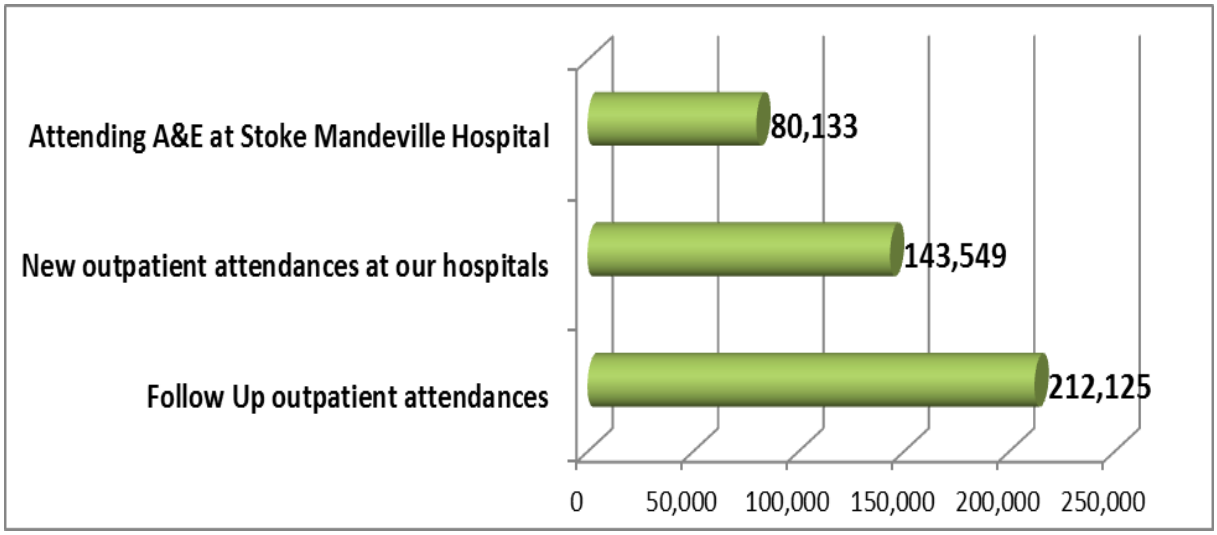
Buckinghamshire Healthcare NHS Trust is one of the first integrated acute and community providers in the country, and is the major provider of specialist, acute and community healthcare services for the people of Buckinghamshire. We deliver our services from a network of facilities including:

- A range of community settings - health centres, schools and patients' own homes;
- Five community hospitals;
- Two acute hospitals located in the two most densely populated areas of Buckinghamshire - High Wycombe and Stoke Mandeville, Aylesbury.

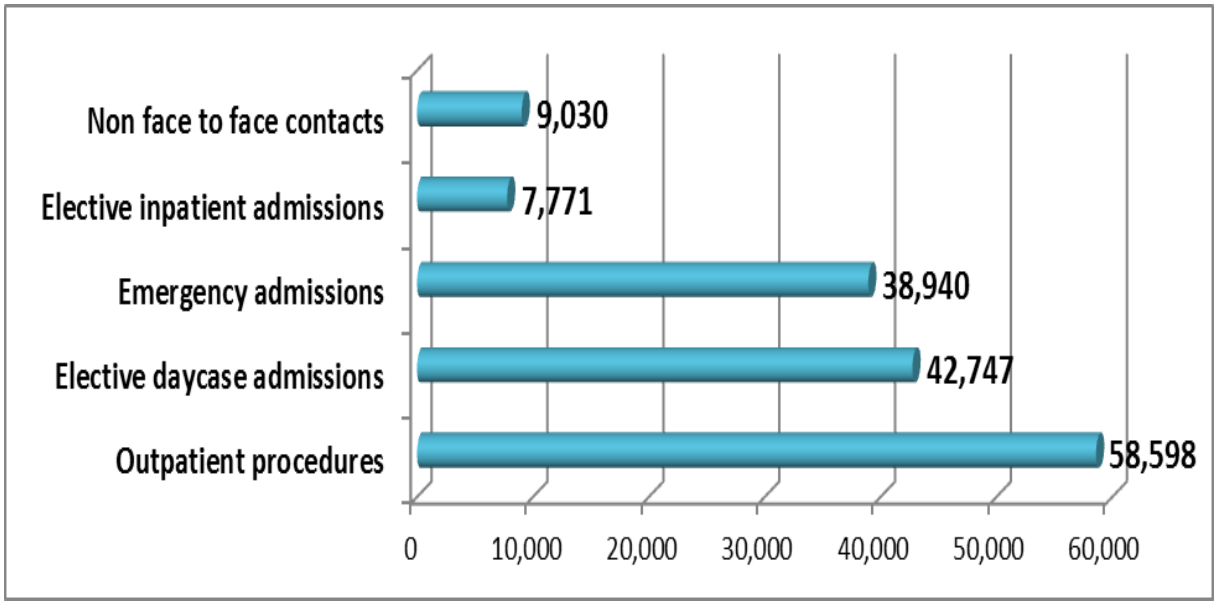
Over 5,700 members of staff provide integrated services to approximately half a million people, including the dispersed population of Buckinghamshire and the surrounding areas of Thame (Oxfordshire), Tring (Hertfordshire) and Leighton Buzzard (Bedfordshire). As well as being a major provider of community and acute hospital care, we are well known for our specialist services. The internationally renowned National Spinal Injuries Centre is one of only a few such centres of expertise in the UK. We are recognised nationally for our urology and skin cancer services. Similarly at a regional level we are a specialist centre for burns care, plastic surgery and dermatology.

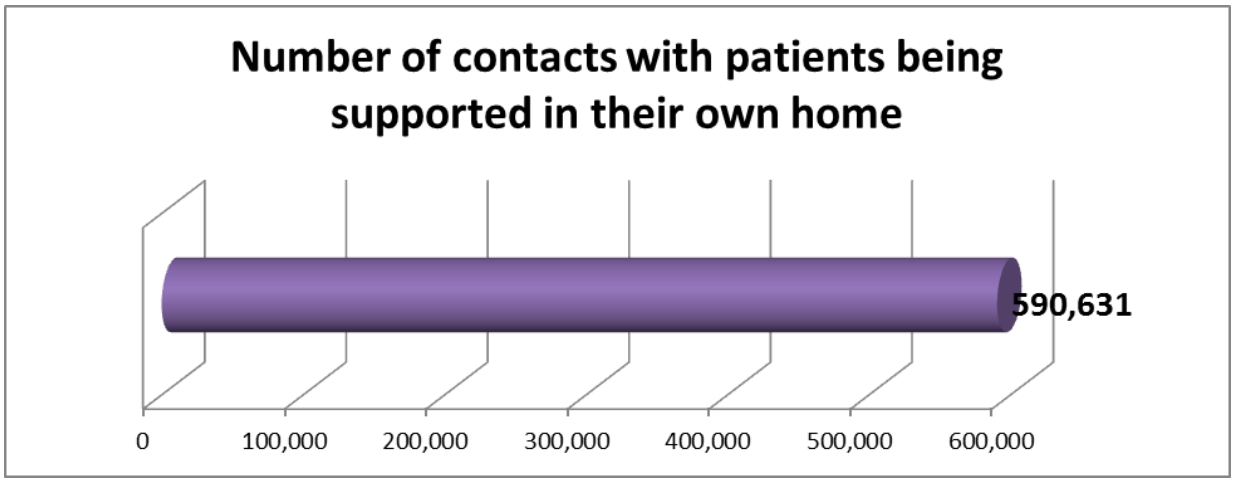
2015/16 in numbers:

Attendances



Procedures and Admissions




Number of contacts with patients being supported in their own home
590,631
0
100,000
200,000
300,000
400,000
500,000
600,000

Where we are based

We provide inpatient facilities from two acute and five community hospitals in Buckinghamshire, and care in people's own homes and from over 20 other settings such as health and leisure centres and GP practices. Our community health services include adult community healthcare teams (district nursing, occupational therapy and physiotherapy), services for children and families, intermediate care, health visitors, community dental services and palliative care.

The acute hospitals

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

Our main community facilities

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

Our headquarters are at Stoke Mandeville Hospital.

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

3. Chairman and Chief Executive Foreword

We are on an exciting journey to transform how we provide care for our patients. The past year has been a significant one in which we have moved with pace and ambition towards our goal of becoming one of the safest healthcare systems in the country.

We have developed a clear strategy for the next five years, aligned with NHS England's own five year forward view, which will enable us to deliver sustainable high quality care for patients. Our strategy is based around three priorities – quality, people and finance – which will be at the heart of everything we do.

We will deliver this *the BHT way*: our ambition to transform BHT so we become the best we possibly can. *The BHT way* will ensure we engage with and involve our patients and communities to develop services that meet their needs and push further with integrating social care, primary and secondary care as well as physical and mental health services to give our patients better outcomes and a better experience. *The BHT way* is also about empowering our leaders within the organisation to make quality improvements. We know that high staff satisfaction leads to improved patient outcomes and to this end we have spent time establishing a new relationship with our staff; building morale, engagement and empowering them to make improvements in the way they deliver care. Following a major piece of work with staff and patients we have developed a culture built around our new CARE values.

We believe this is critical to ensuring the Trust is a place where our patients have an excellent experience and where we are a great place to work.

Most NHS Trusts are facing financial difficulties, and we are no different. We were disappointed to end the 2015/16 financial year in deficit. We have invested time in understanding why. We have recognised that some of the challenges are historic; for example, the income/expenditure difference following our merger to become an integrated Trust in 2010, and the long-term commitment with our Private Finance Initiative (PFI) contracts. Some are more recent; such as our significant investment in staffing as part of our quality improvement plan.

However, we have robust, achievable plans in place to address our finances and 2016/17 marks the beginning of a three-year programme to bring us back to a sustainable financial position. Our three priorities of quality, people and finance will help us do this, engaging our staff and partners to transform the ways in which we work in order to increase productivity and improve services to patients.

An important checkpoint in our journey came with the July 2015 CQC report following an inspection earlier in the year. The Trust maintained its 'requires improvement' rating, but the report recognised a number of improvements in the quality of care provided by the Trust and we were rated 'good' for having caring staff. Particularly pleasing was the recognition by inspectors of the rapid pace of change and improvements we had put into our urgent and emergency care services, which increased from zero to three 'good' ratings.

We are proud of the achievements of our staff and services over the past year:

We have shown pace in our quality improvement and patient experience…

- Our hyper-acute stroke service based at Wycombe Hospital retained its coveted overall 'A' rating in the Royal College of Physician's Sentinel Stroke National Audit Programme (SSNAP) audit – making it amongst the very best in the country.
- We have invested in improving patient safety with 'dementia friendly' renovations to our wards at Amersham Hospital which has reduced anxiety for dementia patients and our 'stay in the bay' initiative to install portable technology in ward bays which has helped nursing staff to spend more time closer to patients rather than having to move away from the beds to do the necessary work at a computer.
- Our endoscopy team achieved the Royal College of Physicians Joint Advisory Group accreditation for 2016, in recognition of the high quality, patient-centred service they provide.
- Our specialist cancer care and haematology ward became the second inpatient ward in England to receive the prestigious Macmillan Quality Environment Mark (MQEM) for offering high standards of care for people affected by cancer.
- 96% of patients in our Friends and Family Test said they would recommend the Trust.

We have taken significant steps in developing and engaging staff…

- We have trained the only nurse angiographer in the country, who is now able to carry out angiograms to identify heart disease which has helped to reduce cancellations and allows for the maximum benefit from the Trust's cardiac catheterization labs.
- Our research team were ranked 24th in the National Institute of Health Research's top 100 for delivery of research.
- Satinder Bhandal, consultant pharmacist was named as this year's clinical pharmacist of the year at the national Royal Pharmaceutical Society (RPS) awards. Ms Bhandal was awarded for her work in setting up a new pharmacist-led clinic for stroke patients which, since it was set up in 2012, has prevented an estimated 200 strokes.
- We had 3000 responses to the staff survey and our best ever results with significant improvements in areas such as staff engagement, raising concerns, and recommending the Trust as a place to work.

However, we know we cannot afford to ignore the challenges we face. There is increasing demand on our A&E services and, whilst we performed well against many national standards in such areas as cancer care, surgery and referral to treatment, we know there is more we can do to continue to improve how patients move through our services and to make the transition from hospital to community and beyond more seamless for them.

Our five-year strategy focuses on forging strong and productive relationships between ourselves and our partners, including GPs, social care and third sector organisations. We will transform healthcare by providing it in the right setting, maximising the unique opportunity of working with our community services and preventing illness by supporting people to manage their own health and wellbeing at home. If patients do need to visit us at hospital we will be there to provide world-class specialist and life-saving care in state-of-the-art facilities. Our successful collaborative work with partners and local people on the way we deliver two of our services (sexual health and musculoskeletal) is a positive step in that direction. A major focus going forward this year is our programme of engaging with our partners and the public to develop 'community hubs' to bring more care closer to the home. We are committed to continue building relationships with our communities and seeking their views to inform our future plans and developments.

The year ahead will be one of ambitious but achievable change. We need to recognise and respond to local and national healthcare challenges, we have the plans, the commitment and the people, to deliver that vision and for BHT to become one of the safest healthcare systems in the country.

Neil Dardis, CEO

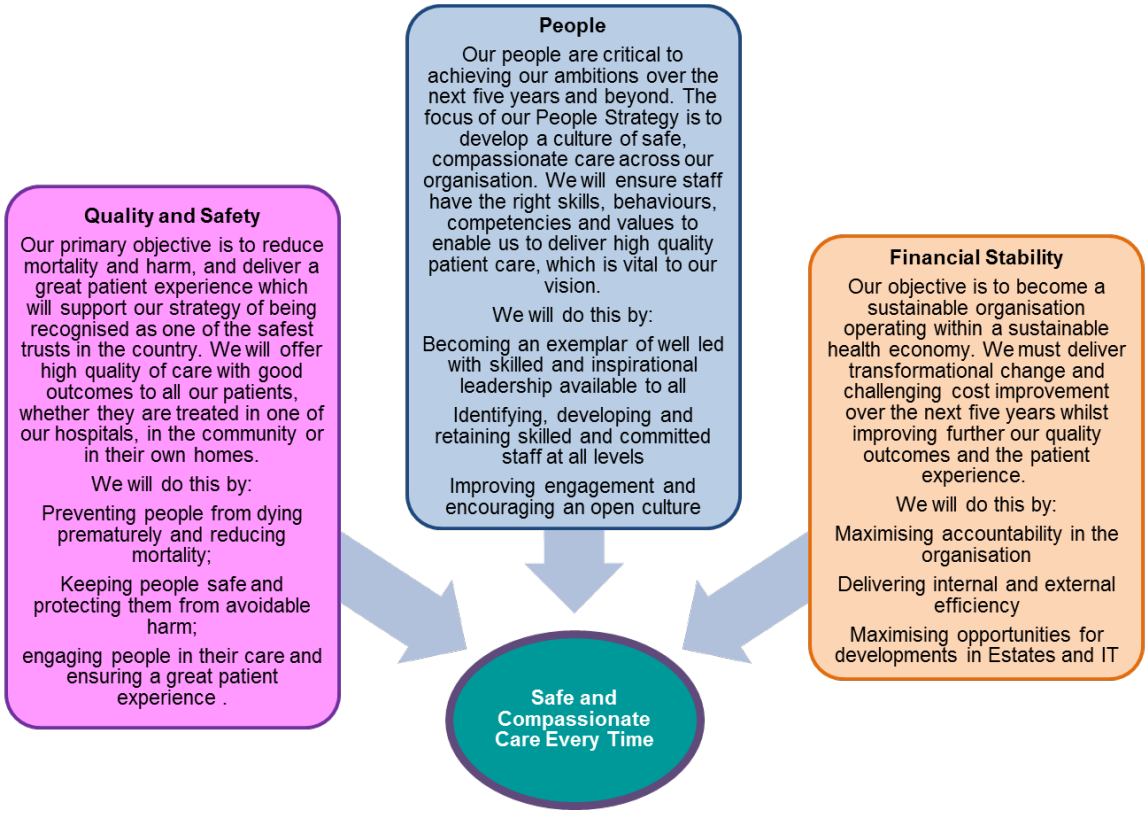
4. STRATEGIC REPORT – Our mission and strategy

4.1. Overview

Throughout 2015/16 much work has gone into developing BHT's Vision and Five-year Strategy. These have been developed by the Board and senior leaders in the organisation, supported by staff sessions and workshops with patients, stakeholders and special interest groups. They took the opportunity to:

- Assess patient feedback into the delivery of the Trust's services
- Re-evaluate its analysis of the external environment
- Assess the Trust's internal capabilities and capacity for the future delivery of care.
- Assess commissioner and stakeholder views on the future of healthcare.
- Take into account the development of NHS England's Five Year Forward View[1] and the Sustainability and Transformation Plan[2]
- Assess the impact of the Carter Review[3] and its implications on the future delivery of services.
- Assess the Trust's current Service Development Plans.

In January 2016, the Board approved three strategic priorities to guide the development of the Trust – **Quality and safety, People, and Financial stability**.



[1] Five Year Forward View, Time to Deliver, NHS England, June 2015
[2] Delivering the Forward View, NHS Planning Guidance, 2016/17-2020/21
[3] Operational productivity and performance in English NHS acute hospitals: unwarranted variations
An independent report for the Department of Health by Lord Carter of Coles, February 2016

In February 2016 the Trust undertook an engagement exercise with its 500 leaders through a series of seven workshops across the Trust. Leaders were asked to highlight from a list of 31 strategic objectives which ones have the most impact on the three strategic priorities -improving quality of care, developing our people and achieving financial stability. This information has been used to shape the corporate objectives.

A Strategic Transformation Committee was set up in May 2015 and has enabled the Trust to receive input and advice from local Commissioners, NHS England and the Trust Development Authority throughout the year resulting in a final presentation of the Trust five-year strategy to the Board in March 2016.

4.2. Vision and strategic framework

The strategy reaffirms the Trust's **mission** to provide **safe and compassionate care, every time.**

The Trust vision

> We are on an exciting journey of transformation and improvement.
>
> We aim to deliver safe and compassionate care by forging a new partnership that puts patients, communities and staff at the heart of everything we do.
>
> Our priority is to build services that are sustainable for the future.
>
> By 2020, we aim to be recognised nationally and internationally for providing high quality specialist services and for leading the way in joining up health and care services in the community.

The vision has been updated in 2015/16 to reflect the central importance of providing high quality specialist services and of leading the way in joining up health and care services in the community.

A strategic framework has been developed which highlights the six strategic drivers that will ensure we meet our three strategic priorities.

Strategic Drivers

These strategic drivers have been developed into outcomes for 2020 and a milestone trajectory for the next five years to achieve our aspirations.

4.3. Sustainability and Transformation Plans

At the end of December 2015 NHS England asked every health and social care system to work together to create an ambitious local blue print for the delivery of the Five Year Forward View, to be known as Sustainability and Transformation Plans (STP).

BHT has played a leading role in coordinating the various workstreams, overseeing the governance and working closely with colleagues from the CCGs, Bucks County Council, Oxford Health NHS Foundation trust and the South Central Ambulance Service in developing the local plan. The Buckinghamshire plan will form part of a larger footprint, Thames Valley, and through the Healthy Bucks Leaders group BHT will be part of the process that develops the broader plan. The Healthy Bucks Leaders group is the local leadership group which is currently chaired by the BHT Chief Executive Officer.

4.4. Quality Strategy

We are aiming to reduce variation across our services and ensure that the people of Buckinghamshire receive safe and compassionate care every time. To achieve that we have an ambitious set of strategic aims which are outlined in our Quality Strategy.

The Quality Strategy aims to do three things. Firstly, this strategy outlines how we will work together to improve the quality of care and ensure that people's needs are at the heart of everything we do. It will do this by describing the specific quality goals for the

organisation, how they will be monitored and reported so that our patients and their families and carers can have confidence in the quality of care we provide.

Secondly, it seeks to explain how we will ensure that when failure is encountered, not only is it rectified, but failure will be investigated and examined so that its root causes can be identified, lessons learned, and action taken to prevent similar failures from recurring.

Finally, the strategy document explains how we will collaborate and work with others to build services for the people of Buckinghamshire that keep people as healthy as possible and out of acute hospital settings.

We aspire to be the best in the country in terms of quality. We want our patients, families, and carers of all ages to choose to come to us to receive their healthcare because they have confidence in our reputation for providing high quality services. To maintain progress toward that aim, we will continue a relentless focus on our top three priorities- Preventing people from dying prematurely and reducing Mortality; Keeping people safe and protecting them from avoidable harm; engaging people in their care and ensuring a great patient experience.
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This vision will only be realised if we aspire to achieve nothing short of excellence and constantly challenge and stretch ourselves to achieve it.

4.5. Corporate Objectives

Our objectives are provided in more detail below:

	Strategic Priorities	Key Performance Indicator by April 2017	Executive Lead
1.	**Quality & Safety – deliver high quality care with good outcomes for all our patients**		
1.1	Sustain HSMR at 92 or below	HSMR < 92	Medical Director
1.2	Achieve a further 25% reduction in avoidable harm in pressure ulcers and falls	Pressure Ulcers – no more than 7 (Grade 3 and 4) Falls with harm – no more than 5	Chief Nurse
1.3	Meet infection control targets of zero MRSA and 32 maximum C.diff cases	C.diff - 32 MRSA - 0	Medical Director & Chief Nurse
1.4	Sustain 95% Friends and Family Test (FFT) approval rating and increase the response rate to 30%	FFT approval rating > 95% Response rate > 30%	Chief Nurse
1.5	Consistently meet the NHS Constitution standards	A& E - 95% of patients seen and treated within four hours Referral to Treatment Time - 92% referral to treatment within 18 weeks Meet cancer waiting times for diagnosis and treatment	Chief Operating Officer
2.	**People - implement our people strategy to develop a culture of safe and compassionate care every time**		
2.1	Improve staff engagement score from 3.76 to 3.90	Staff engagement score = 3.90	Director of Human Resources and Organisational Development
2.2	Reduce total agency spend to £12million for 2016-17	Total agency spend no more than £12million	Director of Human Resources and Organisational Development
2.3	Reach and maintain 90% compliance with statutory training and appraisal completion	At least 90% compliance with statutory training and appraisal	Director of Human Resources and Organisational Development
2.4	Reduce nurse vacancy levels to 7%	Nurse vacancy levels no more than 7%	Director of Human Resources and Organisational Development

	Strategic Priorities	Key Performance Indicator by April 2017	Executive Lead
3.	**Financial Stability - become a sustainable organisation within a sustainable health economy**		
3.1	Deliver an agreed £8.8m year-end deficit.	No more than £8.8m deficit	Director of Finance
3.2	Deliver a CIP programme of £14.6m (4%).	CIP delivery of £14.6m	Director of Finance
3.3	Deliver an £11m capital programme to ensure safe services, progress digital Interoperability and improve our estate.	Delivery of £11m capital programme	Director of Finance
3.4	Agree a five year Sustainability and Transformation Plan for the Buckinghamshire and Thames Valley health communities.	Plan to be submitted by July 2016	Director of Finance & Director of Strategy

	Strategic Drivers	Key Performance Indicator by April 2017	Executive Lead
4.	**Emergency & Urgent Care** Develop emergency and urgent care services which maximise the chances of survival and good recovery.	- Develop Out of Hours and Minor Injury Unit Services in a new model of care with partners in Ambulance and primary care	Chief Operating Officer
5. 1	**Integrated Care** Enhance partnerships between community services, primary health, social care, voluntary sector partners and patients to better support care in people's homes and in other community settings.	- increased admission avoidance - increased early supported discharge	Chief Operating Officer
5.2	Maintain and develop integrated children's services	- Agree Healthy Child Programme (Health Visitors, School Nurses and Family Nurse Practitioners) and children's therapies in line with new Buckinghamshire County Council and CCG specifications.	Director of Strategy

	Strategic Drivers	Key Performance Indicator by April 2017	Executive Lead
6.	**Specialist Care** Expand stroke and cardiac services to treat more Bucks and East Berks patients.	Stroke – Expand service to East Berkshire to accommodate 600 additional patients Cardiac – Expand cardiac services through the provision of an additional Catheter Laboratory	Chief Operating Officer
7.	**Planned Care** Launch a new collaborative MSK service	Implement new model of care to reduce duplication, variation and improve patient experience in MSK services with provider partners	Chief Operating Officer
8.	**Technology & Innovation** IT interoperability	- Receive all Bucks' GP referrals electronically - Diagnostic results to be accessed electronically -100% of discharges submitted electronically	Director of Finance
9.	**Estates** Maximise the efficient use of the Community Estate	Implement 2016/17 plans for the most efficient use of the community estate	Director of Strategy

4.6. Managing risks in relation to our corporate strategy and objectives

The Board of Directors is responsible for reviewing the effectiveness of its internal control systems through its Board Assurance Framework (BAF) and through the Annual Governance Statement.

The Board Assurance Framework document sets out the principal risks to achieving corporate objectives, along with assurances that effective controls have been put in place to protect patients, staff, the public, and other stakeholders against risks of all kinds. The Board Assurance Framework is reviewed by the Board at least three times each year.

The Annual Governance Statement appended to this report contains more detail about the risk and control framework and its effectiveness in 15/16.

4.7. Corporate Governance Report

The summary of the composition and organisation of the entity's governance structures and how they support the achievement of the entity's objectives is set out in the Annual Governance Statement which is included in full at the end of the Annual Report.

4.7.1. Performance highlights and challenges

This section of the report provides information about our performance including how we have done against the national indicators set out in the Operating Framework for 15/16. More detailed information about quality performance can be found in the Trust Quality Accounts 2015/16 published on the Trust website.

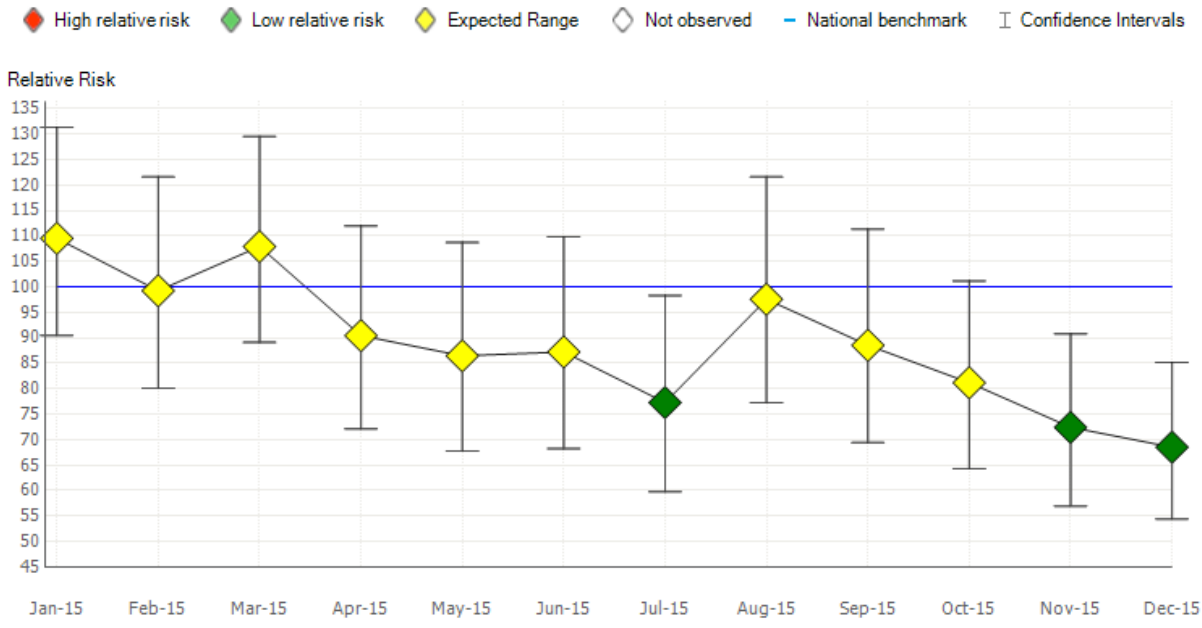
The Board reviews a comprehensive range of key performance indicators each month. These have been selected as metrics from the annual operating plan, performance indicators related to individual Trust objectives, and performance indicators arising from the Quality Improvement Plan. The reliability of these measures is monitored through a programme of external audit, internal audit, clinical audit and external reviews. More detail about these governance processes is contained in the Annual Governance Statement appended to the Annual Report.

4.8. Quality Performance

4.8.1. Reducing Mortality

Our two year aim has been to reduce the HSMR by five points in 2014/15 and by a further five points in 2015/16.

Our HSMR has reduced significantly this year; this is the full year picture from January 2015 to December 2015. We do know that the HSMR from January 2015 was 109, and we are currently reporting a significant reduction in HSMR to 88.7



Given the achievement we are fully committed to reducing our HSMR by continued focus on delivering the actions described below.

The Mortality review process has been successfully embedded with the clinical teams. The aim is for all deaths to be reviewed within 3 months. The mortality review process is working well with plans to develop this into a more multi-disciplinary approach. A particularly complex review where learning is identified is presented at the academic half day sessions. The trust has concentrated on increasing the mortality reviews undertaken across the trust and this now averages between 95-100% of deaths being reviewed by clinicians.

There have been other initiatives aimed at reducing mortality by focusing on early recognition of deteriorating patients. The 90 day Deteriorating Patient programme was launched in November 2015 across five ward areas. Dedicated support, training and use of a structured communication tool have seen us achieve zero serious incidents in this group of patients since then. We have seen an improvement in both recognition and escalation of the deteriorating patient.

The Emergency Department has initiated a new rapid assessment and treatment protocol for patients. This should reduce the impact of ambulance waits on patient well-being and will result in treatment starting earlier for other patients for example with sepsis.

A programme of work is underway in NHS England's Patient Safety Domain, around standardising retrospective case record review (RCRR) for in-hospital deaths. A review of mortality governance will be required to help prepare for roll out of the national programme. It is expected that all trusts will have a mortality surveillance group. The NHS Mandate includes an intention to publish avoidable mortality by Trust. The exact form this will take has yet to be determined and will be considered carefully. To start the process, NHS England has asked all Trusts to conduct a self-assessment of their avoidable mortality which was concluded in January 2016.

We have continued to monitor our crude mortality on a month by month basis through the year, and have not noted variation raising concern.

4.8.2. Reducing harm

Sign up to safety (Falls Reduction)
We have committed to the Sign Up to Safety (SU2S), a national campaign to reduce avoidable harm by half and save 6000 lives over the next three years.

In recognition of the innovation reflected in our Sign Up to Safety action plan we were awarded £500,000 from the NHS Litigation Authority to support our work in reducing falls.
We have launched several new initiatives through this funding, among them the Stay in the Bay campaign where our nurses have received mobile workstations and remain in the bays with their patients, where patient can be directly observed. We have invested in 20 low rise beds and movement sensor equipment. Flooring and environment has been improved at one of our sites. All the areas benefitting from the Su2S initiative have shown a 32% reduction in falls, with an overall 52% reduction in falls with severe harm.

Dementia and Delirium
In 2015/16 we continued to make progress in ensuring that we screened all patients admitted as an emergency over 75 years of age for indications of dementia, and if a screening proved positive ensuring that we facilitated the referral to Memory Clinic via the GP.

We also recognized that while we had improved our understanding of identifying dementia within healthcare, there are behaviors associated with dementia that required multi agency awareness and we have worked with the Police and other emergency services on the management of wandering in dementia.

We have broadened our education programmes to develop awareness of delirium and have commenced work that includes how to involve carers in the care of their loved one. We have achieved compliance with training requirements. We continue to work on ensuring calm and safe clinical environments for the care of people with cognitive loss

and are developing staff awareness of safeguarding procedures and ethical approaches to care including end of life planning. We have commenced a peer review with older people services at Whiteleaf Centre (Oxford Mental Health).

Pressure Ulcers
Eliminating avoidable pressure ulcers remains a challenge for all healthcare organisations. We have focussed our efforts to reduce pressure ulcers through education, training, formulary management, product selection and the SSKIN bundle. We set ourselves a target to achieve 50% reduction in avoidable Grade 3 and 4 pressure ulcers over a 2 year period commencing 2014/15. We over reached on our 25% target reduction in year one by achieving overall reduction of 33%. In year two we have again met our 25% target by achieving a 70% reduction. Further work is planned for 2016/17 to reduce Grade 2 pressure ulcers.

Medicines management
Our Medication errors sub group has focussed on reducing harm from insulin errors, and as a result we have introduced fast track dispensing of insulin when insulin dependent patients are admitted to the hospital without their medication. This has resulted in fewer delays in insulin administration. Nurses have told us that the organisation of insulin in the drug fridges can lead to errors due to similar packaging. We have reorganised storage of insulin in pharmacy fridges to reduce selection errors. Community staff have been proactive in introducing white boards for scheduling patients requiring insulin administration.

To support education, training and self-management of diabetes, we have appointed new Diabetic Specialist Nurses which has proved very successful in supporting the Diabetes transformation work. Our seven day a week clinical pharmacy service has been successful and we have reduced unnecessary delays in administration of drugs through this service. We also embedded pharmacists in the urgent care hub to support the nursing and medical staff working there and to ensure patients get a medication review where appropriate. They are also available in the Hub to facilitate discharges so that patients can return to their own homes as soon as possible.

Safer staffing
We have reviewed our staffing across acute ward areas, maternity, community services and health visiting. All our ward areas are staffed in accordance with the national recommendation of no less than one qualified nurse to eight patients. Many of our wards exceed this number. We monitor the staffing on our wards three times a day. In these reviews we consider not only the number of nurses on the wards but the needs of the patients. For example if there are a number of acutely sick patients or a particularly vulnerable patient we may increase the number of staff on the ward.

In addition we have been chosen as the national pilot site designing and implementing a ward resource planning tool as part of the Lord Carter initiative. We have worked with Netcare to design a tool which is bespoke for our Trust that includes daily acuity and dependency assessment and 24 hour forward planning on resources. The tool is web based and has been successfully implemented across 21 ward areas with 99% approval and planning rating achieved.

The staffing levels are displayed at the entrance to every ward and are updated on every shift. These boards also tell visitors and patients who is in charge of the ward that day. The name of the nurse and consultant responsible for each patient is displayed at the head of each bed.

Maternity

Our maternity strategy has evolved into a five year strategy taking into account the recent publication of the National Maternity Review. Many of the recommendations within this are already underway including personalised care planning, an improved perinatal mental health pathway, electronic maternity records and reporting and multidisciplinary training. The new maternity Medway information system was introduced in September and will provide better clinical information to inform our service planning.

The maternity service delivered 5548 babies in 2015/16 an increase of over 100 extra babies compared to last year. These babies were born within the Consultant unit at Stoke Mandeville, Aylesbury Birth Centre, Wycombe birth centre and at home.

The perinatal mortality rate showed a small decrease from last year and remains below the national average. In contrast the caesarean section rate has increased to 27.2%. The rise reflects the national picture and although our elective rate remains stable there is expected to be further pressure on this rate with this year's Montgomery legal ruling likely to increase the demand for elective sections. Our target for next year, aided by our normal birth strategy will be to reduce this to 25.5% which would be in line with the national average.

The research portfolio is increasing and the maternity team has been involved in several large multi centred trials.

Key areas of focus this year have been the perinatal mental health pathway, reducing low birth weight babies which are known to have a higher morbidity and mortality and the labour ward triage pathway. To these ends we have introduced the following:

Our perinatal health midwife now forms part of a team including two community psychiatric nurses and a designated perinatal psychiatrist.

A specialist preterm birth clinic was commenced in September 2015

A designated triage team has commenced on the labour ward in order to improve the consistency of advice and quality of this service.

We continue to assess staffing and acuity using the birthrate plus tool and the findings this year echo those of the previous year. We have also employed a recruitment and retention midwife in order to develop a robust strategy to counteract the regional problems with midwifery vacancies.

Safeguarding

We have a commitment and a duty to safeguard the children and young People of Buckinghamshire and as such we continue to be actively involved in Buckinghamshire Safeguarding Boards for both adults and children. The Multi-Agency Safeguarding Hub (MASH) co-locates key partners in order to improve the initial response to safeguarding concerns in relation to children as well as vulnerable adults. Its aim is to bring together key partners and to forge stronger links with other agencies enabling information to be shared quickly and effectively and better informed decisions to be made by social care. It is hoped that this approach will assist in identifying risk at an earlier stage and result in appropriate early intervention in order to safeguard vulnerable children. Partnership working has enabled good communication and we have fully engaged with this initiative.

Mental Capacity and Deprivation of Liberty safeguards has been high on the agenda for the trust this year, with 82% of staff trained on how to undertake a mental capacity assessment and DOLs application.

The Child Sexual Exploitation unit, called SWAN Unit has been launched as part of a multi-agency approach to support victims of child sexual exploitation. This unit provides intelligence to aid disruption of perpetrators and monitor levels of risk to children and young people and provide appropriate health assessments and child protection.

A Domestic Violence pathway, produced by partners is in place in order to ensure protection of men, women and their dependents. Women's Aid have worked closely with us to deliver regular training to staff on identifying signs of domestic abuse, and how to refer and report.

We have updated the maternity Guideline for Female Genital Mutilation (FGM) to help staff with identification and provide information with regard to best practice care for safe antenatal and intra-partum care. The guidance is to enable staff to be pro- active and sensitive in giving information to and appropriately referring women. We have appointed a designated Consultant and midwife responsible for the care of women with FGM in the maternity service. Our Named Midwife for safeguarding has been involved in multi-agency working to produce a Buckinghamshire FGM Action Plan and an FGM Strategy.

The new mandatory reporting duty for FGM was introduced via the Serious Crime Act 2015 on 31 October 2015. The duty requires regulated health and social care professionals and teachers in England and Wales to report known cases of FGM in under 18-year-olds to the police.

The Trust named nurse team ensure that all levels of Trust face to face safeguarding children training cover FGM and the mandatory and statutory duties around reporting and recording in relation to under 18y olds.

Midwifery mandatory face to face training also includes FGM. Miss Patil facilitated a session on FGM to the Obstetric medical staff at an academic half day.

Children in care in Buckinghamshire have seen a steady rise in the numbers. Buckinghamshire has over 480 children in care; however 58% of children are placed outside the area. This has raised a challenge for us in respect of meeting the child's initial health assessments. Partnership working is strong in relation to communication for children placed in Buckinghamshire. The voice of the child remains paramount in all interactions with children, and we have worked hard at hearing the voice of the child in all assessments and interactions. To strengthen this process in seeking and ensuring the wishes of children are expressed, we are aiming to implement digital/ electronic feedback. To support feedback, child friendly leaflets explaining the health requirements will be provided to children.

4.8.3. Patient Experience

Complaints and compliments

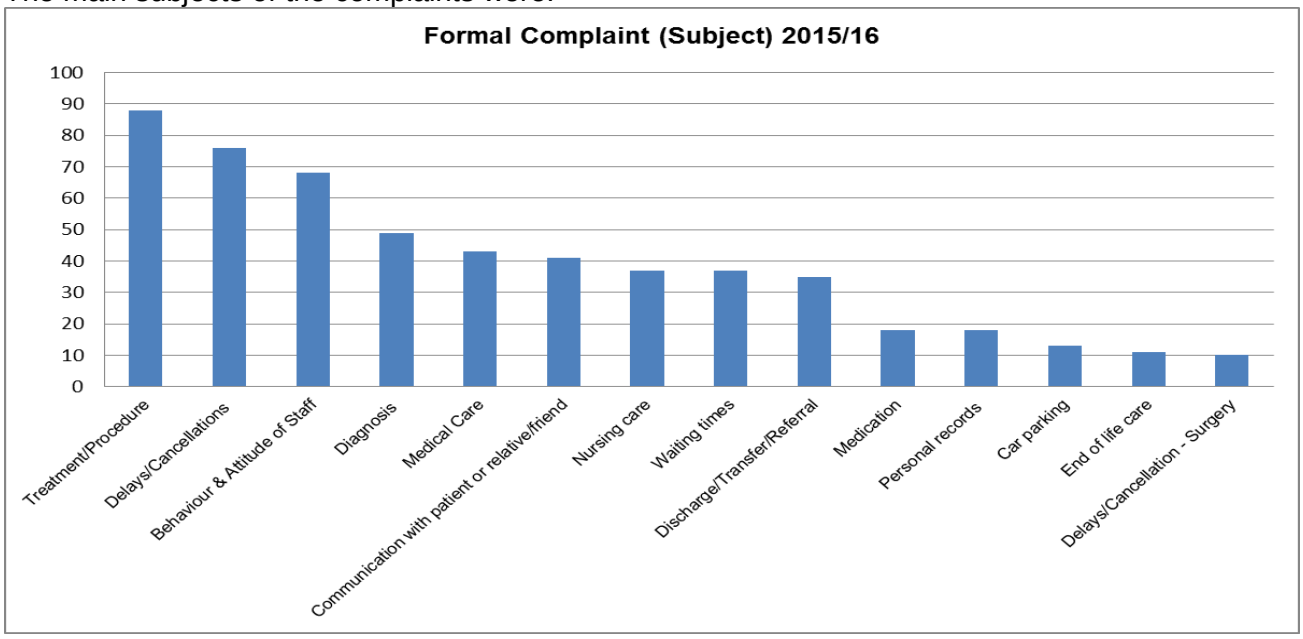
Since 2012 Buckinghamshire Healthcare Trust has operated a single point of access PALS service. PALS and complaints work together to appropriately manage enquiries and concerns that are raised by the public. The Trust has five categories for concerns that it receives. Categories 1 to 3 relate to minor issues that with the agreement of the complainant can be dealt with immediately at a local level with the PALS team. Category 4 and 5 are both formal complaints, however, category 5 relates to complaints that are multi organisational/divisional and/or complex and are allocated 40 or 60 days to be resolved on agreement with the complainant.

The Ombudsman's "Principles for Remedy" state that an attempt to resolve a complaint should be based on:

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

In 2015/16 Buckinghamshire Healthcare Trust received 606 formal complaints compared to 685 formal complaints received in 2014/15. This represents an overall reduction in complaints received of 12% when compared to the previous year.

The main subjects of the complaints were:



Learning from Complaints

The top 3 reasons for concern have remained the same in this reporting period. Delays and cancellations were the highest cause for concerns in the previous reporting period, whereas treatment and procedure rank highest during 2015/16. A key component of every complaint is the learning identified to inform improvement. Each complaint has an action plan that is recorded and monitored by the individual clinical divisions. The Trust during 2016/17 will conduct an audit of complaints action plans to confirm that learning from complaints has been applied and followed through to completion. The outcome of this audit will inform further developments in the process and support sharing of learning through the organisation.

Delays and cancellations have remained a reoccurring theme and the Trust is exploring innovative solutions to help mitigate the causes of complaints in this area.

Some of the benefits of implementing new technology may include:

- A reduction in clinical risk associated with lost referral letters
- An improvement in the quality of our correspondence to patients.
- Patient's referrals processed quicker ready for their first appointment.
- Significant cost benefits to primary care
- Reduction of administrative processes

A review of our complaints process is under way and key tests of change have been introduced that include:

- The triage process of every complaint will include a risk assessment rating for each complaint and oversee the appropriate allocation of the complaint to the divisions, particularly where the complaints are pan divisional, and recommendations for the most appropriate approach to early resolution.
- Complaints investigation template amended to include a new more focussed complaints analysis tool, aim is to analyse each individual component of the complaint. This is based on Root Cause Analysis methodology.
- Investigating officers are required to make contact with the person making the complaint at the beginning of the process to establish if there is anything the Trust can do at the early stage to resolve the complaint, particularly meetings with relevant staff.

Test of Change:

During 2016/17 the complaints team will monitor the new process for improvements/change, particularly:

- Analysing how many complaints were resolved at the initial contact stage by the Investigating Officer.
- Analysing any effect on the complaint response rate.

In 2015/16 there were 6 complaints referred to the Parliamentary and Health Service Ombudsman. This represents 1% of complaints received in the period. A decision to investigate is being awaited for 4 of the cases, 1 case was not upheld and has been closed and one case was partly upheld and is now closed.

Friends and family Test.
The 2015/16 quality improvement plan target for friends and family required the Trust to report a > 95% approval rating and a > 30% response rate for inpatient, maternity and A&E services during the reporting period. Buckinghamshire NHS Trust achieved a 96% approval rating and a 14% response rate as an average across the reporting period.

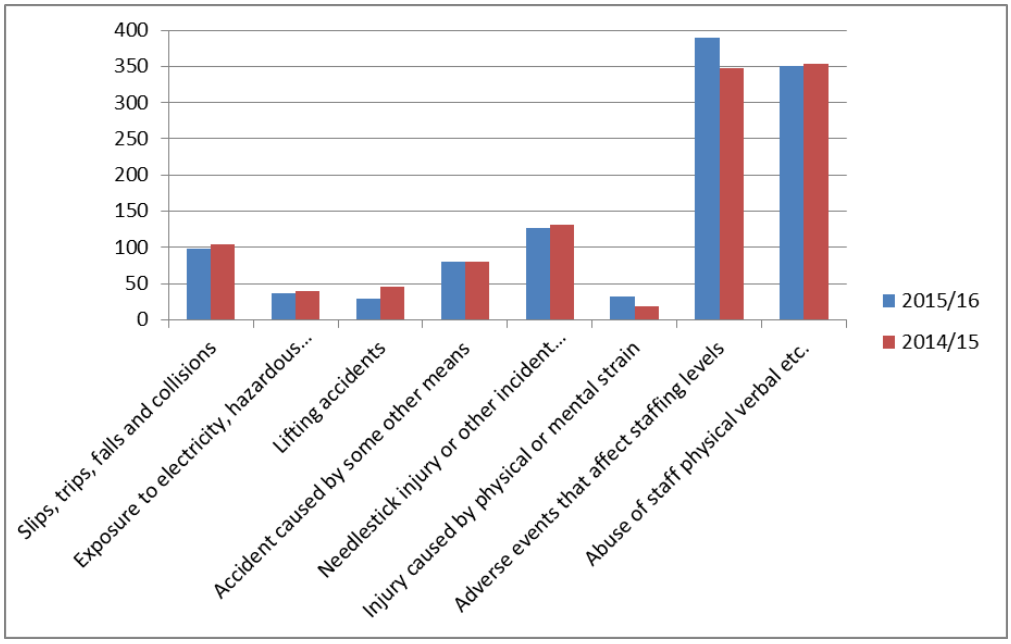
The Trust received compliments about our services throughout 2015/16. When combined with the accolades received as free text as a part of the friends and family responses we have received approximately 11,000 compliments during 2015/16.

During 2016/17 the Trust will further focus on the continuing implementation of the Friend and Family test text survey across our services and on ensuring that a high proportion of our patients respond to give us an accurate reflection of the experience in our services.

We have continued to use our patient experience feedback microsite (www.buckshealthcare.nhs.uk/feedback) to promote what our patients have told us about their care and what actions we have taken as a result.

4.9. Health and Safety

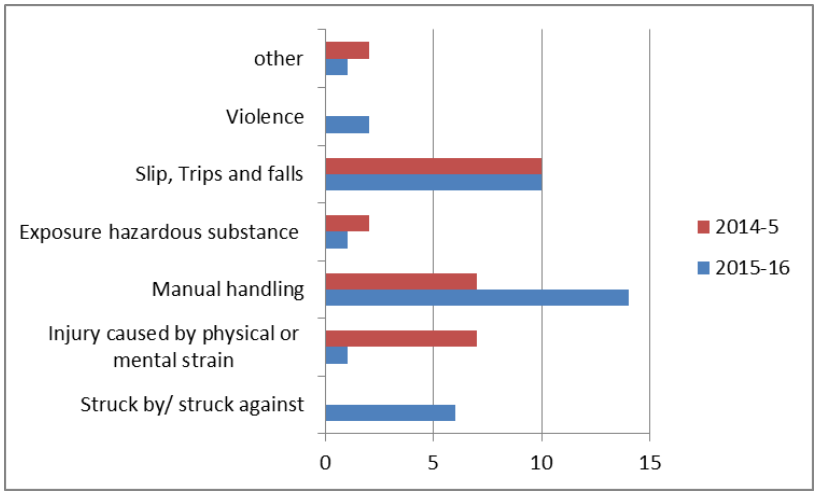
We encourage our staff to report all incidents and accidents, including any incidents which are related to health and safety. Our incident reporting profile for staff related incidents is shown in the graph below:



Reports of adverse events affecting staffing levels was the only category showing a rise from the previous year. A more detailed analysis of this category did not identify any particular patterns.

Across all other categories there was no significant change from the previous year. (Analysis of "lifting accidents" and "physical or mental strain" showed that similar incidents were reported in both these categories.)

The Trust's Health & Safety Committee is informed of incidents reported to the Health and Safety Executive (HSE) under Reporting of Injuries Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). All RIDDOR incidents reported to the HSE are investigated, recorded on a register. A quarterly summary of RIDDOR reports to the HSE is provided to the Health & Safety Committee.



As previously stated, there is overlap in how individuals report incidents either as manual handling or injury caused by physical strain – taking both these categories together there was no significant change in the numbers from the previous year.

There was one contact from the Health and Safety Executive regarding the reported potential exposure of staff to Brucella (exposure to a hazardous substance); no further action was taken by them as a result.

The Health and Safety Committee Membership and Terms of reference were revised in November 2015 to improve effectiveness; Chairmanship was transferred to Director of HR and OD. The Committee met four times in 2015-16.

Health and safety projects which have taken place during 2015/16 include:

- Workplace (Health, Safety & Welfare) Managers Self-Assessment audits conducted via Survey Monkey.
- Review of the Trust Health and Safety Policy.
- A Working Group to review the purchase and maintenance of Hoists.

Training sessions delivered by the Healthcare Safety Team included Health and Safety Awareness (Pay Day Training), Corporate Induction, H&S Awareness for Volunteers, Risk Assessment including COSHH.

4.10. Progress against national standards 2015/16

The following areas are a highlight of a few of the operational developments in clinical services during the course of 2015/16:

- Continued improvements in 'front door' emergency services: the expansion of the ambulatory care service to over 50 attendances per day; the embedding of the multi-disciplinary 'REACT' team in A&E to rapidly assess patients and avoid admission; the introduction of the Rapid Assessment & Treatment rooms in the A&E department to deliver quick consultant assessment.
- The expansion of the macular degeneration service in ophthalmology to deliver faster and more conveniently located access to specialist care.
- The refurbishment of the cardiac catheterization laboratory at Wycombe and the agreement to build a second to meet increasing demand.
- The successful implementation of a new Patient Administration System.
- The agreement to expand Stroke services on the Wycombe site with the agreement to repatriate patients from East Berkshire, reflective of the service's top decile national performance.
- The management of significant growth across all parts of the community services and the launch of community locality team pilots.

Delivery of national access standards:

Standard	Performance	Narrative
Urgent Care Access – 4 hour standard >95%	**93.2%**	Performance higher than national average but significant concerns around quarter 3 & 4 access
Delayed transfers of care <3.5%	**3.6%**	

Standard	Performance	Narrative
Referral to Treatment (18 weeks) >92% pathways <18 weeks Zero patients >52 weeks	92% 1	Maintained performance alongside implementation of new PAS system
Cancer Access 2 week wait >93% 62 days > 85% 31 days >96%	95.1% 88.3% 99.2%	Strong performance across all areas despite rising demand
Diagnostic waits <1% greater than 6 weeks	0.1%	Strong performance
Cancelled operations 0 patients rebooked not rebooked within 28 days Urgent operations not cancelled twice	0 0	Strong performance

Operational performance of the organisation is managed through the 'Performance Management Framework'. Each clinical division formally reports operational delivery of all quality and business standards through a quarterly Performance Improvement Forum (chaired by the Chief Operating Officer, attended by all executives) which in turn reports risk through to the Executive Management Committee. This performance framework is replicated down through the organisation from Divisional level through to individual Service Delivery Units.

4.11. Infection Control

We continue to minimise the risk of our patients acquiring Healthcare-associated Infections and we reported only one MRSA bacteraemia this year.

Regarding Clostridium difficile infections, although we reported 38 cases, against a limit of 32, only one of these was due to a lapse in the care of the patient while in the care of the Trust.

4.12. Looking Forward – 2016/17

The operational focus of the clinical services will be on the delivery of the key 3 part strategy of the organisation in delivering:

- People Development
- Quality
- Improved financial efficiency

There will be a particular focus on the following components:

- Recovery of the 4 hour standard to a 95% delivery: achieved through continued pathway redesign through the Reforming Urgent Care board and transformation of community services to support the avoidance of admissions and partnership working to rapidly support people to recover from hospital admission at home.

- Improvement in elective access with recovery of the 92% standard in Referral to Treatment for surgical specialties.
- Continued delivery of the 62 day standard and compliance at tumour site level.
- Delivery of agreed financial improvement targets, with particular emphasis on productivity in length of stay and theatre utilisation.
- Delivery of the quality strategy with emphasis on continued improvements in improving safety, clinical outcomes and patient experience.
- The delivery of key strategic priorities such as a revised pathway for MSK patients, transformation of community services and the development of services on the Wycombe site.

4.13. External awards and recognition

We are proud of individual members of staff and collective teams who have excelled in their field and had their achievements and commitment recognised in a host of regional and national awards this year.

Dignity and Respect Awards

The Trust came out winners in the health category of Buckinghamshire County Council's Dignity and Respect Awards. Healthcare assistant Salma Hussein, the winner, was nominated by former patient Roy Collis who described the care he received from her as "old-fashioned nursing care with a lovely sense of humour". Consultant ophthalmologist Hiten Sheth was also shortlisted as a finalist and the Amersham ACHT and Jo Birrell, nurse consultant for older people, were commended in the same awards.

Top Hospitals Award

For the first time in its history, the Trust was ranked as one of the UK's top hospitals by
health intelligence specialists CHKS. The 'Top Hospitals' award is based on the evaluation of more than 20 key performance indicators covering safety, clinical effectiveness, health outcomes, efficiency, patient experience and quality of care.

Spinal Injuries Association Awards

Our world-renowned National Spinal Injuries Centre (NSIC) based at Stoke Mandeville Hospital swept the boards again at the annual Spinal Injuries Association awards, winning four of the seven awards it was nominated for. Occupational therapy clinical specialist Ruth Peachment won the health and wellbeing achievement award; operations manager Claire Guy was named outstanding leader; occupational therapist Victoria Munro was awarded in the vocation and employment category, and the physiotherapy team were given the outstanding team award.

CARF Award

The NSIC continues to be the only unit in the UK to hold the coveted CARF international accreditation for excellence in the care of spinal cord injury patients.

Queen's Nurse Award

A number of our nurses have been awarded the title of 'Queen's Nurse' by the Queen's Nursing Institute, in recognition of their commitment to high standards of practice and patient care. They include, for example, our lead nurse for integrated elderly and community care, Helen Mehra, who is a familiar face in the Chilterns with GPs and patients, having spent much of her career as a district nurse in the area.

Clinical Pharmacist of the year

We were thrilled when Satinder Bhandal, the Trust's first consultant pharmacist, was named clinical pharmacist of the year at the national Royal Pharmaceutical Society awards. Dr Bhandal was recognised for her innovative work in setting up the Novel Oral Anticoagulation Clinic which makes it easier for patients to be prescribed medicines to help reduce the risk of stroke.

Clinical Research Impact

Our research and innovation team beat off around 70 other nominees to be shortlisted in the clinical research impact category of the prestigious HSJ Awards 2015. The team was recognised for the work they have done in increasing the number of projects and research recruits within the Trust, and the significant impact the research conducted has had on patient care.

Macmillan Quality Environment Mark

The specialist cancer care and haematology ward at Stoke Mandeville Hospital became only the second inpatient ward in England to receive the Macmillan Quality Environment Mark (MQEM) for offering high standards of care for people affected by cancer. Macmillan cited the extent to which staff have engaged with patients to make small changes which have personalised the environment for cancer patients.

‘A’ rated Stroke Service

The Royal College of Physician’s quarterly Sentinel Stroke National Audit Programme (SSNAP) audit ranked our acute stroke service at Wycombe Hospital as one of the top 7% in the country when it awarded it its coveted overall ‘A’ rating. It was the first time any NHS Trust in the Thames Valley has been awarded the top score in the audit, which is the single source of stroke data across the country.

NHS National Leadership Recognition Awards

Dr Andy Tyerman, consultant clinical neuropsychologist and founding head of our community head injury service (CHIS), along with associate director for service improvement Jo Hockley, were finalists in the NHS National Leadership Recognition Awards. This followed their success as winners in their respective categories in the Thames Valley and Wessex Leadership Academy regional awards where Andy was chosen as NHS Patient Champion of the Year and Jo won the NHS Innovator of the Year.

Ophthalmology

Described by the judges as “the definition that everything that an unsung hero is”, our ophthalmology department medical secretary Janet Sear was a winner at the Bayer Ophthalmology awards for her sterling work as the lynchpin in ensuring our busy department runs smoothly.
Janet’s colleague, Larry Benjamin, consultant ophthalmologist received the Charity Staff Foundation’s ‘Care Service Provider’ award for his voluntary work with blindness prevention charity Orbis. Every year since 2004 Larry dedicates a percentage of his own time to training ophthalmologists and treating children in some of the poorest regions in the world.

Occupational Health

The Trust's occupational health and wellbeing team celebrated being reaccredited as one of the first 150 occupational health services in the country to have the national SEQOHS accreditation. It highlights the quality of our occupational health policies, as well as the vital work our occupational health team do to continuously support staff health and wellbeing.

Endoscopy

Our endoscopy team based at Wycombe Hospital achieved the Gastrointestinal Endoscopy accreditation for 2016, awarded by the Royal College of Physicians. The accreditation demonstrates that the endoscopy team are meeting and continue to meet the quality improvement standards set by JAG and is testament to the quality service the team provides.

Healthcare Superstars

Thirteen individuals and teams were recognised for going above and beyond to make a real difference to patient care at our 'healthcare superstar' annual staff awards. And as always, staff and patients had the opportunity to nominate Trust representatives who they felt should be recognised for our monthly 'going the extra mile awards. This year, we received around 140 nominations for staff in a diverse range of jobs and functions – testament to how every member of staff makes a valuable contribution to our goal of providing safe and compassionate care.

5. Our staff

The Trust is one of the largest employers in the county with a staff headcount of just over 5,900 people. During 2015/16, our numbers of directly employed staff fluctuated between a low of 4940 (full time equivalents (fte)) at 31 March 2015 to a high of 5034 (fte) at 31 March 2016.

5.1. Recruitment and retention

We are committed to recruiting and retaining the highest calibre of staff in all areas. However, we have faced challenges during the year - the annual rolling turnover figure stood at 14.5% in March 2016, above the Trust bench mark for the year of 12% – this figure fluctuated throughout the year, with September 2015 a low of 14.5% to a high of 16.1% in May 2015.

Turnover of both qualified nurses and healthcare assistants (HCAs) contributes significantly to the overall Trust figure and at the end of March stood at 15.7% (qualified nurses), and 16.2% (HCAs), both slightly below the average for the year.

The recruitment of qualified nursing staff remained a priority throughout the year, with retention being a particular focus in the latter half, with a task and finish group approach being put in place.

A review of nurse recruitment numbers for f/y 2015-16 shows that 228.5 fte nurses joined the Trust, with 252.7fte nurses leaving. We have also analysed the number of individuals who have moved to new roles within the Trust, a figure of 244.1 fte. These

figures underline the importance of our work on nurse retention, and we will look to build on our successes as well as reflect on learning from leavers in the forthcoming year.

For other staff groups, we have used a combination of methods to shape the workforce structure and fill vacancies. The recruitment team is providing tailored support to teams across the organisation who face specific recruitment challenges

5.2. Equal Opportunities and Gender distribution

The Trust's Equal Opportunities and Diversity Policy sets out its aims and objectives with regard to management and promotion of equal opportunities and diversity.

The purpose of the policy is to assist the Trust in achieving its aims regarding equality and diversity in employment and in its service delivery, whether or not these are covered by statute.

The Trust Board is fully committed to the principles and practices of Equal Opportunity and Diversity in employment and service delivery. The Trust aims to create a framework which promotes a working environment in which all individuals are able to make best use of their skills, free from discrimination or harassment, and in which all decisions are based on merit and the needs of the service. People's differences will be recognised, accepted and valued.

The gender distribution for all staff and for senior managers is shown below:

As at 31 March 2016	Total headcount	% Male	% Female
All staff	5921	18	82
Senior Managers (as categorised in Electronic Staff Record)	133	35	65
Exec Directors	8	72	38

5.3. Temporary Staffing

Managing spend on agency staffing remains a Trust priority in order to deliver high quality at best value to the organisation. 2015/16 saw significant changes to the management of temporary staffing across the NHS, driven by nationally imposed rules and caps from Monitor and the TDA. These included requirements to:

- procure all agency staff at or below nationally-set price caps
- use approved framework agreements to procure first nursing and then all agency staff
- meet a financial target of 8% for nurse agency spend as a proportion of the total nurse staffing bill

We have had considerable success in meeting these requirements and have led the way regionally in our management of agencies. We haven't used any off-framework nurse agency since the start of September 2016 and have met the price cap rules in all but the most specialist and hard to fill areas. Financial benefits have also started to be realised.

5.4. Employee benefits highlights

The Trust continues to provide a range of employee benefits. These include salary sacrifice schemes for staff with childcare needs in the form of childcare vouchers, for bike purchases as part of a cycle to work scheme and most recently a lease-car scheme. We've also teamed up with a number of gyms and leisure centres across the county to negotiate discounted memberships for staff. The Pilates and Yoga onsite exercise classes at Wycombe and Stoke Mandeville Hospitals are subsidised, competitively priced and in many instances delivered by our own staff.

The staff benefits pages on the new intranet provide a plethora of local and national businesses offering discounted goods and services for staff – for everything from purchasing a new car or mobile phone, to days out with the children, restaurants and beauty services.

5.5. Education, learning and development

The Department of Health Mandate to Health Education England commits to provide all staff with personal development, access to appropriate training for their jobs and line management support to succeed. The Learning and Development team (which incorporates the management of the medical education team) works in close collaboration with the Health Education Thames Valley.

The Trust's approach to the development of our people is focused around five themes:

- Leadership and Management
- Post qualification Education
- Pre-qualification Education
- Vocational Learning
- Foundations for Education, Learning and Development

Ensuring our managers have the skills and competencies needed is key and this has been delivered during 2015-16 through a number of new initiatives within each theme outlined above:

Leadership and Management

Increasing the skills and competences of our leaders has been a key plank of the Trust's Organisational Development Plan in 2015-16. During the year, a Multi-Professional Leadership Pathway has been rolled out to more than 120 senior managers, a third of whom are Consultants. We have also rolled out a coaching programme, "Coaching to Promote Positive Behaviours Programme" to circa 200 band 6 and 7 employees.

Bite-size Leadership and Management Modules are available for employees seeking development within specific areas.

Lessons Learnt Feedback Sessions

The 2015-16 Lessons Learnt sessions (open to all staff) have been held across the 3 hospital sites; 108 people have attended. These sessions review incidents that have occurred in the Trust and disseminate the learning to ensure that we all learn the lessons of the case and improve the quality of care we provide.

Preceptorship

Clinical skills training continues to be allocated to preceptees at the beginning of their Preceptorship programme, giving them and their manager a clear plan of learning for the year ahead. The programmes of learning reflected the clinical skills needs of the Trust. The Clinical Skills Lead ensured that the programmes continued to remain current and up to date, incorporating any national changes to practice, initiatives or recommendations, as well as reflecting relevant comment and feedback.

Statutory Training
In December 2015, compliance reached 89%, against an overall Trust target of 90%. Since then we have seen compliance levels reduce, with compliance at 84% in March 2016. This reflects the challenging target set by the Trust - operational managers and the HR Team are continuing to work collaboratively to achieve the Trust target of 90% as a priority - face to face training sessions continue and the HR Team and managers are targeting those individuals with low levels of compliance which could include disciplinary action. Payday training has had a successful uptake and dates have been planned for next year and are available for booking via the intranet.

5.6. Values Roll Out

During the year, we developed and rolled out refreshed Trust values and associated behaviours:

- **C**OLLABORATE – together as a team
- **A**SPIRE – to be the best
- **R**ESPECT – everyone, valuing each person as an individual
- **E**NABLE – people to take responsibility

The "CARE" values were developed by a cross section of staff to help celebrate the great care that already takes place right across our Trust and to reinforce the fantastic work staff do day in, day out. They are incorporated into corporate induction, appraisal process and leadership and management training, with further embedding and celebration planned for 2016-17.

5.7. Staff in Agenda for Change Band 1-4

The development of staff in Bands 1-4 is a key element of our workforce planning as we look to respond to the five-year forward view; reviewing the skill mix of our staff and providing a clear development pathway, will enable us to develop a sustainable workforce for the future.

We continue to provide the National Care Certificate (we were an initial pilot site in April 2014) which was implemented following the Francis report in response to standards of care.

Each new recruit undertakes a comprehensive induction programme over the first 3-4 months' of employment, followed by a Development Programme which culminates in a Level 3 Healthcare qualification completed within 2 years of employment

The Trust has completed more apprenticeship (105 in total) than any other health care provider in Thames Valley in the financial year 2015/6; these staff are predominantly Health Care Assistants (98) and other Bands 1-4 staff (8). The majority (88) are undertaking a Health & Social Care (level 3) Apprenticeship, with other level 3 Apprenticeships including Peri-Operative Support, Allied Health Professional Support, Pharmacy Support and Admin & Clerical. We have also supported Business Administration (level 4) Apprenticeships.
We are embedding the role of Band 4 Assistant Practitioners within the organisation. 13 students graduated in September 2015, with a further 15 students are continuing into the second year and due to qualify in July 2016. Specialist services such as Radiology and Audiology are also supporting foundation Degree Students. Moving forwards we are looking to increase our commissions.
Assistant Practitioner roles are an important strand of our plans to developing our future workforce; as part of this we are also in dialogue to commission ongoing CPD and the provision of clinical skills training and competencies, alongside other developmental opportunities.

5.8. Occupational health, Staff Wellbeing and Healthier Lifestyles Services

Throughout the year we addressed the NHS Constitution pledge to provide support and opportunities for staff to maintain their health, wellbeing and safety. Improving staff health and wellbeing is a Trust priority and impacts on our ability to retain staff. We have re-configured the service so there are now 3 distinct aspects – OH Services, Staff Wellbeing and Healthier Lifestyles services – with the later also being available to patients and visitors to The Trust.

We have further enhanced our pro-active interventions, including our resilience work to individuals and teams, funded via HETV. The staff survey results reflect this activity and we are in the top 20% Trusts for taking an interest and action in staff health and wellbeing.

Benefits to the business of improved staff health and wellbeing include higher productivity, increased flexibility and customer service, for example to cover for absence and holidays, raised morale, motivation, commitment and engagement, reduced absenteeism, improved recruitment and retention and OHW works closely with HR and management colleagues to provide support initiatives where staff wellbeing is a component.

We have an established health and wellbeing steering group and Champions group and close collaboration with BCC public health team

A Case Manager approach to the pro-active management of sickness absence is led by the HR Business Partners and the OHW Sickness Absence Case Mangers, and supported by our Occupational Health and Wellbeing service, with a particular focus on Health Summits being more widely established. Other key interventions include:

- A self-care course to HCA's and there plans to widen this to other staff groups
- Regular health checks and other wellbeing events for staff
- Fast track services to psychological wellbeing support
- Fast-track physiotherapy

5.9. National staff survey 2015

In 2015 we participated in the 13th annual NHS national staff survey. There were significant changes made to the staff survey core questionnaire in 2015 and the number of key findings changed from 29 to 32.

For the first time, we were benchmarked against combined trusts (acute and community trusts, of which there are 38 (new category nationally). In 2015 for the first time we took the decision to sample all staff (previously we had just sampled 850)

We achieved a 52% response rate in 2015 compared with 44% in 2014. The national average for acute and community trusts in 2015 is 41% (the highest response rate was 59%)
Staff engagement has improved from 3.60 (ranked worst 20% Trusts in 2014) to 3.76 now ranked as average, with the national average being 3.79 (highest scoring trust 4.03)

In 2015, we decided to focus on five key priorities and saw improvements in all areas.

Priority	2015 results	2014 results
Improve our response rate to staff survey to 60%	All staff surveyed 52% response rate achieved National average was 41%	850 staff surveyed 44% response rate achieved
Improve our staff engagement score Achieve national average 3.74	3.76 National average 3.79 Ranked average	3.60 national average 3.74 Ranked worst 20% trusts
Improve our score in KF9 (now KF 10) the percentage of staff receiving support from immediate managers Achieve national average 3.65	3.71 National average 3.72 Ranked average	3.53 national average 3.65 Ranked worst 20% trusts
Improve our score in KF21 (now KF6) the percentage of staff reporting good communication between senior management and staff Achieve national average 30%	27% National average 30% Ranked below average	22% national average 30% Ranked worst 20% trusts
Improve our score in KF15 (now KF31) the percentage of staff agreeing they would feel secure raising concerns about unsafe clinical practice Achieve threshold for top 20% of trusts	3.55 National average 3.64 Ranked below average	3.42 National average (not comparable) Ranked worst 20% trusts

More widely, the Trust also no longer feature in worst 20% of Trusts for any key finding, with 18 average, 3 better than average and 11 worse than average.

5.10. Consultation, negotiation and communications

The Trust recognises and has developed a positive working relationship with its trades unions, staff organisations and professional bodies over many years. We work with these bodies on a number of areas - for example organisational change, working conditions and pay, disciplinary and grievance, health and safety, harassment and bullying and improving working lives.

5.11. Communications and provision of information to employees

During 2015-16, the Chief Executive has led the development of the BHT way. In particular, in relation to our workforce, a new relationship with our staff has been established with significant steps taken in developing our culture. A regular forum headed up by the Chief Executive and Board colleagues has been established for 500 leaders across the Trust. This forum is used to develop and shape strategy.
In addition, there are well-defined strategies supported by robust delivery mechanisms to involve staff with clinical, service, strategic and organisational developments.
Regular activities include the monthly team-briefing from the CEO or Director to ensure messages are cascaded verbally throughout the organisation, a weekly staff e-bulletin, and a chief executive blog. These activities are supported through the Trust intranet, which has been significantly enhanced over the past year, with up-to-date news and features, a staff blog, and a comment function on stories to encourage a two-way dialogue on Trust matters.

5.12. Whistleblowing and raising concerns

Raising concerns and Whistleblowing was a priority for the Organisation in 2015-16. We were pleased with the progress we made this year, and will continue to seek improvements in this area.
As well as measuring progress through the National Staff Survey, we monitored how safe our staff feel raising concerns through the inclusion of a question in the quarterly staff Friends and Family Test. We also carried out a self-assessment using the NHS

Employers “Draw the Line” toolkit – the outcomes from this work will inform on-going and future activities. Interventions included the launching of a dignity and respect listening service (set up to offer staff a confidential listening ear and to support and signpost) and a number of focus groups for staff. Our work has been highlighted the work through quarterly communications in the Trust staff bulletin.

5.13. Staff Recognition and Reward

As an employer we recognise the value and importance of recognising and rewarding achievement. Annually, we host a Staff Awards programme; this event, now in its 12th year, continues to be well received within the organisation. In addition, the “Going the Extra Mile Awards” continue and in 2016 we linked these to our new values and behaviours – CARE awards. This is monthly scheme in which staff nominated by either patients or colleagues are awarded a cash voucher by the Chief Executive at the Trust Board meetings as a “thank you” in recognition of their work. Our Long service awards recognise staff who have achieved twenty years or more continuous service in the NHS. These awards are celebrated annually.

6. Our partners and stakeholders

6.1. Stakeholders

Working and engaging with a variety of stakeholders so they support BHT in shaping health services in Buckinghamshire is an integral element of ‘the BHT way’. This engagement includes:

- System leadership:
    - the Chief Executive chairs the Bucks Healthy Leaders Group
    - a strong partnership with Oxford ASHN, and the Chief Executive chairs the clinical innovation group
    - member of the Bucks Health and Wellbeing Board
- We meet and present to the Health and Adult Social Care Select Committee throughout the year
- The Chief Executive meets with Healthwatch quarterly
- The Chief Executive and Chair, along with commissioning group leaders, meet with all local MPs on a quarterly basis
- We have developed a programme of stakeholder engagement, attending council, community and charity group meetings and events throughout the year.
- Production of BHT Connect, an e-bulletin sent to over 600 local stakeholders

6.2. How we have been engaging and involving our patients and carers

During this period we have engaged or involved more than 550 patients and carers on a variety of different subjects and in different ways. The following highlights just a few of our key examples and demonstrates how positive change has been informed as a result.

6.2.1. End of Life (EOL) – Our EOL patient reference panel which was formed as a result of our original listening event with patients, relatives and carers has been working with us consistently for the past 12 months to inform ongoing developments in our EOL improvement journey. This has helped to ensure the patient and carer view is placed at the heart of changes made. The focus of this work has been end of life care in our general ward areas rather than those already dedicated to supporting end of life.

A showcase follow up event was held in autumn of last year, when all previous attendees and others were invited to hear a mid-year progress update. Reporting back to the public, relatives and carers was an important step in transparency and to make an additional sensor check of our direction of travel with the wider set of patient and relative views. Importantly, five of our EOL patient panel took part in presenting back the progress made and explained to the audience how their views and input had been taken into account and helped to shape the changes made.

- ***Examples of changes achieved, include***:
    - A new Trust wide patient centred EOL care plan has been implemented, helping to improve, care, communication and awareness of patient wishes. This has been an extensive piece of work.
    - A significant increase in staff education and training opportunities across the Trust. We now have a new lead role in place to support this.
    - A lot of work has been achieved and is ongoing regarding improved awareness and understanding on advanced care planning. This includes the difficult conversations about patient's wishes on receiving cardio pulmonary resuscitation at the end stages of life.
    - Review and development of patient information leaflets.
    - A new name for our bereavement office team to offer improved clarity and to help culture appropriate expectations for relatives as well as better signposting from other staff
    - Partnership working with Macmillan to increase specialist nursing support
    - Working and planning with commissioners which includes achieving outreach training for some GPs. We are hoping this will be expanded.

Finally, results of an annual national EOL care audit only very recently published has shown Buckinghamshire to be in a much improved position.
It clearly demonstrates the very real benefits of this significant programme of focused work that has been jointly and meaningfully informed by staff and patients.

One of our patient panel members said:
"We now can see some of the fruits of our labours which makes it worthwhile. We feel we have really contributed and that we have spent our time effectively".
Following our EOL showcase event one of our attendees fed this back to us……..

"On the way home with her son, one lady who is registered blind realised that they hadn't previously talked about her wishes for her end of life and she didn't know what her son's were. They then spoke in detail about what their wishes leading up to and following their death ……Some of the conversation found both of them being very surprised by what each other had said. "x" knew it was a hard conversation to have with her son but she told us she was encouraged to bring the subject up on her way home because what they had heard during the evening at our EOL event"

6.2.2. Enhanced Recovery Programme (ERP) in elective care – Members of staff working within our elective care teams for colorectal, urological and orthopaedic pathways were already receiving positive patient feedback, but they wanted to know more about the experience of patients they were caring for and whether there were further improvements that could be made.

We held two initial listening events called "Learning from You" and we invited people who had been a patient of one of these services over the past year. The patients provided a lot of feedback and ideas about areas they felt might help to further improve the patient experience. These mainly centred on four main areas:

- Patient information,
- Pain management and knowing more about when to ask for more pain relief if needed
- Patient diaries- (more relevant to colorectal services initially)
- A point of contact on the ward provided to the patient at discharge for follow up in case of any problems or concerns when home.

The teams undertook individual projects based on the feedback with an undertaking to involve patients in the developments e.g. patient diaries, patient information etc.

10 months later, we ran a further two showcase events to demonstrate the improvements made based on all the feedback we had received. We invited all those who had attended the first sessions and provided the original feedback but we also invited recent patients so we could ask them if what we were presenting back at the showcase event resonated with their experience. This was a very successful set of events which has resulted in a range of patient informed changes which have and continue to benefit current and future patients.

- ***Examples of changes achieved, include*** :
- An increase in enhanced recovery nurse capacity has been supported and achieved.
- We have implemented patients telling their story of their experience into pre op education classes, we were told this would be really helpful for orthopaedic patients to share learning about degrees of actual mobility when home. *(See audit results below and the impact on patient attendance).* Some of those suggesting this are now involved in delivering it.
- Patient information leaflets have been developed and informed by patients on the wards.
- Patient diaries have been developed and implemented in the colorectal pathway with such success they are being implemented in the other pathways. Patients who were on the colorectal ward informed their development.
- Both of the above have also been designed to help address better pain management information for patients.
- A named point of contact and telephone number is now provided to patients on discharge for these pathways
- Follow up calls have been implemented for patients on discharge from these pathways. 89% of orthopaedic patients received follow up calls in a recent audit period, with similar results for Colorectal and Urology
- Follow up calls have also provided the opportunity to collect ongoing patient experience information and feedback.
- Urology have developed a one stop shop approach for pre op assessment based on what they heard
- Work with our pain management team has resulted in better awareness for staff and patients

The team have implemented many more improvements based on what they heard and audited the changes they had made, presenting results back at the showcase event:

Finally, key results of the audit demonstrated some positive results.

- The colorectal pathway showed a readmit rate of only **6%** which is extremely good performance against the national average of **20%.**
- **92%** of patients were mobilised on day 1 following their colorectal surgery.

- 82% of patients rated their colorectal care as excellent and **18%** rated it as very good.
- 75% of patients are now attending the new pre op education classes which is a big improvement in attendance by patients. (See above patients telling their stories)
- A specific protocol has also been developed and implemented for those patients with Parkinson's coming into elective care as we heard feedback from some patients and carers who had highlighted this was necessary.

One participant who attended the showcase event said: "I nearly didn't come tonight, my friends said it would be a talking shop but you have done so much it's amazing, you really listened to what we told you!"

6.2.3. Sexual Health Service – Feedback from users of these services has always been positive but as part of the commissioners tendering processes, we wanted to use the opportunity to look at how we could further improve our provision. In thinking about a new model of care and modernising provision to meet the needs of busy people of all ages, we wanted to seek the input of service users to ask their views about existing provision and what they felt future provision might look like if different.

Using a survey method to protect the anonymity of the service users, 163 responses were collected.
The level of response and the level of positive response about their care was extremely good.

- ***Examples of changes achieved, include*** :
  Changes were limited in this case because of the feedback - see below

    - The implementation of better access to services via evening clinics is already underway and will go on to develop as was suggested by the patients in their feedback. Locations and geographical spread was also looked into.
    - Service users also highlighted a preference when asked for a one stop approach model to sexual health services i.e. sexually transmitted diseases and the provision of education, advice and contraceptives. This has been reflected in the new model wherever possible.

Finally, just a few of the very positive key results from the survey of 163 patients:

- 72% rated the service they had received that day as excellent and 25% rated it as good**.**
- 100% of all respondents said they felt they were treated with dignity and respect by all staff
- 100% of all respondents said they felt confident in the people who advised them/treated them
- 99% said they valued the quality of care they received via this service
- 99% said the staff who treated or advised them had a non-judgemental attitude
- 98% found the service to be efficient and they found the service easy to access

One respondent added in their response: "The staff are always very friendly and helpful and help you to feel relaxed, the nurse I saw today was very compassionate and understanding and would recommend her 100% and the clinic".

In addition to these more detailed examples of the work we do, there are many other examples which span a range of activities and areas:

- We sought the input and views of more than 50 patients carers and relatives about a potential future design for our A&E and we were specific to make sure we asked the views of those with a sensory and physical impairment. Some immediate actions like portable hearing loops being made available in our current A&E resulted immediately from these discussions.
- We continue to recruit and train patient assessors for the Patient Led Assessments of the Care Environment (PLACE) which are undertaken on an annual basis as part of a national programme.
- We have sought input from 100 patients about information governance this year
- We ran a Carers Voice workshop to inform the development of a new Carers strategy.
- We continue to run our Patient Experience Group (PEG) who influence change and provide feedback on a regular basis, they also review all new patient information.
- We also have a number of patient representatives who sit on committees or groups.

We carry out equality monitoring at our face to face engagement and involvement events and our surveys and evaluations at all our face to face sessions.

7. Equality and Diversity

We have a commitment to ensure that equality and diversity is integrated at the core of our organisation and as part of this we ensure that we meet all the legislative and good practice requirements in this area.

The Public Sector Equality Duty (PSED), which is placed upon all NHS Trusts, provides a legal framework protecting against discrimination, harassment and victimisation, promoting equality of opportunity and nurturing good relations between people who share a 'protected characteristic' and those who don't. We publish information relating to this duty on an annual basis on the Trust Website.

In February 2015, we carried out our Equality Delivery System 2 (EDS) assessment. We undertake this assessment cycle every two years, and reported the detailed findings in last year's report. These are also currently on our website.

As a result of the 2015 EDS2 assessment, the following equality objectives based on the engagement and resulting feedback from staff and patients were agreed by the Board. Work to achieve these objectives continued this year and is ongoing.

Patient related equality objectives

Objective
1) To demonstrate an increased use of British Sign Language (BSL interpreters across the Trust by raising awareness with staff.
2) To undertake a targeted engagement exercise to promote awareness of PALS and complaints with a view to seeing improved diversity in complainants
3) To be able to evidence how we have taken the additional needs of those with sensory impairment e.g. hearing / sight into the redesign of our urgent care environment.

Staff and leadership related equality objectives

3) To see an improved response from staff to outcome 3.4 on bullying and harassment in the next staff EDS2 survey.
4) To review opportunities to progress robust evidence that meets requirements to demonstrate fair and equal pay in line with requirements
5) To further develop robust evidence for the uptake and evaluation of training by staff and by protected characteristic

On 1 April 2015, NHS England launched the Workforce Race Equality Standard (WRES) for all NHS organisations. The WRES was developed to address workforce inequalities relating to (Black & Minority Ethnic) BME staff across the NHS workforce. It draws on research that provides evidence of a less favourable experience and in some cases, disadvantage. It highlights the important links between the consequences of this and patient care.

From 1 April 2015, all NHS organisations were required to demonstrate through the nine point Workforce Race Equality Standard (WRES) metric how they are addressing race equality issues in a range of staffing areas.

We published our data, as required on our website by the deadline of 1 July 2015. During f/y 2015-16 we have been working to address any data shortcomings and to understand and address shortfalls identified by the WRES indicators.

Particular interventions in relation to staff and leadership during 2015-16 were

- Equality & Diversity Training, including a focus on unconscious bias
- A new service delivery model for equality and diversity was designed and launched in each clinical division (Equality Standard)
- An analysis of the on-boarding experience of staff

Moving forwards, we are looking to maintain the momentum of this work. We have also highlighted WRES metrics from the national staff survey as a priority for 2016-17.

With regards to our patients and services, we have been progressing work focused on our patient related equality objectives as above:

- The PALS team have been including the promotion of interpretation and translation services in their PALS training to all staff and this has included community staff in community sites. This includes British Sign language.(BSL)
- In 2015/16 there has been a 12% increase in the number of requests for the use of our interpreting services over the same period in 2014/15 although this rise is not specific to BSL but all languages.

- PALS have also helped to raise awareness with staff regarding the reporting of concerns and complaints continuing to show representation largely from a white British population. It has slightly improved but more work to do.
- We have developed a welcome slide (the word welcome is in 17 different languages) for our digital screens which are displayed in at least 8 high footfall locations across the Trust.
- Posters are in final draft for the advertisement of our interpretation and translation services to be displayed across the Trust in public areas.
- When available and relevant, patient stories are placed into the staff bulletin to highlight issues for those with a sensory impairment as we continue to raise awareness about meeting the needs of our patients e.g. “Meet Tony”
- We hosted an event aimed at those with a sensory impairment to feedback their views on a new design for the future refurbishment of our A&E, whilst attendance was very poor we did receive some very helpful feedback:

    - Those who attended told us staff need to feel more confident to ask people if they have an impairment and that people do want to be asked. This was heard by senior clinicians in the department and has been fed back to the wider team.

- We also heard that people do not want to have to keep repeating their impairment to different clinicians as they proceed through the department. Our senior lead clinician made an immediate request to ask if our booking in system in the department could have a question added about impairment for the check in process.
- Patients with a hearing impairment told us portable hearing loops would be really helpful and these were invested in directly after the event and are now in place.

- In addition there has been an increase in the amount of equality monitoring on patient experience as a result of a newly implemented texting service to supplement our Family and Friends test. This is a significant improvement in our ability to make more meaningful analysis. Our annual publication of equality monitoring as part of our PSED will reflect this once published.

As we look to 2016-2017 we are looking forward to delivering our first one day equality conference “Personal, Fair and Diverse services” which will take place on the 23rd June this year.

8. Charitable and voluntary services partners

The Trust is incredibly grateful to the many people who give their time for free and donations in support of improving our services for patients. They include:

- the charity **Scannappeal**
- **the League of Friends, working across our acute and community** hospital sites
- the **Cancer Care and Haematology Fund** at Stoke Mandeville Hospital
- the **RVS**, staffed almost exclusively by volunteers
- the **Florence Nightingale Hospice Charity.**

Along with individual volunteers these groups have all made a significant contribution to helping our teams improve the experience and environment for patients.

The Trust's charitable fund receives income which is made up of donations, legacies, funds from activities and investment income. These monies are used to enhance services focused on patients' welfare, staff welfare, research and general charitable hospital purposes. In year the Charity has purchased equipment, provided an enhanced environment for our patients, including paying for refurbishment of the Spinal Injuries Centre reception and open areas and supported our staff. We are grateful for everyone who has contributed to the Charity to help us to help our patients.

The Trust Board is the corporate trustee of the funds, and a separate annual report and accounts are produced for the charity, which are available from our website www.buckshealthcare.nhs.uk. The Charity also has a section on the website providing more information on its activities. In 2013/14 accounting rules were applied which means that the Trust was required to provide both accounts in its own right and also accounts showing the consolidated results of the Charity, which remains the case for 2015/16. However, it should be emphasised that the Charity works independently of the Trust in the allocation of its resources and does not exist to subsidise NHS expenditure.

9. Academia and Industry - The Oxford Academic Health Science Network (AHSN)

Buckinghamshire Healthcare NHS Trust is involved as a partner organisation within Oxford AHSN's work programme.

The Best Care Programme consists of 10 Clinical Networks, each working to deliver a number of measurable improvement projects.

The key objective of the Clinical Innovation Adoption (CIA) Programme is to increase the speed and spread of clinical innovation adoption across the region. The Trust is involved with the following projects**:**

Project
Atrial Fib & ECG Monitor (now combined)
Electronic Blood Transfusion
IPC Sleeve
Early Inflammatory Arthritis
Gestational Diabetes Medicine
Intra Operative Fluid Management
Falls
Alcohol Care Teams
Fragility Fracture
Heart Failure (IV in community/home)
Biosimilars
Dementia & SHaRON

Other projects which are likely to be of interest are the following:

Project
CAUTI – Bladder Scanners
Respiratory
Patient Monitoring

10. Our estate and sustainability

The sustainability report is shown in Appendix 4.

11. Emergency planning, resilience and response (EPRR)

In line with its statutory obligations under the Civil Contingencies Act as a Category 1 responder, the Trust continues to provide a proactive and visible service for EPRR.

The Trust continues to work on developing and improving its resilience and ability to respond to significant incidents. Assurance for this process is run through the Trust Resilience Committee. This is chaired by the Trust COO who is the designated Accountable Emergency Officer responsible for ensuring our compliance against NHS England EPRR Core Standards. The Trust is assessed against these standards on a yearly basis. The annual assessment process run by NHS England has identified some areas of best practice and these have been shared regionally with other providers. This included our model for the Resilience Committee and associated project groups and Incident Response Policy.

The Trust Resilience Committee looks to ensure that its annual work programme addresses the requirements and compliance against the core standards as required by the NHS Commissioning Board Emergency Preparedness Framework (2013)

Reporting to the Resilience Committee are a number of project groups who work on the individual work streams. These project groups are chaired by a number of senior Trust staff from across all specialties and disciplines. The membership of each project group being specific to the work stream ensures that specialist and focused work is being done behind the scenes to ensure all plans and resources are reviewed, tested and fit for purpose.

In line with requirements the Trust takes part in the bi annual regional communications cascade exercise ‘Talk Talk’ and work this year has been focussed on ensuring individual departmental cascades are in place.

As a minimum the Trust is also required to hold an annual table top exercise. In order to comply with this and to enable us to test a number of plans and ensure access for all Gold and Silver Commanders and key staff to participate in a table top exercise, the Trust hold a number through the year. Plans held in the last year include a Pandemic Flu exercise which had good representation from across the Trust as well as whole system partners from NHS England, Public Health England and CCG. A further table top exercise based on a Hazmat/CBRN incident was also successfully held. Exercises are planned for the remainder of the year to test planning around Business Continuity Issue and Mass casualties.

The Trust also continues to develop an on-going training schedule across all areas and sessions range from Loggist training, training for management of contaminated casualties, fit testing for FFP3 patients, Training for Gold and Silver Commanders, Business Continuity workshops, through to specific training for issues such as management of potential Ebola patients.

EPRR continues to work closely with key departments to ensure plans are integrated with daily practice and makes best use of available resources and expertise. This includes work with other stakeholders such as NHS England, CCG, primary care providers and private establishments. The Trust is well represented by the Emergency Planning Officer at a number of regional forums including the Counties Local Resilience Forum and the LHRP Business Group.

12. Information governance

The Trust recognises the importance of managing information appropriately and securely and has a nominated executive director as the senior information risk owner (SIRO).

The role is responsible for ensuring the Board has reliable assurance that appropriate controls are in place and that risks are managed in relation to all the information used for clinical, operational and financial purposes.

The Trust Caldicott Guardian is responsible for the establishment of procedures governing access to, and the use of, person-identifiable patient information and the transfer of that information to other bodies, where this permitted.

The Caldicott and Information Governance Committee monitors the performance of the Trust against the requirements of the Information Governance Toolkit. The Trust has self-assessed its performance on information governance requirements using Version 13 of the HSCIC Information Governance Toolkit. The Trust's end of year overall submission for 2015/16 achieved a score of 85% resulting in a 'satisfactory' rating. During 2015/16, internal Auditors RSM reviewed Version 13 of the Toolkit to provide assurance on the accuracy and quality of the submission. Detailed testing was undertaken for selected samples and the draft report suggests that areas for focus are data mapping across the organisation and establishing a comprehensive information asset register.

The Trust continues to improve information risk controls which includes ensuring that all staff undertake mandatory annual information governance training. Regular communication to staff on information handling, information security and best practice continues to be a priority for the Trust and is supported by policies and guidance.

During 2015/16 there have been five Level 2 serious incident data breaches. Four of these were disclosures of information in error and one was a corruption of data on our Medway patient administration system. These breaches were reported to the Information Commissioner's Office (ICO) via the IG Toolkit and four of the five have been assessed and closed by the ICO with no further action required. The ICO are still in the process of investigating one incident. All incidents were reported to the Caldicott Guardian and were thereby assessed for the level of seriousness. The incidents were then considered by the Caldicott Guardian to determine where improvements to information security and confidentiality can be made and to seek assurance that internal policies and procedures adequately reflect the rules on confidentiality.

Committed to Freedom of Information

The Trust received in total 526 Freedom of Information requests in the period 1 April 2015 to 31 March 2016, 16 fewer than in the same period the previous financial year. Despite the slight decrease in volume it is worth noting that many FOI requests were complex and multi-faceted, requiring detailed information from various departments.

Twelve requests were referred on to another organisations as information requested was not held by the Trust and three were withdrawn by the requestor. Three requests were closed because no response from the requestor was received after four months following a request for clarification. Full exemptions were applied to 35 requests where no information was provided to the requestor and there were 202 other requests where only part of the information was made available due to partial exemption.

13. Counter Fraud

The Trust continues to take its responsibilities serious to combat fraud and has a full programme in place to support this.

14. Our Trust Board

The Trust Board provides strategic leadership to the organisation. It sets the strategic direction, ensuring management capacity and capability, monitoring and managing performance and fosters the appropriate culture.

It outlines the vision of the organisation and champions and safeguards its values, keeping the safety of patients at the centre of its work and ensuring obligations to all key stakeholders are met. By ensuring the effective and efficient use of resources it safeguards public funds.

Non-executive and executive directors both have responsibility to constructively challenge the decisions of the Board. Non-executive directors have a particular duty to hold the executive directors to account, ensuring appropriate challenges are made. As well as bringing their own expertise to the Board, non-executive directors scrutinise the performance of management in reaching goals and objectives, and monitor the reporting of performance. They need to satisfy themselves as to the quality and integrity of financial, clinical and other information, and ensure that the financial and quality controls of risk management are robust.

14.1. Directors and the register of interests

The register is maintained by the Senior Board Administrator who holds the original signed declaration forms. These are available for inspection by contacting the Head of the Executive Office on 01296 418186.

Name	Position	Interests Declared
Dipti Amin	Non-Executive Director	Medical Information and Toxicology Services (non paid Director) Trustee of Faculty of Pharmaceutical Medicine Member of the Innovation Board of the ABPI
Ian Anderson	Director of Human Resources	None
Neil Dardis	Chief Executive Officer (Interim)	None
Rachel Devonshire	Associate Non-Executive Director	None
David Garmon-Jones	Non-Executive Director Designate	Niece working in the National Spinal Injuries Centre. Chairman of a company called Decideum. This small company specialises in advising its customers on health policy matters e.g. it helps support disease specific initiatives like All Party Parliamentary Groups and advises individual pharmaceutical companies on health policy matters.
Rajiv Jaitly	Non-Executive Director	Board Apprentice Ltd – ceased to be a director on 20 April 2016, MHS Homes Ltd, Member of the Finance Risk & Audit Committee (non-executive) 21 November 2013 to-date (UK); GFG Ltd, Advisory Board Member, 10 January 2013 to-date (Jersey); Greenwish Partners, Advisory Board Member, 1 January 2012 to-date (France); Jaitly LLP, Managing Partner, 21 April 2009 to-date (UK); shares in GSK and Astsra Zeneca through a self-invested ISA. East Thames Group Ltd, non-executive director and chair Group Risk Management and Audit Committee effective 21 March 2016. Heirloom Investment Fund SPC - appointed non-executive director 11 April 2016
Graeme Johnston	Non-Executive Director	Member of local PPG (chair); Member of Aylesbury vale CCG (north locality) patient engagement group; Member of the scientific advisory board for immunology for UCB Pharmaceuticals of Belgium for which he receives a small honorarium Patient (lay) Member of worldwide pharmaceutical initiative "Patient Focussed Medicine Development" for which he receives out of pocket expenses and travel benefits. Chair of the Fitness to Practice Panel, Buckingham

Name	Position	Interests Declared
		Medical School which meets on an ad hoc basis and for which he is paid on an hourly rate
Tina Kenny	Medical Director	Visiting Professor, Buckinghamshire New University
Hattie Llewelyn-Davies	Chair	Chair Viridian Housing Group. Directors' fees payable of £20k p.a. from 1.8.14 Owner/Director of consultancy business that does not undertake work with the NHS but may advise organisations that do. Working with Capsticks solicitors around housing. Daughter a student with Bucks New University.
Mary Lovegrove	Non-Executive Director	Director of Allied Health Solutions Director of Allied Health Enterprise Development Centre (Joint venture between Allied Health Solutions and Buckinghamshire New University Member of Board of Trustees-British School of Osteopathy Emeritus Professor - London South Bank University
Neil Macdonald	Acting Chief Operating Officer	Wife managing partner of Marlow Medical Group
Carolyn Morrice	Chief Nurse	None
David Sines	Associate Non-Executive Director	Emeritus Professor - Buckinghamshire New University Non-Executive Director Central London Community Healthcare Trust Trustee - The Burdett Trust for Nurses
Dominic Tkaczyk	Interim Director of Finance	None
David Williams	Director of Strategy and Business Development	Brother is a personal injury lawyer and may act for clients from the spinal injury unit and elsewhere across the Trust.

REMUNERATION REPORT

14.2. Remuneration report Directors' remuneration

The Secretary of State for Health determines the remuneration of the Chair and non-executive directors nationally. Remuneration for executive directors is determined by the Trust's remuneration committee.

The remuneration committee is made up of all the non-executive directors and is responsible for agreeing the remuneration of the executive team and senior managers who are not subject to Agenda for Change (the national pay system adopted by the NHS). The committee reviews the pay of executive directors annually taking into account prevailing factors such as national pay rises and salaries paid by other NHS employers.

The executive directors are employed within a standard employment contract which provides for a six month notice period. On termination of employment the director would be entitled to contractual severance terms, such as pay in lieu of notice and redundancy.

The non-executive directors are appointed for a set term of office. Their original date of appointment, date of expiry and extended date of tenure (if applicable) are set out below:

Name	Date of appointment	Date of leaving	Date of expiry	Extended date of tenure
Ms Hattie Llewelyn-Davies (Chair)	March 2014		March 2016	March 2018
Mr Les Broude	May 2007		April 2015	April 2016
Professor Mary Lovegrove	May 2014		April 2016	April 2018
Mr John Pulsinelli	May 2014	May 2015		
Mr Graeme Johnston	March 2013		March 2015	March 2017
Mr Rajiv Jaitly	June 2015		June 2017	
Ms Dipti Amin	June 2015		June 2017	

There are no rolling contracts, nor is there any performance related pay for any director.

In 2015/16 there have been no significant awards or compensation payments made to past directors, and no amounts are payable to third parties in respect of any director.

Membership of the remuneration committee during 2015/16:

Ms Hattie Llewelyn-Davies (Chair)
Mr Les Broude
Professor Mary Lovegrove
Mr John Pulsinelli (until May 2015)
Mr Graeme Johnston
Mr Rajiv Jaitly
Dr Dipti Amin

Full details of directors' remuneration and pension benefits are given below:

	2015-16					2014-15				
Name and Title	Service as Director in year	Salary (bands of £5000) £000	Expense Payments (taxable)* total to nearest £100 £00	All pension related benefits (bands of £2,500) Rounded to the nearest £100 £000	Total (bands of £5000) £000	Service as Director in year	Salary (bands of £5000) £000	Expense Payments (taxable) total to nearest £100 £00	All pension related benefits (bands of £2,500) Rounded to the nearest £100 £000	Total (bands of £5000) £000
Chairman Mrs H Llewelyn-Davies	Full Year	35-40	-	n/a	35-40	Full Year	35-40	-	n/a	35-40
Non-Executive Directors Mr L Broude	Full Year	5-10	-	n/a	5-10	Full Year	5-10	-	n/a	5-10
Mr G Johnston	Full year	5-10	-	n/a	5-10	Full year	5-10	-	n/a	5-10
Prof. M Lovegrove	Full Year	5-10	-	n/a	5-10	1/5/14 to 31/3/15	5-10	-	n/a	5-10
Mr R Jaitly	15/6/15 to 31/3/16	0-5	-	n/a	0-5	n/a*	n/a*	n/a*	n/a*	n/a*
Ms D Amin	15/6/15 to 31/3/16	5-10	-	n/a	5-10	n/a*	n/a*	n/a*	n/a*	n/a*
Mr J Pulsinelli	1/4/15 to 27/5/15	0-5	-	n/a	0-5	Full year	5-10	-	n/a	5-10
Associate Non-Executive Director Prof D Sines	Full Year	5-10	-	n/a	5-10	Full Year	5-10	-	n/a	5-10
Ms R Devonshire	1/12/15 to 31/3/16	0-5	-	n/a	0-5	n/a*	n/a*	n/a*	n/a*	n/a*
Non-Executive Director (Designate) Mr D Garmon-Jones	15/6/15 to 31/3/16	0-5	-	n/a	0-5	n/a*	n/a*	n/a*	n/a*	n/a*
Interim Chief Executive Mr Neil Dardis	Full Year	150-155	-	102.5-105	255-260	Full Year	130-135	-	0-2.5	130-135
Interim Chief Operating Officer Mr N MacDonald	Full Year	110-115	-	75-77.5	185-190	n/a*	n/a*	n/a*	n/a*	n/a*
Director of Finance Mr M Naylor	Full Year	145-150		0	145-150	1/7/14-31/3/15	105-110		0	105-110
Mr D Tkaczyk	5/1/16 to 31/3/16	80-85	-	-	80-85	n/a*	n/a*	n/a*	n/a*	n/a*
Chief Nurse and Director of Patient Care Standards Mrs C Morrice	Full year	95-100	-	2.5-5	100-105	Full year	95-100	-	210-212.5	95-100
Medical Director Dr T Kenny	Full year	165-170	-	10-12.5	175-180	Full year	165-170	-	0	165-170
Director of HR and organisational development Mr I Anderson	Full year	110-115	-	-	110-115	n/a*	n/a*	n/a*	n/a*	n/a*
Director of Strategy Mr D Williams	Full year	110-115	-	15-17.5	125-130	Full year	110-115	-	112.5-115	220-225

*Expense payments relate to the provision of a lease car that is also available for private use.
n/a Non-Executive Directors are not entitled to pension benefits
n/a* Prior year or part-year comparators are not applicable

Name and Title	Real increase in pension at age 60	Real increase in pension lump sum at age 60	Total accrued pension at age 60 at 31 March 201	Lump sum at age 60 related to accrued pension at 31 March 2016	Cash Equivalent Transfer Value at 31 March 2016	Cash Equivalent Transfer Value at 31 March 2015	Real Increase in Cash Equivalent Transfer Value*	Employer's Contribution to stakeholder pension**
	(bands of £2500) £000	(bands of £2500) £000	(bands of £5000) £000	(bands of £5000) £000	£000	£000	£000	To nearest £100 £
Interim Chief Executive Mr N Dardis	5-7.5	7.5-10	35-40	95-100	475	406	44	-
Interim Chief Operating Officer Mr N MacDonald	2.5-5	5-7.5	15-20	45-50	208	166	25	-
Medical Director Dr C Kenny	0-2.5	2.5-5	45-50	140-145	1,012	954	22	-
Director of Nursing Ms C Morrice	0-2.5	0-2.5	30-35	90-95	526	503	4	-
Director of HR and Organisational Development Mr I Anderson	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC
Director of Strategy Mr D Williams	0-2.5	0	30-35	90-95	538	515	2	-

* The Real Increase In Cash Equivalent Transfer Value is net of employee contributions to the pension scheme.

**There have not been any contributions to a stakeholder pension scheme by the Trust

*** These Directors are members of NHS Pension Scheme 2008 section and are therefore not entitled to a lump sum.

This table only includes Executive Directors w here the Trust has made contributions to a pension scheme.

The information in the tables above has been subject to audit.

Sickness Absence Data

NHS organisations are required to disclose information on sickness absence in year. This is included in Note 9.3 in the Financial Statements below.

Staff Numbers

The number of staff employed within each staff grouping can be found within Note 9.2 of the Financial Statements below.

Banding of Senior Managers

The breakdown of senior managers, by band, is shown below.

Managers/Senior Managers as at 31st March 2016	
Agenda for Change Banding	**Headcount**
Band 7	51
Band 8	64
Band 9	10
Non Agenda for Change contracts	8
Total	**133**

Pay multiples

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director in Buckinghamshire Healthcare NHS Trust in the financial year 2015/16 was £165,000 to £170,000 (2014/15 £170,000 to £175,000). This was 5.6 times (2014/15 6.0 times) the median remuneration of the workforce, which was £29,992 (2014/15 £28,951).

The increase in median pay relates to the 1% pay award for 2015/16 and additional activity payments.

In 2015/16 2 employees (2014/15 2 employees) received remuneration in excess of the highest-paid director. Remuneration ranged from £170,000 to £175,000 (2014/15 £175,000 to £183,000).

Total remuneration includes salary, non-consolidated performance-related pay (none awarded in 2015/16 or 2014/15) benefits-in-kind but not severance payments. It does not include employer pension contributions and the cash equivalent transfer values of pensions. None of the employees who received remuneration in excess of the highest paid director received redundancy payments in 2015/16 (2014/15 nil).

There were 1% pay increases for most staff, except for those on the highest pay bands, in 2015/16. In addition, the Trust employed more temporary staff than in the previous year who earned over the median salary.

The information above has been subject to audit.

'Off Payroll' employees

The 'Review of Tax Arrangements of Public Sector Appointees' was published by the HM Treasury in 2012, which was followed up with its Annual Reporting Guidance in December 2012. This requires the Trust to have in place contractual arrangements that allow it to assure itself of the tax arrangements of those people employed by the Trust, but not through payroll, for a period of more than six months at a cost of more than £220 per day.

The Trust is required to provide disclosures on how many of those arrangements it had in place at 31st March 2016, and new engagements during the period 1st April 2015 to 31st March 2016.

Table 1	Number
Number of existing engagements as of 31 March 2016	1
Of which, the number that have existed:	
for less than one year at the time of reporting	0
for between one and two years at the time of reporting	1
for between 2 and 3 years at the time of reporting	0

for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

Table 2	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2015 and 31 March 2016	5
Number of new engagements which include contractual clauses giving the Buckinghamshire Healthcare NHS Trust the right to request assurance in relation to income tax and National Insurance obligations	0
Number for whom assurance has been requested	0
Of which:	
assurance has been received	0
assurance has not been received	0
engagements terminated as a result of assurance not being received	0

All off payroll engagements are subject to a risk assessment as to whether assurance is required on the individual's tax affairs.

In addition the Trust is required to provide the disclosure in the table below regarding the number of board members or managers with financial responsibility employed on such a basis.

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the year	1
Number of individuals that have been deemed "board members, and/or senior officers with significant financial responsibility" during the financial year. This figure includes both off-payroll and on-payroll engagements	5

The information above has been subject to audit.

Audit committee

The directors who were members of the audit committee during the year were:

Les Broude (Chair)	Non-Executive Director
John Pulsinelli	Non-Executive Director (1st April 2015 to 27th May 2015)
Graeme Johnston	Non-Executive Director
Rajiv Jaitly	Non-Executive Director (15th June 2015 to 31st March 2016)

David Garmon-Jones Non-Executive Director (15th June 2015 to 31st March 2016)

Auditors

Ernst and Young are appointed to provide external audit services to the Trust.

The scale fees for 2015/16 were set at £83,790 plus VAT for the audit of the financial statements, plus £10,000 plus VAT for Quality Accounts audit work.

Directors' declaration in respect of audit

In line with current guidance, each director has given a statement that, as far as they are aware, there is no relevant audit information of which Ernst and Young (the Trust's auditors) is unaware. Each director has taken all the steps that they ought to have taken as a director in order to make themselves aware of any relevant audit information, and to establish that Ernst and Young is aware of that information.

15. Our financial performance

The external auditors are required to ensure that the information given below is in line with that shown in the audited Financial Statements, and gives a consistent view of the Trust's financial position to that outlined in those statements.

15.1. Improving financial management to deliver better value for money

The Trust is required to demonstrate that it achieves Value for Money for taxpayers by demonstrating economy, efficiency and effectiveness in the use of the resources available to it.

The majority of our services are commissioned by other NHS organisations and Local Authorities, which accounts for over 98% of our income. Within the prices that we are paid for most of this activity (known as the tariff), there is the in-built assumption that we will make efficiency savings of 1.9%. This, when combined with other factors such as inflationary pressures, meant that the Trust had to plan to deliver savings in 2015/16 of £15.3m, or 4.1% of its total expenditure, in order to deliver its planned surplus of £5.5m.

There were a number of pressures on the Trust finances in year which meant that the Trust deliver not deliver its savings programme in the way that was planned, which are considered further in section 15.3 below. Following discussions in late 2015 and early 2016 with the Trust Development Authority, the Trust amended its forecast year end position to a deficit of £9.4m. Despite a considerable amount of work to ensure that the Trust continued to meet its financial duties the Trust has had to report a deficit of £10,867,000 (after allowable technical adjustments). The Trust is required to 'breakeven' over a period of three financial years and achieved a deficit of £7.5m in 2014/15.

Ernst and Young the Trust's external auditors, consider whether the Trust has put into place proper arrangements to secure economy, efficiency and effectiveness in its use of resources as part of the audit work it carries out on the Trust. When it became apparent at year end that the Trust would be in deficit, the external auditors wrote to the Secretary of State for Health to alert him to their view that the Trust as at risk of breaching its statutory duty to breakeven as laid down in the National Health Service Act 2006.

In addition, the external auditors are required to provide an opinion on whether they are satisfied that, in all significant respects, the Trust has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2016.

15.2. The efficiency programme

As outlined above, there was a 'deflator' of 1.9% built into the tariff that the Trust is paid for its activity for 2015/16 that meant that the Trust was required to deliver savings of £15.3m in year.

Efficiency savings of £14.3m were achieved, £1.0m under requirement. The main issue preventing the Trust from delivering its savings target was a re-alignment of clinical capacity, meaning that efficiencies could not be generated in line with plans.
The recurrent element within this is £13.1m, which means that the Trust has to increase its planned savings for 2016/17 to cover the non-recurrent element delivered in 2015/16.

The Trust has recognised that year-on-year delivery of savings at a level required to achieve a balanced budget is unsustainable. Although the tariff has an in-built inflator rather than deflator for the first time in 2016/17, this is negated by other increases in costs such as increases in National Insurance payments. As a result, and even taking into account the intention to deliver strong financial management, the Trust considers it more realistic to plan a deficit for 2016/17, albeit a smaller one than 2015/16. Plans include allowance for an efficiency programme of £14.6m to achieve a deficit of £8.8m.

15.3.Performance in year

The Trust should plan to achieve a surplus of 1% of turnover, approximately £3.6m, each year. It became apparent in the first few months of 2015/16 that, for the NHS to meet its overall financial target, NHS Provider Trusts needed to deliver better results. Following discussion with the TDA, the Trust agreed to a 'stretch target' of £5.5m. As outlined above, the efficiency programme was formulated to achieve this. However, in 2014/15, the Trust had reported a deficit of £7.5m, despite taking a one-off benefit of a reduction in its depreciation of £5.2m following a full revaluation. It therefore needed to reduce its ongoing 'run-rate' of an approximate £1m per month deficit to a level where the efficiency programme would contribute in meeting the planned surplus. It became increasingly apparent that the Trust faced a number of operational pressures which made delivery of a reduction in run-rate ambitious and the achievement of either the planned surplus or the stretch-target challenging. These pressures included:

- Staffing costs, including investment into posts to ensure that staffing levels met safer staffing requirements. In addition, the use of agency staff has increased significantly to enable unfilled vacancies to be covered. There is a premium on temporary staffing costs while the Trust recruits into its vacancies for permanent posts

- Failure throughout the health economy to reduce demand for services to a level that the whole health economy can afford. Additional activity, over and above that planned, leads to inefficiencies in service provision as pressure is placed on beds, with staffing levels having to be readjusted, additional beds opened and patients being placed in wards not specific to that speciality.

- The requirement to meet targets such as the 18 week Referral Time to Treatment, 2 week cancer referrals and A&E waiting times, and to assist in the provision of additional winter resilience, has led to the Trust needing to pay incentive payments in order to increase capacity through evening and weekend working. Despite this, the Trust has incurred fines for not meeting some of these targets.

As a result of these pressures, the Trust was unable to achieve its planned surplus.

The Trust is reporting a deficit before technical adjustments of £24,315,000. These technical adjustments relate to central changes in accounting policies that impact on the reported financial performance of the Trust, and are:

- Removing the impact of the impairment to the value of land and buildings, resulting from the revaluation in year, that was charged to the Statement of Comprehensive Income, of £2,404,000.

- Reversing the impact of the change in accounting treatment for the Stoke Mandeville PFI (Private Finance Initiative) as a result of the transition to International Financial Reporting Standards (IFRS). This includes the impairment to the value of the PFI buildings, resulting to a change in the treatment of VAT in the valuation of construction of these buildings. The overall adjustment is to reduce the retained deficit by £11,674,000.

- The Trust received £630,000 more donated assets (which are treated as income) than the associated expense of depreciation on donated assets. If this was not taken out, the Trust would show a higher surplus.

The combination of these factors, when taken in addition to the retained deficit, generates the deficit of £10,867,000 against which the Trust is performance managed.

The Trust is required to meet, or undershoot, certain targets known as 'External Financing Limit' and 'Capital Resource Limit'. In 2015/16 the Trust achieved these targets within acceptable levels.

The external auditors are required to give the Trust a conclusion on whether, in their opinion, it obtains 'Value for Money'. In reaching this conclusion, the auditors review whether the Trust has proper arrangements for securing financial resilience and challenging how it secures economy, efficiency and effectiveness. The Trust was given unqualified conclusions in 2010/11, 2011/12, 2012/13, although in 2013/14 the auditors qualified the conclusion as the auditors felt that the Trust was not demonstrating financial resilience, despite achieving a small surplus as it had required cash support and not met its Cost Improvements in the way planned. For 2014/15 and 2015/16 the auditors have qualified the conclusion as the Trust reported a deficit for each year.

'Going concern' basis

In preparing the financial statements, the Trust needs to assess whether the presumption that it is a 'going concern' is correct. Guidance contained within the Manual for Accounts suggests that, if there is ongoing financial provision for the services provided by the Trust, then, in the absence of information to the contrary, the 'going concern' basis should be adopted. However, the external auditors referred the Trust to the Secretary of State for Health in March 2016 under Section 30 of the Local Audit & Accountability Act 2014. They had assessed that the Trust was likely to breach its statutory duty under the National Health Service Act 2006 to breakeven over a three-year period. As a result of this, and the Trust's ongoing cash issues, they requested confirmation from the Trust Development Authority that the 'going concern' basis was relevant for adoption.

The Trust Development Authority, in their letter of 31st March 2016, stated that they fully supported the Trust's view that the organisation's accounts should be prepared on a going concern. They have also stated that it is reasonable for the directors of Buckinghamshire Healthcare NHS Trust to assume that the Department of Health will make sufficient cash financing available to the organisation, either through an Interim Revolving Working Capital

Support Facility or an Interim Revenue Support Loan, over the next 12 month period such that the organisation is able to fund all essential operational liabilities.

Expense recognition
In 2015/16 a small number of staff were made redundant due to service redesigns and restructurings that took place. The number of staff affected and the value of their exit packages is shown below. All exit packages were within contractual terms and no additional non-contractual payments were made.

Exit package cost band (including any special payment element)	Number and cost of compulsory redundancies	Number and cost of other departures agreed	Total number and cost of exit packages	Number and cost of departures where special payments have been made
Less than £10,000	1 £2,472	11 £37,000	12 £39,472	0 £0
£10,000 - £25,000				0 £0
£25,001 - £50,000	1 £25,012		1 £25,012	0 £0
£50,001 - £100,000	1 £73,506		1 £73,506	0 £0
£100,001 - £150,000				0 £0
£150,001 - £200,000				0 £0
>£200,000				0 £0
Total	3 £101,020	11 37,000	14 £138,020	

Consultancy spend

The Trust spent £372,000 in year (2014/15 £1,378,000) on consultancy. A breakdown on project type is shown below.

Type	Number of projects	Amount £000s
Information Technology	1	86
Procurement	6	123
Strategy	4	141
Marketing and Communications	3	22
Total	14	372

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Non-current assets

The Trust is required to report the 'fair value' of its non-current assets. In assessing the fair value, it takes into account the advice of experts, where appropriate. The Trust commissioned a full revaluation of its land and buildings, to take into account their existing use, from Cushman and Wakefield, a firm of specialist valuers at 1st April 2014. This valuation showed that the value of land and buildings was approximately £25 million lower than had been previously accounted. Where property values decrease, any revaluation reserve balances are

used to absorb the reduction, with any remainder charged through the Statement of Comprehensive Income. This valuation was reviewed at 31st March 2015 in light of the movement in market prices and the value was found to have recovered by approximately £6m. The 'first call' on any valuation increase is to reverse any previous decrease taken through the Statement of Comprehensive Income. If there had been no previous charge, or it has been fully reversed, any residual increase is taken to the Revaluation Reserve.

In 2015/16 a further review of the valuation was undertaken. The overall movement was a reduction in value of land, buildings and dwellings of £13.5m. The most significant changes related to a review of the valuation methodology of our PFI buildings due to differences in VAT treatment, and the assessment of the 'fair value' of assets brought into use.

The Trust is not aware of any material differences between the carrying value of its properties and their market value in their current condition.

Donations

We were extremely fortunate again in 2015/16 to benefit from support from Scannappeal, the Trust charities and the League of Friends; with the purchase of medical and other equipment exceeding £1.7milllion. There have also been donations of smaller items of equipment and charitable support for activities such as training and research, for which we are extremely grateful.

Depreciation of donated assets in the year was charged at £1.1million. The excess of the value donated over depreciation is considered to be a 'technical adjustment' to the Trust's reported performance, as stated above.

Pension liabilities

Past and present employees of the Trust are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme and is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the Trust of participating in the scheme is equal to the contributions payable to the scheme for the accounting period. Further details can be found in note 9 of the Trust's 2015/16 financial statements.

Financing arrangements

At the beginning of 2015/16 the Trust had three Department of Health approved loans in place. The first is a Revenue Support Loan, taken out in March 2013. This loan had a principle of £8m when drawn down in March 2013 and is repayable over seven years in twice yearly instalments of £0.571m (September and March). At 31st March 2015 then was £4.572m outstanding.

The Trust had a Capital Investment Loan of £9m approved in 2014/15 to support significant investments in capital projects over a two year period, which is to be utilised as required,. £3.1m of the total loan value of £9.0m was drawn down in March 2015 to match capital expenditure incurred to that point, with a further £3.4m drawn down in February and March 2016. The remainder of £2.5m is due to be drawn down in 2016/17. The interest rate is 1.45% and repayments are due to commence in September 2016.

In March 2015 the Trust had an Interim Revolving Working Capital Facility approved by the Department of Health for £28.2m. This allows the Trust to draw down and repay short-term financing support, required to maintain a cash balance between set parameters, up to this

limit. Interest is payable at 3.5% of the outstanding balance. The Trust had utilised £27.1m of this facility at the end of March 2016.

During the financial period, the Trust incurred £903,000 (2014/15 £91,000) in interest on its loans.

During 2015/16 the Trust received £34,000 Public Dividend Capital to fund specific equipment in relation to a centrally-funded scheme to improve maternity services. This is not repayable or interest-bearing.

Under IFRS, the Trust is required to account for the Private Finance Initiative (PFI) schemes and any equipment held under finance leases by accounting for both the value of the asset and the future liability to pay. This future liability is shown on the Statement of Financial Position as 'borrowings'. The amount paid to our PFI partners is accounted for as either service charges for the services provided, or finance charges on the 'borrowing' for the buildings in the Income Statement. In 2015/16 the Trust accounted for £11,709,000 (2014/15 £11,930,000) in finance charges in relation to the PFIs.

Cash flow
The Trust had a year-end cash balance of £7.5m. It is required to manage its cash in order to meet, or 'undershoot', its External Financing Limit (EFL). The Trust underspent against its EFL by £1.4m in 2015/16

The Trust actively manages its operational cash flows by pursuing its debt in order to minimise amounts outstanding and by paying its creditors as they fall due.

The Trust's loan arrangements are discussed under 'Financing Arrangements' above.
The Trust has modelled its future cash flows in order to meet its financing obligations and capital expenditure requirements, and these form the basis of its cash management strategy. The Trust earns interest on its bank balances and is subject to interest rate fluctuations on these earnings. Interest rates are currently very low, so the risk of them reducing by a material amount and thus reducing the Trust's income earned is also considered to be low. The Trust's loans are at fixed interest rates so the Trust is not exposed to interest rate risk in respect of loans.

Interest earned on bank balances during the year amounted to £36,000 (2014/15 £31,000).

Better payment practice code
The Better Payment Practice Code (BPPC) requires the Trust to aim to pay all valid NHS and non-NHS trade creditors by the due date, or within 30 days of receipt of goods or a valid invoice, whichever is later. The Trust's performance in 2015/16 is shown in Note 10.1 of the Financial Statements below.

The Trust is working to improve its performance under the Better Payments Practice Code, which requires that 95% of undisputed invoices should be paid within 30 days of receipt. Further efforts will be made in 2015/16 to improve the percentage achieved.

The Trust has also signed up to the 'Prompt Payments' code, which encourages organisations to act responsibly in making payments to their suppliers in a timely way.

Compliance with setting charges for information
The Trust is compliant with the Treasury's guidance on setting charges for information which can be found under http://www.hm-treasury.gov.uk/psr_mpm_annexes.htm

15.4. 2016/17 and beyond

NHS England's Five Year Forward View shows that the challenges for the Trust going forward remain as considerable in the past. However, the Trust is planning to meet those challenges, both as an individual organisation and also as a body within the wider health economy which includes services provided by other health bodies and local authorities. The Trust is committed to continue to deliver its services in the most effective way, ensuring that the capacity in our services is available to meet the demands being placed on them.

The Trust will be continuing to work with NHS Improvement on ensuring that it is financially stable and resilient in the longer term. However, as part of this process there is a requirement to take medium term actions to support this. As a result, the Trust is planning to report a deficit, albeit improved over that for 2015/16, in 2016/17. It will also need further cash support until such time as it generates sufficient surpluses to meet its financing and investing requirements.

Despite acknowledging the need to report a deficit for 2016/17, the Trust needs to stabilise its financial footing. The Trust has worked with its commissioners in agreeing contracts for activity levels in 2016/17 to provide an element of certainty over income levels. It will also focus on minimising levels of expenditure, including reducing the requirement for higher cost temporary staffing and taking into account the recommendations of the Lord Carter review on expenditure in the NHS.

2015-16 Annual Accounts of Buckinghamshire Healthcare NHS Trust

STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTABLE OFFICER OF THE TRUST

The Chief Executive of the NHS Trust Development Authority has designated that the Chief Executive should be the Accountable Officer to the trust. The relevant responsibilities of Accountable Officers are set out in the Accountable Officers Memorandum issued by the Chief Executive of the NHS Trust Development Authority. These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;

- value for money is achieved from the resources available to the trust;

- the expenditure and income of the trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;

- effective and sound financial management systems are in place; and

- annual statutory accounts are prepared in a format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

I confirm that, as far as I am aware, there is no relevant audit information of which the trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the trust's auditors are aware of that information.

I confirm that the annual report and accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the annual report and accounts and the judgments required for determining that it is fair, balanced and understandable.

NB: sign and date in any colour ink except black

Signed.....  .....Chief Executive

Date.....31 MAY 2016.....

STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of the Treasury, directs that these accounts give a true and fair view of the state of affairs of the trust and of the income and expenditure, recognised gains and losses and cash flows for the year. In preparing those accounts, directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;

- make judgements and estimates which are reasonable and prudent;

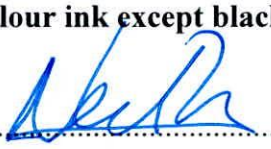
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

By order of the Board

NB: sign and date in any colour ink except black

31 MAY 2016 .....Date.....  .....Chief Executive

31/5/16 .....Date.....  .....Finance Director

FINANCIAL STATEMENTS

Buckinghamshire Healthcare NHS Trust

Annual Accounts for the period

1 April 2015 to 31 March 2016

Statement of Comprehensive Income for year ended 31 March 2016

	NOTE	2015-16 £000s	2014-15 £000s	Consolidated 2015-16 £000s	Consolidated 2014-15 £000s
Gross employee benefits	9.1	**(236,666)**	(230,829)	**(236,666)**	(230,829)
Other operating costs	7	**(140,281)**	(142,032)	**(142,346)**	(146,036)
Revenue from patient care activities	4	**345,713**	344,217	**345,713**	344,217
Other operating revenue	5	**24,512**	25,627	**26,283**	27,797
Operating surplus/(deficit)		**(6,722)**	(3,017)	**(7,016)**	(4,851)
Investment revenue	11	**36**	31	**275**	306
Other gains and (losses)	12	**227**	(44)	**227**	(44)
Finance costs	13	**(12,642)**	(12,091)	**(12,642)**	(12,091)
Surplus/(deficit) for the financial year		**(19,101)**	(15,121)	**(19,156)**	(16,680)
Public dividend capital dividends payable		**(5,507)**	(6,004)	**(5,507)**	(6,004)
Transfers by absorption - gains		**0**	0	**(24,663)**	0
Retained surplus/(deficit) for the year		**(24,608)**	(21,125)	**(24,663)**	(22,684)

Other Comprehensive Income

	2015-16 £000s	2014-15 £000s	2015-16 £000s	2014-15 £000s
Net gain/(loss) on revaluation of property, plant & equipment	**1,454**	(7,029)	**1,454**	(7,029)
Net gain/(loss) on revaluation of financial assets	**0**	0	**(357)**	241
Total Other Comprehensive Income	**1,454**	(7,029)	**1,097**	(6,788)
Total comprehensive income for the year*	**(23,154)**	(28,154)	**(23,566)**	(29,472)

Financial performance for the year

Retained surplus/(deficit) for the year		**(24,608)**	(21,125)
IFRIC 12 adjustment (including IFRIC 12 impairments)	a)	**11,674**	(1,921)
Impairments (excluding IFRIC 12 impairments)	b)	**2,697**	16,737
Adjustments in respect of donated asset reserve elimination	c)	**(630)**	(1,137)
Adjustment re absorption accounting		**0**	0
Adjusted retained surplus/(deficit)		**(10,867)**	(7,446)

The financial performance of an NHS Trust is based on its retained surplus or deficit for the year which is adjusted as below. It is not based on the Consolidated results with its associated Charity shown above.

a) The revenue costs of bringing PFI assets onto the Statement of Financial Position due to the introduction of International Accounting Standards (IFRS) accounting in 2009/10
NHS Trusts' financial reporting performance measurement needs to be aligned with the guidance by HM Treasury measuring departmental expenditure. Therefore the incremental revenue expenditure resulting from the application of IFRS to PFI, which has no cash impact, and is therefore not chargeable for overall budgeting purposes, should be reported as technical. The additional cost is not considered part of the organisation's operating position.

b) Impairments to the value of Non-Current Assets and Reversals
Movements in the value of non-current assets, caused by such factors as fluctuations in the property market or as a result of valuation methodology, are not considered to be part of an organisation's operating position.

c) Change in accounting policy in respect of donated assets
HM Treasury issued new guidance in 2011/12, which stated that donated assets will be recognised in full in the SOCI in the year of receipt. Any difference between receipt and depreciation charged on donated assets is recorded as a technical adjustment.

Note 1.4 to the Accounts provides information on the Consolidated Trust and associated Charity figures above. NHS financial performance is not measured on the Consolidated position

The notes on pages 6 to 46 form part of this account.

Statement of Financial Position as at 31 March 2016

	NOTE	31 March 2016 £000s	31 March 2015 £000s	Consolidated 31 March 2016 £000s	Consolidated 31 March 2015 £000s
Non-current assets:					
Property, plant and equipment	14	**259,309**	267,812	**259,309**	267,812
Intangible assets	15	**733**	994	**733**	994
Other Investments - Charitable				**7,380**	8,036
Trade and other receivables	19.1	**2,005**	2,182	**2,005**	2,182
Total non-current assets		**262,047**	270,988	**269,427**	279,024
Current assets:					
Inventories	18	**5,903**	5,693	**5,905**	5,700
Trade and other receivables	19.1	**29,152**	29,719	**29,612**	29,784
Other current assets	20	**163**	163	**163**	163
Cash and cash equivalents	21	**7,531**	1,769	**8,380**	3,007
Sub-total current assets		**42,749**	37,344	**44,060**	38,654
Non-current assets held for sale	22	**325**	0	**325**	0
Total current assets		**43,074**	37,344	**44,385**	38,654
Total assets		**305,121**	308,332	**313,812**	317,678
Current liabilities					
Trade and other payables	23	**(30,228)**	(37,285)	**(30,232)**	(37,518)
Other liabilities	24	**(165)**	(25)	**(165)**	(25)
Provisions	28	**(437)**	(430)	**(437)**	(430)
Borrowings	25	**(2,904)**	(2,834)	**(2,904)**	(2,834)
DH revenue support loan	25	**(1,142)**	(1,142)	**(1,142)**	(1,142)
DH capital loan	25	**(723)**	0	**(723)**	0
Total current liabilities		**(35,599)**	(41,716)	**(35,603)**	(41,949)
Net current assets/(liabilities)		**7,475**	(4,372)	**8,782**	(3,295)
Total assets less current liablilities		**269,522**	266,616	**278,209**	275,729
Non-current liabilities					
Trade and other payables	23	**(624)**	(936)	**(624)**	(936)
Other liabilities	24	**(338)**	(361)	**(338)**	(361)
Provisions	28	**(1,286)**	(1,352)	**(1,286)**	(1,352)
Borrowings	25	**(61,543)**	(63,762)	**(61,543)**	(63,762)
DH revenue support loan	25	**(30,532)**	(4,574)	**(30,532)**	(4,574)
DH capital loan	25	**(5,777)**	(3,100)	**(5,777)**	(3,100)
Total non-current liabilities		**(100,100)**	(74,085)	**(100,100)**	(74,085)
Total assets employed:		**169,422**	192,531	**178,109**	201,644
FINANCED BY:					
Public Dividend Capital		**181,951**	181,917	**181,951**	181,917
Retained earnings		**(50,367)**	(25,806)	**(50,367)**	(25,806)
Revaluation reserve		**37,838**	36,420	**37,838**	36,420
Charitable Funds Reserve				**8,687**	9,113
Total Taxpayers' Equity:		**169,422**	192,531	**178,109**	201,644

The notes on pages 6 to 46 form part of this account.

The financial statements on pages 2 to 5 were approved on behalf of the Board on 31st May 2016 and signed on its behalf by

Chief Executive: Date:

Statement of Changes in Taxpayers' Equity
For the year ending 31 March 2016

	Public Dividend capital £000s	Retained earnings £000s	Revaluation reserve £000s	Total reserves £000s
Balance at 1 April 2015	**181,917**	**(25,806)**	**36,420**	**192,531**
Changes in taxpayers' equity for 2015-16				
Retained surplus/(deficit) for the year		(24,608)		**(24,608)**
Net gain / (loss) on revaluation of property, plant, equipment			1,454	**1,454**
Transfers between reserves		36	(36)	**0**
Reclassification Adjustments				
Permanent PDC received - cash	34			**34**
Other movements	0	11	0	**11**
Net recognised revenue/(expense) for the year	**34**	**(24,561)**	**1,418**	**(23,109)**
Balance at 31 March 2016	**181,951**	**(50,367)**	**37,838**	**169,422**
Balance at 1 April 2014	**168,449**	**(4,681)**	**43,449**	**207,217**
Changes in taxpayers' equity for the year ended 31 March 2015				
Retained surplus/(deficit) for the year		(21,125)		(21,125)
Net gain / (loss) on revaluation of property, plant, equipment			(7,029)	(7,029)
Reclassification Adjustments				
New temporary and permanent PDC received - cash	36,468			36,468
New temporary and permanent PDC repaid in year	(23,000)			(23,000)
Net recognised revenue/(expense) for the year	**13,468**	**(21,125)**	**(7,029)**	**(14,686)**
Balance at 31 March 2015	**181,917**	**(25,806)**	**36,420**	**192,531**

Statement of Changes in Taxpayers' Equity
For the year ending 31 March 2016

Consolidated

	Public Dividend capital £000s	Retained earnings £000s	Revaluation reserve £000s	Charitable Funds Reserve £000s	Total reserves £000s
Balance at 1 April 2015	**181,917**	**(25,806)**	**36,420**	**9,113**	**201,644**
Changes in taxpayers' equity for 2015-16					
Retained surplus/(deficit) for the year		(24,608)		(55)	**(24,663)**
Net gain / (loss) on revaluation of property, plant, equipment			1,454	(357)	**1,097**
Transfers between reserves		36	(36)		**0**
Reclassification Adjustments					
Permanent PDC received - cash	34				**34**
Other movements	0	11	0		**11**
Revaluation and impairment of Charitable fund assets				0	**0**
Charitable Funds Adjustment				(14)	**(14)**
Net recognised revenue/(expense) for the year	**34**	**(24,561)**	**1,418**	**(426)**	**(23,535)**
Balance at 31 March 2016	**181,951**	**(50,367)**	**37,838**	**8,687**	**178,109**
Balance at 1 April 2014	**168,449**	**(4,681)**	**43,449**	**10,444**	**217,661**
Changes in taxpayers' equity for the year ended 31 March 2015					
Retained surplus/(deficit) for the year		(21,125)		(1,559)	(22,684)
Net gain / (loss) on revaluation of property, plant, equipment			(7,029)	241	(6,788)
New temporary and permanent PDC received - cash	36,468				36,468
New temporary and permanent PDC repaid in year	(23,000)				(23,000)
Charitable Funds Adjustment				(13)	(13)
Net recognised revenue/(expense) for the year	**13,468**	**(21,125)**	**(7,029)**	**(1,331)**	**(16,017)**
Balance at 31 March 2015	**181,917**	**(25,806)**	**36,420**	**9,113**	**201,644**

Statement of Cash Flows for the Year ended 31 March 2016

	NOTE	2015-16 £000s	2014-15 £000s	Consolidated 2015-16 £000s	Consolidated 2014-15 £000s
Cash Flows from Operating Activities					
Operating surplus/(deficit)		**(6,722)**	(3,017)	**(6,722)**	(3,017)
Depreciation and amortisation	7	**11,093**	10,766	**11,093**	10,766
Impairments and reversals	16	**14,215**	14,702	**14,215**	14,702
Donated Assets received credited to revenue but non-cash	5	**(1,710)**	(1,987)	**(1,710)**	(1,987)
Interest paid		**(12,580)**	(12,092)	**(12,580)**	(12,092)
PDC Dividend (paid)/refunded		**(6,015)**	(6,370)	**(6,015)**	(6,370)
Release of PFI/deferred credit		**0**	66	**0**	66
(Increase)/Decrease in Inventories	18	**(210)**	(168)	**(210)**	(168)
(Increase)/Decrease in Trade and Other Receivables	19	**1,358**	(6,737)	**1,358**	(6,737)
(Increase)/Decrease in Other Current Assets	20	**0**	(16)	**0**	(16)
Increase/(Decrease) in Trade and Other Payables	23	**(6,885)**	10,097	**(6,885)**	10,097
(Increase)/Decrease in Other Current Liabilities	24	**117**	(25)	**117**	(25)
Provisions utilised	28	**(379)**	(381)	**(379)**	(381)
Increase/(Decrease) in movement in non cash provisions	28	**325**	194	**325**	194
NHS Charitable Funds - net adjustments for working capital movements, non-cash transactions and non-operating cash flows				**(389)**	(1,686)
Net Cash Inflow/(Outflow) from Operating Activities		**(7,393)**	5,032	**(7,782)**	3,346
Cash Flows from Investing Activities					
Interest Received	11	**36**	32	**36**	32
(Payments) for Property, Plant and Equipment		**(13,464)**	(16,393)	**(13,464)**	(16,393)
(Payments) for Intangible Assets	15	**0**	(6)	**0**	(6)
Proceeds of disposal of assets held for sale (PPE)	12	**25**	750	**25**	750
NHS Charitable Funds - net cash flows relating to investing activities				**0**	0
Net Cash Inflow/(Outflow) from Investing Activities		**(13,403)**	(15,617)	**(13,403)**	(15,617)
Net Cash Inflow / (outflow) before Financing		**(20,796)**	(10,585)	**(21,185)**	(12,271)
Cash Flows from Financing Activities					
Gross Temporary (2014/15 only) and Permanent PDC Received	SOCITE	**34**	36,468	**34**	36,468
Gross Temporary (2014/15 only) and Permanent PDC Repaid	SOCITE	**0**	(23,000)	**0**	(23,000)
Loans received from DH - New Capital Investment Loans	25	**3,400**	3,100	**3,400**	3,100
Loans received from DH - New Revenue Support Loans	25	**27,100**	0	**27,100**	0
Loans repaid to DH - Working Capital Loans/Revenue Support Loans	25	**(1,142)**	(3,642)	**(1,142)**	(3,642)
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT	**25**	**(2,834)**	(2,091)	**(2,834)**	(2,091)
NHS Charitable Funds - net cash flows relating to Financing activities					
Net Cash Inflow/(Outflow) from Financing Activities		**26,558**	10,835	**26,558**	10,835
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		**5,762**	250	**5,373**	(1,436)
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period		**1,769**	1,519	**3,007**	4,443
Cash and Cash Equivalents (and Bank Overdraft) at year end	**21**	**7,531**	1,769	**8,380**	3,007

NOTES TO THE ACCOUNTS

1. Accounting Policies

The Secretary of State for Health has directed that the financial statements of NHS trusts shall meet the accounting requirements of the Department of Health Group Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DH Group Manual for Accounts 2015-16 issued by the Department of Health. The accounting policies contained in that manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted by the trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.2 Acquisitions and discontinued operations

Activities are considered to be 'acquired' only if they are taken on from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

1.3 Movement of assets within the DH Group

Transfers as part of reorganisation fall to be accounted for by use of absorption accounting in line with the Treasury FReM. The FReM does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the SOCI, and is disclosed separately from operating costs.

Other transfers of assets and liabilities within the Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

1.4 Charitable Funds

Under the provisions of IAS 27 Consolidated and Separate Financial Statements, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entity's financial statements. In accordance with IAS 1 Presentation of Financial Statements, restated prior period accounts are presented where the adoption of the new policy has a material impact.

The Trust Board is Corporate Trustee of the Buckinghamshire Healthcare NHS Trust Charitable Fund (registered number 1053113) and the valuation of the investement portfolio of that Charity is considered material within the Trust's Accounts. Therefore the Charity is considered to be under common control, with a requirement for consolidation. The main financial statements therefore have consolidated comparators, with further detail provided in Note 38 to the Accounts.

The Accounting Policies adopted by the Charity are disclosed in full in Note 38.

1.5 Critical accounting judgements and key sources of estimation uncertainty

In the application of the NHS trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.5.1 Critical judgements in applying accounting policies

Details of the critical judgements, apart from those involving estimations (set out in 1.5.2 below), that management has made in the process of applying the NHS trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements are included within the individual Policies .

No material uncertainty exists that may cast significant doubt about the ability of the Trust to continue as a going concern has been identified by the directors.

1.5.2 Key sources of estimation uncertainty

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

• The Trust depreciates the value of its assets over their estimated economic lives. It therefore has to estimate economic lives by taking into account such factors as depreciation and technical obsolence. The actual life of the asset may be different to that estimated and, therefore, the amount of depreciation charged, and the carrying value of the asset at the date of the Statement of Financial Position, may be different to that which can subsequently be shown as should have been the case.

• In order to calculate the carrying value of the Trust's provisions there are a number of areas which are required to be estimated :-

— The Trust will need to estimate the amount of its liability. In the case of legal claims, for example, it will use the advice of its experts but the actual amount of the liability will not be known until the outcome of the litigation.

— The Trust will need to estimate the probability of a liability existing. The outcome of the litigation may be uncertain but the Trust will use the advice of its experts on whether it is probable that it will be found liable.

— In the case of pensions and other benefits to be paid in the future, an estimate will be made for the length of time that the payment will be required to be made, using actuarial mortality tables. Discount rates will be used to estimate the present value of the future payments.

NOTES TO THE ACCOUNTS

- The Trust will need to estimate the level of recovery of its receivables and make allowances for the expected level of impairment of those receivables. Actual experience may differ from these estimates.

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

1.6 Revenue

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. The main source of revenue for the trust is from commissioners for healthcare services. Revenue relating to patient care spells that are part-completed at the year end are apportioned across the financial years on the basis of length of stay at the end of the reporting period compared to expected total length of stay.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

The NHS trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The NHS trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

The Charity's Accounting Policy on recognising income is disclosed in full in Note 38.

1.7 Employee Benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees, *except for bonuses earned but not yet taken which, like leave earned but not yet taken is not accrued for at the year end, on the grounds of immateriality.

Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the Trust commits itself to the retirement, regardless of the method of payment.

1.8 Other expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

1.9 Property, plant and equipment

Recognition
Property, plant and equipment is capitalised if:
● it is held for use in delivering services or for administrative purposes;
● it is probable that future economic benefits will flow to, or service potential will be supplied to the Trust;
● it is expected to be used for more than one financial year;
● the cost of the item can be measured reliably; and
● the item has cost of at least £5,000; or
● Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
● Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

Valuation
All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value.
Land and buildings used for the Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any impairment.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:
● Land and non-specialised buildings – market value for existing use
● Specialised buildings – depreciated replacement cost

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Subsequent expenditure
Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

1.10 Intangible assets

Recognition
Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the trust; where the cost of the asset can be measured reliably, and where the cost is at least £5000.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:
- the technical feasibility of completing the intangible asset so that it will be available for use
- the intention to complete the intangible asset and use it
- the ability to sell or use the intangible asset
- how the intangible asset will generate probable future economic benefits or service potential
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it
- the ability to measure reliably the expenditure attributable to the intangible asset during its development

Measurement
The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.11 Depreciation, amortisation and impairments
Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the NHS trust expects to obtain economic benefits or service potential from the asset. This is specific to the NHS trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

At each reporting period end, the NHS trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.12 Donated assets
Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

1.13 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when the sale is highly probable, the asset is available for immediate sale in its present condition and management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the revaluation reserve is transferred to retained earnings.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.14 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The trust as lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the trust's surplus/deficit.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

The NHS trust as lessor

Amounts due from lessees under finance leases are recorded as receivables at the amount of the NHS trust's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the trust's net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

1.15 Private Finance Initiative (PFI) transactions

HM Treasury has determined that government bodies shall account for infrastructure PFI schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The Trust therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

a) Payment for the fair value of services received;
b) Payment for the PFI asset, including finance costs; and
c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

Services received

The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'

PFI Asset

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16.

PFI liability

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Income.

Lifecycle replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Assets contributed by the NHS trust to the operator for use in the scheme

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the NHS trust's Statement of Financial Position.

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

1.16 Inventories

Inventories are valued at the lower of cost and net realisable value. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.17 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the NHS trust's cash management.

1.18 Provisions

Provisions are recognised when the NHS trust has a present legal or constructive obligation as a result of a past event, it is probable that the NHS trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate of -1.55%, -1.0%, -0.80% in real terms (0-5 years, 6-10 years and over 10 years respectively) or 1.37% for employee early departure obligations.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the Trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

1.19 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the NHS trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the trust is disclosed at Note 28.

1.20 Non-clinical risk pooling

The NHS trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the NHS trust pays an annual contribution to the NHS Litigation Authority and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.21 Carbon Reduction Commitment Scheme (CRC)

CRC and similar allowances are accounted for as government grant funded intangible assets if they are not expected to be realised within twelve months, and otherwise as other current assets. They are valued at open market value. As the NHS body makes emissions, a provision is recognised with an offsetting transfer from deferred income. The provision is settled on surrender of the allowances. The asset, provision and deferred income amounts are valued at fair value at the end of the reporting period.

1.22 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the NHS trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the NHS trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

1.23 Financial assets

Financial assets are recognised when the NHS trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories: financial assets at fair value through profit and loss; held to maturity investments; available for sale financial assets, and loans and receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Loans, Public Dividend Capital and any other interests with government departments are reported at historic cost, less any impairments. Where the receivable is expected to be paid within the next year no doscounting of future cashflows takes place.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

At the end of the reporting period, the NHS trust assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

1.24 Financial liabilities
Financial liabilities are recognised on the statement of financial position when the NHS trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Loans from the Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value.

1.25 Value Added Tax
Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.26 Foreign currencies
The Trust's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the trust's surplus/deficit in the period in which they arise.

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

1.27 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the trust has no beneficial interest in them. Details of third party assets are given in Note 38 to the accounts.

1.28 Public Dividend Capital (PDC) and PDC dividend

Public dividend capital represents taxpayers' equity in the NHS trust. At any time the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

An annual charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities (except for donated assets and cash balances with the Government Banking Service). The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets.

In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.29 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

1.30 Subsidiaries

Material entities over which the NHS trust has the power to exercise control are classified as subsidiaries and are consolidated. The NHS trust has control when it is exposed to or has rights to variable returns through its power over another entity. The income and expenses; gains and losses; assets, liabilities and reserves; and cash flows of the subsidiary are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the NHS trust or where the subsidiary's accounting date is not co-terminus.

Subsidiaries that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

From 2013/14, the NHS trust has consolidated the results of Buckinghamshire Healthcare NHS Trust Charitable Fund over which it considers it has the power to exercise control in accordance with IFRS10 requirements.

1.31 Research and Development

Research and development expenditure is charged against income in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the SOCI on a systematic basis over the period expected to benefit from the project. It should be revalued on the basis of current cost. The amortisation is calculated on the same basis as depreciation, on a quarterly basis.

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

1.32 Accounting Standards that have been issued but have not yet been adopted

The HM Treasury FReM does not require the following Standards and Interpretations to be applied in 2015-16. These standards are still subject to HM Treasury FReM interpretation, with IFRS 9 and IFRS 15 being for implementation in 2018-19, and the government implementation date for IFRS 16 still subject to HM Treasury consideration.

● IFRS 9 *Financial Instruments* – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
● IFRS 15 *Revenue for Contracts with Customers* - Application required for accounting periods beginning on or after 1 January 2017, but not yet adopted by the FReM: early adoption is not therefore permitted
● IFRS 16 *Leases* – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

2. Operating segments

The Trust operates in only one segment - namely the provision of healthcare services.

The Trust's main commissioners were NHS England and Clinical Commissioning Groups (CCGs) which are considered to be under common control. The Trust's income from NHS England and CCGs for patient care activities during the period was £330,559,000 (2014/15 £332,419,000).

No other single customer accounted for more than 10% of the Trust's income.

3. Income generation activities

The Trust has not undertaken income generation activities with an aim of achieving profit, whose costs or are otherwise material.

4. Revenue from patient care activities

	2015-16 £000s	2014-15 £000s
NHS Trusts	**0**	1,266
NHS England	**70,681**	72,499
Clinical Commissioning Groups	**259,878**	259,920
Foundation Trusts	**1,223**	0
Department of Health	**0**	1
NHS Other (including Public Health England and Prop Co)	**1,057**	412
Non-NHS:		
Local Authorities	**9,452**	6,065
Private patients	**2,094**	2,273
Overseas patients (non-reciprocal)	**293**	182
Injury costs recovery	**929**	593
Other	**106**	1,006
Total Revenue from patient care activities	**345,713**	344,217

Injury costs recovery income is subject to a provision for the impairment of receivables for 2015/16 of 21.99% (2014/15 18.9%) to reflect expected rates of collection

5. Other operating revenue

	2015-16 £000s	2014-15 £000s
Education, training and research	**12,030**	12,423
Charitable and other contributions to revenue expenditure -non- NHS	**863**	792
Receipt of donations for capital acquisitions - Charity	**1,710**	2,057
Non-patient care services to other bodies	**2,942**	2,478
Income generation (Other fees and charges)	**3,885**	3,480
Other revenue	**3,082**	4,397
Total Other Operating Revenue	**24,512**	25,627
Total operating revenue	**370,225**	369,844

Other revenue includes:-

£1,775,000 (2014/15 £1,800,000) in respect of staff accommodation and other rental services

£910,000 in respect of Winter Resilience Funding (2014/15 £0)

2014/15 includes £1,100,000 in respect of monies owed on contract variations with our PFI partner, which was reversed in 2015/16.

6. Overseas Visitors Disclosure

	2015-16 £000	2014-15 £000s
Income recognised during 2015-16 (invoiced amounts and accruals)	**293**	182
Cash payments received in-year (re receivables at 31 March 2015)	**7**	39
Cash payments received in-year (iro invoices issued 2014-15)	**70**	18
Amounts added to provision for impairment of receivables (iro invoices issued 2014-15)	**0**	30
Amounts written off in-year (irrespective of year of recognition)	**30**	93

7. Operating expenses

	2015-16 £000s	2014-15 £000s
Purchase of healthcare from non-NHS bodies	**986**	1,160
Trust Chair and Non-executive Directors	**84**	97
Supplies and services - clinical	**63,372**	53,268
Supplies and services - general	**1,052**	10,466
Consultancy services	**372**	1,378
Establishment	**4,478**	4,293
Transport	**2,681**	2,483
Service charges - ON-SOFP PFIs and other service concession arrangements	**17,710**	18,170
Business rates paid to local authorities	**1,124**	1,600
Premises	**13,177**	12,643
Hospitality	**28**	61
Insurance	**269**	281
Legal Fees	**326**	365
Impairments and Reversals of Receivables	**34**	96
Depreciation	**10,734**	10,409
Amortisation	**359**	357
Impairments and reversals of property, plant and equipment	**14,215**	14,702
Internal Audit Fees*	**151**	
Audit fees	**115**	158
Clinical negligence	**5,996**	6,210
Research and development (excluding staff costs)	**7**	6
Education and Training	**1,623**	1,775
Change in Discount Rate	**(6)**	53
Other	**1,394**	2,001
Total Operating expenses (excluding employee benefits)	**140,281**	142,032

*Internal audit fees were categorised as 'Other' in 2014/15. The comparable amount was £164,000

Other expenditure includes:
Energy conservation costs £176,000 (2014/15 £171,000)
Laboratory testing for public health £162,000 (2014/15 £135,000)
and expenditure on interpreting fees, carriage charges and compensation for lost items.

Employee Benefits		
Employee benefits excluding Board members	**235,500**	229,936
Board members	**1,166**	893
Total Employee Benefits	**236,666**	230,829
Total Operating Expenses	**376,947**	372,861

8. Operating Leases

The Trust leases cars and other vehicles used for Trust business through operating leases. These are usually taken out under a three year term. There are penalties for early termination of the lease and there is no automatic transfer of ownership or ability to purchase at non-market terms under these leases.

8.1. Buckinghamshire Healthcare NHS Trust as lessee

	Other £000s	2015-16 Total £000s	2014-15 £000s
Payments recognised as an expense			
Minimum lease payments		**290**	270
Total		**290**	270
Payable:			
No later than one year	109	**109**	46
Between one and five years	229	**229**	260
After five years	0	**0**	0
Total	**338**	**338**	306

9. Employee benefits and staff numbers

9.1. Employee benefits

	2015-16		
	Total £000s	**Permanently employed £000s**	**Other £000s**
Employee Benefits - Gross Expenditure			
Salaries and wages	**201,945**	171,398	30,547
Social security costs	**14,265**	14,265	0
Employer Contributions to NHS BSA - Pensions Division	**21,816**	21,816	0
Other pension costs	**0**	0	0
Termination benefits	**30**	30	0
Total employee benefits	**238,056**	**207,509**	**30,547**
Employee costs capitalised	**1,390**	1,390	0
Gross Employee Benefits excluding capitalised costs	**236,666**	**206,119**	**30,547**

Employee Benefits - Gross Expenditure 2014-15	**Total £000s**	**Permanently employed £000s**	**Other £000s**
Salaries and wages	197,592	170,621	26,971
Social security costs	13,791	13,791	0
Employer Contributions to NHS BSA - Pensions Division	20,865	20,865	0
Other pension costs	0	0	0
Termination benefits	108	108	0
TOTAL - including capitalised costs	232,356	205,385	26,971
Employee costs capitalised	1,527	1,527	0
Gross Employee Benefits excluding capitalised costs	230,829	203,858	26,971

In 2012-13 there were rows for 'other post-employment benefits' and 'other employment benefits'. These are now included within the 'Salaries and wages' row.

9.2. Staff Numbers

	2015-16			2014-15
	Total Number	**Permanently employed Number**	**Other Number**	Total Number
Average Staff Numbers				
Medical and dental	**645**	624	21	616
Administration and estates	**1,085**	1,016	69	1,224
Healthcare assistants and other support staff	**782**	697	85	876
Nursing, midwifery and health visiting staff	**2,087**	1,805	282	1,921
Nursing, midwifery and health visiting learners	**8**	8	0	0
Scientific, therapeutic and technical staff	**441**	391	50	296
Healthcare Science Staff	**422**	413	9	422
Other	**10**	2	8	0
TOTAL	**5,480**	**4,956**	**524**	5,355
Of the above - staff engaged on capital projects	**0**	0	0	36

9.3. Staff Sickness absence and ill health retirements

	2015-16 Number	2014-15 Number
Total Days Lost	40,750	36,810
Total Staff Years	4,971	4,836
Average working Days Lost	8.20	7.61

	2015-16 Number	2014-15 Number
Number of persons retired early on ill health grounds	**7**	4
	£000s	£000s
Total additional pensions liabilities accrued in the year	**161**	305

9.4. Exit Packages agreed in 2015-16

2015-16

Exit package cost band (including any special payment element)	*Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed.	Total number of exit packages	Total cost of exit packages	Number of Departures where special payments have been made	Cost of special payment element included in exit packages
	Number	£s	Number	£s	Number	£s	Number	£
Less than £10,000	1	2,472	11	37,000	**12**	**39,472**	0	0
£10,000-£25,000	0	0	0	0	**0**	**0**	0	0
£25,001-£50,000	1	25,012	0	0	**1**	**25,012**	0	0
£50,001-£100,000	1	73,536	0	0	**1**	**73,536**	0	0
£100,001 - £150,000	0	0	0	0	**0**	**0**	0	0
£150,001 - £200,000	0	0	0	0	**0**	**0**	0	0
>£200,000	0	0	0	0	**0**	**0**	0	0
Total	**3**	**101,020**	**11**	**37,000**	**14**	**138,020**	**0**	**0**

2014-15

Exit package cost band (including any special payment element)	*Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed.	Total number of exit packages	Total cost of exit packages	Number of Departures where special payments have been made	Cost of special payment element included in exit packages
	Number	£s	Number	£s	Number	£s	Number	£
Less than £10,000	3	14,149	0	0	**3**	**14,149**	0	0
£10,000-£25,000	0	0	0	0	**0**	**0**	0	0
£25,001-£50,000	0	0	0	0	**0**	**0**	0	0
£50,001-£100,000	1	93,680	0	0	**1**	**93,680**	0	0
£100,001 - £150,000	0	0	0	0	**0**	**0**	0	0
£150,001 - £200,000	0	0	0	0	**0**	**0**	0	0
>£200,000	0	0	0	0	**0**	**0**	0	0
Total	**4**	**107,829**	**0**	**0**	**4**	**107,829**	**0**	**0**

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Scheme. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table.

This disclosure reports the number and value of exit packages agreed in the year. Note: The expense associated with these departures may have been recognised in part or in full in a previous period.

9.5. Exit packages - Other Departures analysis

	2015-16 Agreements	2015-16 Total value of agreements	2014-15 Agreements	2014-15 Total value of agreements
	Number	£000s	Number	£000s
Contractual payments in lieu of notice	11	37	0	0
Total	11	37	0	0
Non-contractual payments made to individuals where the payment value was more than 12 months of their annual salary	0	0	0	0

This disclosure reports the number and value of exit packages agreed in the year. Note: the expense associated with these departures may have been recognised in part or in full in a previous period

As a single exit packages can be made up of several components each of which will be counted separately in this Note, the total number above will not necessarily match the total numbers in Note 9.4 which will be the number of individuals.

The Remuneration Report includes disclosure of exit payments payable to individuals named in that Report.

9.6. Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2016, is based on valuation data as 31 March 2015, updated to 31 March 2016 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account their recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

10. Better Payment Practice Code

10.1. Measure of compliance

	2015-16 Number	2015-16 £000s	2014-15 Number	2014-15 £000s
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**77,836**	**228,710**	64,816	162,641
Total Non-NHS Trade Invoices Paid Within Target	**61,986**	**204,990**	53,392	144,725
Percentage of NHS Trade Invoices Paid Within Target	**79.64%**	**89.63%**	82.37%	88.98%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**2,162**	**11,405**	2,287	**10,596**
Total NHS Trade Invoices Paid Within Target	**1,121**	**5,060**	1,509	**3,949**
Percentage of NHS Trade Invoices Paid Within Target	**51.85%**	**44.37%**	65.98%	37.27%

The Better Payment Practice Code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

10.2. The Late Payment of Commercial Debts (Interest) Act 1998

	2015-16 £000s	2014-15 £000s
Amounts included in finance costs from claims made under this legislation	**9**	10
Total	**9**	10

11. Investment Revenue

	2015-16 £000s	2014-15 £000s
Bank interest	**36**	31
Total investment revenue	**36**	31

12. Other Gains and Losses

	2015-16 £000s	2014-15 £000s
Gain/(Loss) on disposal of assets other than by sale (PPE)	**202**	0
Gain (Loss) on disposal of assets held for sale	**25**	(44)
Total	**227**	(44)

13. Finance Costs

	2015-16 £000s	2014-15 £000s
Interest		
Interest on loans and overdrafts	**862**	106
Interest on obligations under finance leases	**41**	25
Interest on obligations under PFI contracts:		
- main finance cost	**10,316**	10,538
- contingent finance cost	**1,393**	1,392
Interest on late payment of commercial debt	**9**	10
Total interest expense	**12,621**	12,071
Other finance costs	**0**	0
Provisions - unwinding of discount	**21**	20
Total	**12,642**	12,091

14.1. Property, plant and equipment

2015-16	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Cost or valuation:									
At 1 April 2015	45,408	186,064	4,782	11,644	44,858	207	32,310	4,356	**329,629**
Additions of Assets Under Construction				510					**510**
Additions Purchased	0	3,413	0		2,927	0	6,065	0	**12,405**
Additions - Non Cash Donations (i.e. physical assets)	0	384	0	43	1,175	0	10	0	**1,612**
Additions Leased (including PFI/LIFT)	0	0	0		790	0	0	0	**790**
Reclassifications	0	2,882	0	(11,416)	792	(25)	7,681	86	**0**
Reclassifications as Held for Sale and reversals	0	0	(324)	0	0	0	0	0	**(324)**
Disposals other than for sale	0	0	0	0	(1,059)	0	0	0	**(1,059)**
Upward revaluation/positive indexation	603	851	0	0	0	0	0	0	**1,454**
Impairment/reversals charged to operating expenses	176	(21,891)	186	0	0	0	0	0	**(21,529)**
At 31 March 2016	**46,187**	**171,703**	**4,644**	**781**	**49,483**	**182**	**46,066**	**4,442**	**323,488**
Depreciation									
At 1 April 2015	0	3,412	81		30,479	174	24,524	3,147	**61,817**
Reclassifications	0	0	0		0	0	0	0	**0**
Reclassifications as Held for Sale and reversals	0	0	1		0	0	0	0	**1**
Disposals other than for sale	0	0	0		(1,059)	0	0	0	**(1,059)**
Impairments/reversals charged to operating expenses	0	(7,149)	(165)		0	0	0	0	**(7,314)**
Charged During the Year	0	3,859	84		3,098	1	3,483	209	**10,734**
At 31 March 2016	**0**	**122**	**1**	**0**	**32,518**	**175**	**28,007**	**3,356**	**64,179**
Net Book Value at 31 March 2016	**46,187**	**171,581**	**4,643**	**781**	**16,965**	**7**	**18,059**	**1,086**	**259,309**
Asset financing:									
Owned - Purchased	46,187	92,868	4,150	650	11,801	0	17,460	999	**174,115**
Owned - Donated	0	9,667	493	131	4,178	7	599	87	**15,162**
Held on finance lease	0	3,697	0	0	986	0	0	0	**4,683**
On-SOFP PFI contracts	0	65,349	0	0	0	0	0	0	**65,349**
Total at 31 March 2016	**46,187**	**171,581**	**4,643**	**781**	**16,965**	**7**	**18,059**	**1,086**	**259,309**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2015	19,615	13,949	6	0	2,771	7	0	71	**36,419**
Movements (specify)	603	851	0	0	0	0	0	0	**1,454**
At 31 March 2016	**20,218**	**14,800**	**6**	**0**	**2,771**	**7**	**0**	**71**	**37,873**

Additions to Assets Under Construction in 2014-15

Land	0
Buildings excl Dwellings	510
Dwellings	0
Plant & Machinery	0
Balance as at YTD	**510**

14.2. Property, plant and equipment prior-year

2014-15	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Cost or valuation:									
At 1 April 2014	45,110	225,725	5,635	3,448	46,464	258	31,592	4,453	**362,685**
Additions of Assets Under Construction				8,328					**8,328**
Additions Purchased	0	5,208	0		1,209	0	1,648	0	**8,065**
Additions - Non Cash Donations (i.e. Physical Assets)	0	812	0	0	1,000	25	150	0	**1,987**
Additions - Purchases from Cash Donations & Government Grants	0	0	0	0	70	0	0	0	**70**
Additions Leased (including PFI/LIFT)	0	0	0		298	0	0	0	**298**
Reclassifications	0	0	0	0	150	0	0	(150)	**0**
Reclassifications as Held for Sale and Reversals	0	0	0	0	0	0	(44)	0	**(44)**
Revaluation	239	(31,400)	(853)	(132)	(310)	0	0	0	**(32,456)**
At 31 March 2015	**45,349**	**200,345**	**4,782**	**11,644**	**48,881**	**283**	**33,346**	**4,303**	**348,933**
Depreciation									
At 1 April 2014	0	24,988	439	0	31,315	247	21,583	2,865	**81,437**
Revaluation	0	(24,988)	(439)		0	0	0	0	**(25,427)**
Impairments/negative indexation charged to operating expenses	141	14,259	19	0	503	0	0	0	**14,922**
Reversal of Impairments charged to operating expenses	(200)	0	(20)	0	0	0	0	0	**(220)**
Charged During the Year	0	3,434	82		2,684	3	3,977	229	**10,409**
At 31 March 2015	**(59)**	**17,693**	**81**	**0**	**34,502**	**250**	**25,560**	**3,094**	**81,121**
Net Book Value at 31 March 2015	**45,408**	**182,652**	**4,701**	**11,644**	**14,379**	**33**	**7,786**	**1,209**	**267,812**
Asset financing:									
Owned - Purchased	45,408	94,570	4,170	11,644	10,112	24	7,067	1,151	**174,146**
Owned - Donated	0	9,913	531	0	3,281	9	719	58	**14,511**
Held on finance lease	0	0	0	0	986	0	0	0	**986**
On-SOFP PFI contracts	0	78,169	0	0	0	0	0	0	**78,169**
Total at 31 March 2015	**45,408**	**182,652**	**4,701**	**11,644**	**14,379**	**33**	**7,786**	**1,209**	**267,812**

14.3. (cont). Property, plant and equipment

The Trust receives donations from, or equipment funded by, the Buckinghamshire Hospitals Charitable Fund, Scannappeal and the Leagues of Friends associated with the Trust's hospital sites

The Trust commissioned a valuation of the 'fair value' of its land, buildings and dwellings at 1st April 2014 from a firm of independent valuers, DTZ. The valuation was carried out in accordance with the appropriate standards contained within the RICS Valuation - Professional Standards (the 'Red Book'). The inspections were carried out by a team of surveyors who were all members of the Royal Institute of Chartered Surveyors. They confirmed that they had the knoweledge, skills and understanding to undertake the valuations competently.

The basis of the valuation was on depreciated replacement cost and assuming the asset would be replaced by an modern equivalent, not a building of identical design, with the same service potential of the existing asset. They have confirmed that market value would not be in excess of existing use value.

Movements in asset valuation are either taken to the Revaluation Reserve (if there was an existing balance for that asset class and site) or through the Statement of Comprehensive Income as an impairment.

Interim valuations have been provided by the same firm of valuers, who have changed their name to Cushman & Wakefield, at 31st March 2015 and 31st March 2016. The impact of these interim valuations is shown in Note 14.

Note 14.1 also includes the effect of impairments to asset values caused by the assessment of the fair value of assets brought into use, which had initially been valued at cost.

14.4 Asset Lives

The Useful Economic Lives of the Trust assets are within the ranges below:

Asset Group	Minimum Life (Years)	Maximum Life (Years)
Intangible Assets		
Software Licences	5	12
Property, Plant and Equipment		
Buildings exc Dwellings	5	85
Dwellings	10	57
Plant & Machinery	5	21
Transport Equipment	7	10
Information Technology	5	12
Furniture and Fittings	7	23

15. Intangible non-current assets

15.1. Intangible non-current assets 2015-16

	Computer Licenses	Total
	£000's	£000's
At 1 April 2015	**1,798**	**1,798**
Additions - Non Cash Donations (i.e. physical assets)	98	**98**
At 31 March 2016	**1,896**	**1,896**
Amortisation		
At 1 April 2015	**804**	**804**
Charged During the Year	359	**359**
At 31 March 2016	**1,163**	**1,163**
Net Book Value at 31 March 2016	**733**	**733**
Asset Financing: Net book value at 31 March 2016 comprises:		
Purchased	632	**632**
Donated	101	**101**
Total at 31 March 2016	**733**	**733**

15.2. Intangible non-current assets prior year 2014-15

	Computer Licenses	Total
	£000's	£000's
Cost or valuation:		
At 1 April 2014	1,792	1,792
Additions - purchased	6	6
At 31 March 2015	1,798	1,798
Amortisation		
At 1 April 2014	447	447
Charged during the year	357	357
At 31 March 2015	804	804
Net book value at 31 March 2015	994	994
Net book value at 31 March 2015 comprises:		
Purchased	991	991
Donated	3	3
Total at 31 March 2015	994	994

15.3. Intangible non-current assets

The Trust has purchased licenses which enable it to use a number of software applications. These licenses are held at cost and amortised over the period that the license is valid.

16. Analysis of impairments and reversals recognised in 2015-16

All impairments and reversals have been against Property, Plant and Equipment. There have been none recognised against other categories, such as Intangible Assets.

	2015-16 Total £000s
Other	3,470
Changes in market price	10,745
Total charged to Annually Managed Expenditure	**14,215**
Total Impairments of Property, Plant and Equipment charged to SoCI	**14,215**
Total Impairments charged to SoCI - DEL	**0**
Total Impairments charged to SoCI - AME	**14,215**
Overall Total Impairments	**14,215**
Donated and Gov Granted Assets, included above	
PPE - Donated and Government Granted Asset Impairments: amount charged to SOCI - DEL	(363)
Intangibles - Donated and Government Granted Asset Impairments: amount charged to SOCI - DEL	0

The Trust incurs capital expenditure on improving the ability of Trust assets to meet service provision requirements, including the usage of different wards and departments. This expenditure, although necessary, may not enhance the overall value of the asset. The Trust would not know this at the commencement of the project. Once the asset is ready to be brought into use the independent valuer is asked to provide a valuation of the new asset. The total of these valuations is compared to the toal amount spent and any difference recognised as either an impairment if negative (as shown under 'Other' above) or as a revaluation gain if positive.

The Trust engaged an independent valuer to undertake an interim valuation of the Trust's land, buildings and dwellings. Where there was a downwards valuation and any revaluation reserve balance was insufficient to cover the movement, the impairment is included within 'Changes in Market Price' above. Where there was an upwards movement, and a previous impairment against that asset had been recognised, this impairment has been reversed through the SOCI before a revaluation reserve balance created. The net figure is shown above. The gross figures are:

	£'000
Reversals of previous impairments	(1,587)
New impairments recognised	12,332
Total	10,745

17. Commitments

17.1. Capital commitments

Contracted capital commitments at 31 March not otherwise included in these financial statements:

	31 March 2016	31 March 2015
	£000s	£000s
Property, plant and equipment	**2,822**	1,886
Intangible assets	**0**	0
Total	**2,822**	1,886

18. Inventories

	Drugs	Consumables	Energy	Total	Of which held at NRV
	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2015	**3,042**	**2,584**	**67**	**5,693**	0
Additions	34,414	24,536	76	**59,026**	0
Inventories recognised as an expense in the period	(34,497)	(24,231)	(88)	**(58,816)**	0
Balance at 31 March 2016	**2,959**	**2,889**	**55**	**5,903**	**0**

19.1. Trade and other receivables

	Current		Non-current	
	31 March 2016	31 March 2015	**31 March 2016**	31 March 2015
	£000s	£000s	**£000s**	£000s
NHS receivables - revenue	**13,360**	16,956	**0**	0
NHS prepayments and accrued income	**230**	0	**0**	0
Non-NHS receivables - revenue	**4,705**	4,850	**0**	0
Non-NHS prepayments and accrued income	**8,886**	6,505	**0**	0
PDC Dividend prepaid to DH	**684**	176		
Provision for the impairment of receivables	**(446)**	(446)	**0**	0
VAT	**1,394**	1,301	**0**	0
Other receivables	**339**	377	**2,005**	2,182
Total	**29,152**	29,719	**2,005**	2,182
Total current and non current	**31,157**	31,901		

The Trust has not prepaid any of its pension contributions due.

The great majority of trade is with NHS England and Clinical Commissioning Groups. . As these NHS bodies are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.

19.2. Receivables past their due date but not impaired

	31 March 2016	31 March 2015
	£000s	£000s
By up to three months	**4,832**	2,794
By three to six months	**1,744**	147
By more than six months	**1,567**	2,049
Total	**8,143**	4,990

19.3. Provision for impairment of receivables

	2015-16	2014-15
	£000s	£000s
Balance at 1 April 2015	**(446)**	(454)
Amount written off during the year	**34**	104
Amount recovered during the year	**0**	0
(Increase)/decrease in receivables impaired	**(34)**	(96)
Balance at 31 March 2016	**(446)**	(446)

20. Other current assets

	31 March 2016 £000s	31 March 2015 £000s
EU Emissions Trading Scheme Allowance	**0**	0
Other Assets	**163**	163
Total	**163**	163

21. Cash and Cash Equivalents

	31 March 2016 £000s	31 March 2015 £000s
Opening balance	**1,769**	1,519
Net change in year	**5,762**	250
Closing balance	**7,531**	1,769
Made up of		
Cash with Government Banking Service	**7,425**	1,715
Cash in hand	**106**	54
Cash and cash equivalents as in statement of financial position	**7,531**	1,769
Cash and cash equivalents as in statement of cash flows	**7,531**	1,769
Third Party Assets - Monies on deposit	3	2

22. Non-current assets held for sale

	Dwellings	Information Technology	Total
	£000s	£000s	£000s
Balance at 1 April 2015	0	0	**0**
Plus assets classified as held for sale in the year	325	0	**325**
Balance at 31 March 2016	**325**	**0**	**325**
Balance at 1 April 2014	0	0	**0**
Plus assets classified as held for sale in the year	0	44	**44**
Less assets sold in the year	0	(44)	**(44)**
Balance at 31 March 2015	**0**	**0**	**0**

The Trust holds a residential flat which is being actively marketed for sale in 2016-17. This property is shown at its current market valuation above.

23. Trade and other payables

	Current		Non-current	
	31 March 2016 £000s	31 March 2015 £000s	**31 March 2016 £000s**	31 March 2015 £000s
NHS payables - revenue	**2,600**	2,862	**0**	0
NHS accruals and deferred income	**1,090**	1,090	**0**	0
Non-NHS payables - revenue	**10,476**	12,475	**0**	0
Non-NHS payables - capital	**2,135**	2,659	**0**	0
Non-NHS accruals and deferred income	**6,003**	8,651	**0**	0
Social security costs	**2,057**	3,978		
Accrued Interest on DH Loans	**6**			
VAT	**312**	325	**624**	936
Tax	**2,172**	2,101		
Other	**3,377**	3,144	**0**	0
Total	**30,228**	37,285	**624**	936
Total payables (current and non-current)	**30,852**	**38,221**		
Included above:				
outstanding Pension Contributions at the year end	**3,045**	(2,940)		

24. Other liabilities

	Current		Non-current	
	31 March 2016 £000s	31 March 2015 £000s	**31 March 2016 £000s**	31 March 2015 £000s
PFI/LIFT deferred credit	**23**	25	**338**	361
Other (Private Patients' Deposits against future treatment)	**142**	0	**0**	0
Total	**165**	25	**338**	361
Total other liabilities (current and non-current)	**503**	**386**		

25. Borrowings

	Current		Non-current	
	31 March 2016 £000s	31 March 2015 £000s	**31 March 2016 £000s**	31 March 2015 £000s
Loans from Department of Health	**1,865**	1,142	**36,309**	7,674
PFI liabilities:				
Main liability	**2,088**	2,157	**58,444**	60,532
Finance lease liabilities	**816**	677	**3,099**	3,230
Total	**4,769**	**3,976**	**97,852**	**71,436**
Total other liabilities (current and non-current)	**102,621**	**75,412**		

Borrowings / Loans - repayment of principal falling due in:

		31 March 2016	
	DH £000s	**Other £000s**	**Total £000s**
0-1 Years	1,865	2,904	**4,769**
1 - 2 Years	1,865	3,226	**5,091**
2 - 5 Years	31,558	8,963	**40,521**
Over 5 Years	2,886	49,354	**52,240**
TOTAL	**38,174**	**64,447**	**102,621**

26. Deferred income

	Current		Non-current	
	31 March 2016 £000s	31 March 2015 £000s	**31 March 2016 £000s**	31 March 2015 £000s
Opening balance at 1 April 2015	**1,676**	1,108	**0**	0
Deferred revenue addition	**0**	568	**0**	0
Transfer of deferred revenue	**(391)**	0	**0**	0
Current deferred Income at 31 March 2016	**1,285**	1,676	**0**	0
Total deferred income (current and non-current)	**1,285**	1,676		

27. Finance lease obligations as lessee

The Trust has entered into a finance lease arrangement with one of its PFI partners to construct a Multi-Storey Car Park at Stoke Mandeville hospital. In exchange for financing this construction, the Trust has to forego a guaranteed amount of income from the car parks over the term of the lease which is 6.3 years.

Amounts payable under finance leases (Buildings)	**Minimum lease payments**		**Present value of minimum**	
	31 March 2016 £000s	31 March 2015 £000s	**31 March 2016 £000s**	31 March 2015 £000s
Within one year	**708**	720	**592**	571
Between one and five years	**2,595**	2,599	**2,360**	2,244
After five years	**0**	721	**0**	685
Less future finance charges	**(351)**	(540)		
Minimum Lease Payments / Present value of minimum lease payments	**2,952**	3,500	**2,952**	3,500
Included in:				
Current borrowings			**592**	571
Non-current borrowings			**2,360**	2,929
			2,952	3,500

The Trust has a number of finance leases for equipment including endoscopes, beds and mattresses. The leases are based on the standard NHS lease contract. The terms of the leases vary, depending on the equipment covered, but range from 3 to 15 years, with approximately 5 being the average.

The leases bear no automatic right for the Trust to take possession, to purchase the equipment at a reduced price, or extend the leases at the end of their term, and any extension is negotiated at the time of expiry of the primary lease.

The leases carry an early termination clause, which obliges the Trust to pay the lease payments during the remainder of the term of the lease. The Trust will be responsible for all maintenance and insurance of the leased assets. The Trust would not be able to sub-lease, amend, or otherwise transfer the asset, without the permission of the lease company.

Amounts payable under finance leases (Other)	**Minimum lease payments**		**Present value of minimum**	
	31 March 2016 £000s	31 March 2015 £000s	**31 March 2016 £000s**	31 March 2015 £000s
Within one year	**268**	146	**224**	106
Between one and five years	**733**	432	**636**	301
After five years	**124**	0	**103**	0
Less future finance charges	(162)	(171)		
Minimum Lease Payments / Present value of minimum lease payments	**963**	407	**963**	407
Included in:				
Current borrowings			**224**	106
Non-current borrowings			**739**	301
			963	407

28. Provisions

		Comprising:		
	Total	**Early Departure Costs**	**Legal Claims**	**Other**
	£000s	**£000s**	**£000s**	**£000s**
Balance at 1 April 2015	**1,782**	209	1,372	201
Arising during the year	**324**	4	132	188
Utilised during the year	**(379)**	(37)	(160)	(182)
Reversed unused	**(19)**	0	0	(19)
Unwinding of discount	**21**	3	18	0
Change in discount rate	**(6)**	0	(6)	0
Balance at 31 March 2016	**1,723**	**179**	**1,356**	**188**
Expected Timing of Cash Flows:				
No Later than One Year	**437**	39	210	188
Later than One Year and not later than Five Years	**545**	113	432	0
Later than Five Years	**741**	27	714	0

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:

As at 31 March 2016	90,083
As at 31 March 2015	58,399

The uncertainty of timing or amounts relating to the classes of provision above are:

- Pensions - uncertainty in respect of the length of time payable and therefore for the obligation for future payments.
- Legal Claims - For Employer Liability claims there are uncertainties relating to the likelihood of the Trust being held liable and the amount of any award.
- For Injury benefit claims the uncertainty relates to the length of time over which these may be payable.
- Other Provisions relate to carbon trading assessments, where there is an uncertainty of amount.

29. Contingencies

	31 March 2016	31 March 2015
	£000s	£000s
Contingent liabilities		
NHS Litigation Authority legal claims	**(55)**	(45)
Employment Tribunal and other employee related litigation	**(23)**	0
Net value of contingent liabilities	**(78)**	(45)

30. PFI and LIFT - additional information

The Trust has two Private Finance Initiative (PFI) contracts known as the 'South Bucks' contract for the buildings at Wycombe and Amersham Hospitals and the 'Stoke Mandeville' contract for the building at Stoke Mandeville.

The South Bucks scheme was for the provision of a new building at Wycombe Hospital, and an almost complete rebuild of Amersham Hospital. The contract was signed in December 1997 and the new buildings were fully operational in November 2000. The contract length is 63 years and the Trust has an option to break the contract at 33 years, 43 years and every 5 years after that.

The Trust provided two smaller sites to the PFI partner in exchange for a reduced unitary payment during the contract term and the value of this exchange is accounted for as deferred expenditure. As part of this contract, the facilities management services at Wycombe and Amersham will be provided by the PFI partner over the lifetime of the contract.

The Stoke Mandeville scheme was for the re-provision of 11 wards (238 beds), a new entrance and restaurant and a new burns unit on the Stoke Mandeville site. The contract was signed in May 2004 and the new buildings became fully operational in August 2006. The contract was for 32 years from the date of signing.

As part of the contract terms, the PFI partner will be responsible for the provision of facilities management during the lifetime of the contract and will receive a guaranteed amount of income from catering and provision of car parking.

In both cases the Trust retains the ownership of the land. During the period of the contract the Trust is obliged to retain buildings, although it can specify what services are provided on each site.

Under IFRIC 12 the Trust treats the assets (buildings) resulting from these contracts as its own and their value is included within the Statement of Financial Position (totalling £65,349,000 for both sites). It also includes a liability for the payment that is required to be made to the PFI partners (totalling £60,532,000).

The Unitary Payment paid to the PFI partners is accounted for partly as costs relating to the supply of the facilities management services under General Supplies and Services and partly as finance costs relating to the lease of the buildings.

The information below is required by the Department of Heath for inclusion in national statutory accounts

Charges to operating expenditure and future commitments in respect of ON SOFP PFI

	2015-16 £000s	2014-15 £000s
Service element of on SOFP PFI charged to operating expenses in year	**17,710**	18,170
Total	**17,710**	18,170

Payments committed to in respect of the service element of on SOFP PFI

No Later than One Year	**19,214**	18,474
Later than One Year, No Later than Five Years	**76,858**	73,896
Later than Five Years	**236,503**	245,373
Total	**332,575**	337,743

Imputed "finance lease" obligations for on SOFP PFI contracts due

	2015-16 £000s	2014-15 £000s
No Later than One Year	**11,914**	11,855
Later than One Year, No Later than Five Years	**47,282**	47,492
Later than Five Years	**207,949**	243,928
Subtotal	**267,145**	303,275
Less: Interest Element	**(206,613)**	(240,586)
Total	**60,532**	62,689

Present Value Imputed "finance lease" obligations for on SOFP PFI contracts due Analysed by when PFI payments are due	**2015-16 £000s**	2014-15 £000s
No Later than One Year	**2,088**	2,157
Later than One Year, No Later than Five Years	**9,193**	8,913
Later than Five Years	**49,251**	51,619
Total	**60,532**	62,689

Number of on SOFP PFI Contracts

Total Number of on PFI contracts	**2**
Number of on PFI contracts which individually have a total commitments value in excess of £500m	**0**

31 Impact of IFRS treatment - current year

The information below is required by the Department of Heath for budget reconciliation purposes	**Expenditure £000s**	Expenditure £000s
Revenue costs of IFRS: Arrangements reported on SoFP under IFRIC12 (e.g PFI / LIFT)		
Depreciation charges	1,302	1,106
Interest Expense	10,316	11,930
Impairment charge - AME	11,518	(2,035)
Impairment charge - DEL	0	0
Other Expenditure	19,103	18,023
Revenue Receivable from subleasing		
Impact on PDC dividend payable	59	112
Total IFRS Expenditure (IFRIC12)	**42,298**	**29,136**
Revenue consequences of PFI / LIFT schemes under UK GAAP / ESA95 (net of any sublease revenue)	30,624	31,057
Net IFRS change (IFRIC12)	**11,674**	**(1,921)**
Capital Consequences of IFRS : LIFT/PFI and other items under IFRIC12		
Capital expenditure 2015-16	**0**	0
UK GAAP capital expenditure 2015-16 (Reversionary Interest)	**517**	500

	2015-16 Income/ Expenditure IFRIC 12 YTD £000s	**2015-16 Income/ Expenditure ESA 10 YTD £000s**
Revenue costs of IFRS12 compared with ESA10		
Depreciation charges	**1,302**	
Interest Expense	**10,316**	
Impairment charge - AME	**11,518**	
Impairment charge - DEL	**0**	
Other Expenditure		
Service Charge	**17,710**	30,624
Contingent Rent	**1,393**	
Lifecycle	**0**	
Impact on PDC Dividend Payable	**59**	
Total Revenue Cost under IFRIC12 vs ESA10	**42,298**	**30,624**
Revenue Receivable from subleasing	**0**	**0**
Net Revenue Cost/(income) under IDRIC12 vs ESA10	**42,298**	**30,624**

32. Financial Instruments

32.1. Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with its Clinical Commissioning Groups (CCGs) and the way those CCGs are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk
The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk
The Trust borrows from government for capital expenditure, subject to affordability as confirmed by the Trust Development Authority (now NHS Improvement). The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2016 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk
The Trust's operating costs are incurred under contracts with CCGs, which are financed from resources voted annually by Parliament . The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

32.2. Financial Assets

	Loans and receivables	Total
	£000s	£000s
Embedded derivatives		**0**
Receivables - NHS	12,768	**12,768**
Receivables - non-NHS	9,635	**9,635**
Cash at bank and in hand	7,531	**7,531**
Other financial assets	0	**0**
Total at 31 March 2016	**29,934**	**29,934**
Embedded derivatives		0
Receivables - NHS	16,956	16,956
Receivables - non-NHS	9,395	9,395
Cash at bank and in hand	1,769	1,769
Other financial assets	0	0
Total at 31 March 2015	28,120	28,120

32.3. Financial Liabilities

	Other	Total
		£000s
Embedded derivatives		**0**
NHS payables	5,318	**5,318**
Non-NHS payables	18,339	**18,339**
Other borrowings	38,174	**38,174**
PFI & finance lease obligations	64,448	**64,448**
Other financial liabilities	0	**0**
Total at 31 March 2016	**126,279**	**126,279**
Embedded derivatives		0
NHS payables	3,952	3,952
Non-NHS payables	22,608	22,608
Other borrowings	8,816	8,816
PFI & finance lease obligations	66,596	66,596
Other financial liabilities	0	0
Total at 31 March 2015	101,972	101,972

33. Events after the end of the reporting period

There have been no such events that require disclosure or amendment to these financial statements.

34. Related party transactions

During the year none of the Department of Health Ministers, Trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with Buckinghamshire Healthcare NHS Trust

The Department of Health is regarded as a related party. During the year the Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. For example :

Chiltern Clinical Commissioning Group
Aylesbury Vale Clinical Commissioning Group
Herts Valleys Clinical Commissioning Group
Bedfordshire Clinical Commissioning Group
Wessex Area Team
Thames Valley Local Area Team
NHS Litigation Authority
Health Education England

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with HMRC in respect of taxes and national insurance contributions, Bucks County Council in respect of Public Health activity and Aylesbury Vale District Council and Wycombe District Council both in respect of rates.

The Trust has also received revenue and capital payments from a number of charitable funds, certain of the trustees for which are also members of the Trust board. The summary financial statements of the Funds Held on Trust are consolidated in this annual report and accounts.

35. Losses and special payments

The total number of losses cases in 2015-16 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	147,441	38
Special payments	31,285	43
Total losses and special payments	178,726	81

The total number of losses cases in 2014-15 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	200,598	140
Special payments	11,766	37
Total losses and special payments	212,364	177

36. Financial performance targets

The figures given for periods prior to 2009-10 are on a UK GAAP basis as that is the basis on which the targets were set for those years.

36.1. Breakeven performance

	2006-07 £000s	2007-08 £000s	2008-09 £000s	2009-10 £000s	2010-11 £000s	2011-12 £000s	2012-13 £000s	2013-14 £000s	2014-15 £000s	2015-16 £000s
Turnover	252,488	275,643	280,557	294,906	345,367	340,397	350,921	359,449	369,844	**370,225**
Retained surplus/(deficit) for the year	43	1,729	(2,750)	(28,090)	2,654	4,338	(7,202)	5,229	(21,125)	**(24,608)**
Adjustment for:										
Timing/non-cash impacting distortions:										
Pre FDL(97)24 agreements	0	0	0	0	0	0	0	0	0	**0**
2007/08 PPA (relating to 1997/98 to 2006/07)	0									
2008/09 PPA (relating to 1997/98 to 2007/08)	0	0								
Adjustments for impairments			0	28,236	(2,407)	(2,751)	7,226	(5,670)	14,702	**14,215**
Adjustments for impact of policy change re donated/government grants assets						734	(341)	37	(1,137)	**(630)**
Consolidated Budgetary Guidance - adjustment for dual accounting under IFRIC12*				0	779	527	616	724	114	**156**
Absorption accounting adjustment							0	0	0	**0**
Other agreed adjustments	0	0	0	0	0	0	**0**	0	0	**0**
Break-even in-year position	**43**	**1,729**	**(2,750)**	**146**	**1,026**	**2,848**	**299**	**320**	**(7,446)**	**(10,867)**
Break-even cumulative position	**(2,934)**	**(1,205)**	**(3,955)**	**(3,809)**	**(2,783)**	**65**	**364**	**684**	**(6,762)**	**(17,629)**

* Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, NHS Trust's financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to IFRIC 12 schemes (which would include PFI schemes), which has no cash impact and is not chargeable for overall budgeting purposes, is excluded when measuring Breakeven performance. Other adjustments are made in respect of accounting policy changes (impairments and the removal of the donated asset and government grant reserves) to maintain comparability year to year.

	2006-07 %	2007-08 %	2008-09 %	2009-10 %	2010-11 %	2011-12 %	2012-13 %	2013-14 %	2014-15 %	2015-16 %
Materiality test (I.e. is it equal to or less than 0.5%):										
Break-even in-year position as a percentage of turnover	0.02	0.63	-0.98	0.05	0.30	0.84	0.09	0.09	-2.01	**-2.94**
Break-even cumulative position as a percentage of turnover	-1.16	-0.44	-1.41	-1.29	-0.81	0.02	0.10	0.19	-1.83	**-4.76**

The amounts in the above tables in respect of financial years 2005/06 to 2008/09 inclusive have **not** been restated to IFRS and remain on a UK GAAP basis.

The anticipated date of break-even recovery is 2018/19.

36.2. Capital cost absorption rate

The dividend payable on public dividend capital is based on the actual (rather than forecast) average relevant net assets based on the pre audited accounts and therefore the actual capital cost absorption rate is automatically 3.5%.

36.3. External financing

The Trust is given an external financing limit which it is permitted to undershoot.

	2015-16 £000s	2014-15 £000s
External financing limit (EFL)	**23,007**	14,263
Cash flow financing	**20,796**	10,585
Finance leases taken out in the year	**790**	3,500
Other capital receipts	**0**	0
External financing requirement	**21,586**	14,085
Under/(over) spend against EFL	**1,421**	178

36.4. Capital resource limit

The Trust is given a capital resource limit which it is not permitted to exceed.

	2015-16 £000s	2014-15 £000s
Gross capital expenditure	**15,415**	18,258
Less: book value of assets disposed of	**0**	0
Less: donations towards the acquisition of non-current assets	**(1,710)**	(2,057)
Charge against the capital resource limit	**13,705**	16,201
Capital resource limit	**16,546**	16,515
(Over)/underspend against the capital resource limit	**2,841**	314

37. Third party assets

The Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2016 £000s	31 March 2015 £000s
Third party assets held by the Trust.	**3**	2

38 Consolidation of Associated Charity

As outlined in Note 1.4 to the Accounts, where the Trust has an associated Charity under common control, it is required to produce consolidated financial statements. The information below outlines the consolidation process, the Charity's results and amounts consolidated.

The Charity shares the same financial year as the Trust, but is not subject to the NHS reporting timetable. Therefore at the point of preparation and audit of these Accounts, the Charity's results had not been audited and may be subject to change.

In addition the Charity is not required to report under International Financial Reporting Standards. It is required to comply with UK Generally Accepted Accounting Practice and there will be differences in Accounting Standards and Policies between the two. As a part of the consolidation exercise, areas which may be affected by the divergence in Accounting Standards, particularly around valuation of assets and liabilities, were assessed, and there was no resultant requirement to restate the Charity's results.

Where there have been transactions between the Trust and the Charity, the impact of these transactions needs to be removed to avoid 'double-counting'. For example, where the Charity has expenditure with the Trust, which the Trust has recorded as income, both entries need to be removed to avoid over-inflating the results. However, where the Charity has provided funding against Trust expenditure which has been recharged, the expenditure will only be shown in the Charity's figures.

There will be specific Accounting Policies which may not be applicable to the Trust, but which may affect the recognition and valuation of financial transactions within the Charity's Accounts. In particular:

a. All incoming resources are met in full as soon as three factors are met:

   Entitlement - when a particular resource is receivable or the Charity becomes legally entitled,

   Certainty - when there is reasonable certainty that the incoming resource will be received, and

   Measurement - when the monetary value can be measured with sufficient reliability

   This is of relevance when considering legacies. When confirmation has been received from representatives of the estate that payment of the legacy will be made or property transferred and, once all conditions attached to the legacy have been fulfilled, the incoming resource will be recognised.

b. Expenditure is recognised when a liability is incurred. Grant commitments are recognised when a constructive obligation arised that results in payment being unavoidable. Liability for unconditional grants is recognised when approval is given by the Trustee. Where the Trustee pledges support for the cost of an ongoing project the costs are accrued within the Charity as the costs are incurred on the project.

c. Investment fixed assets are shown at market value.
   •Quoted stocks and shares are included in the Statement of Financial Position at mid-market price, excluding
   •Other investment fixed assets are included at the Trustee's best estimate of market value.

   All gains and losses are taken to the Income Statement as they arise. Realised gains and losses on investments are calculated as the difference between sale proceeds and opening market value (or cost at date of purchase if later). Unrealised gains and losses are calculated as the difference between market value at the year end and opening market value (or cost at date of purchase if later).

   Due to the exposure to market value of investments the Charity's, and therefore the Group's, exposure to risk with regard to financial assets is different to that of the Trust. Market values of investments can go down as well as up.

38.1 Group Statement of Comprehensive Income

	2015-16				2014-15			
	Trust Only £'000	Charity Only £'000	Inter - Company** £'000	**Consolidated £'000**	Trust Only £'000	Charity Only £'000	Inter - Company** £'000	**Consolidated £'000**
Gross employee benefits	(236,666)	0	0	**(236,666)**	(230,829)	0	0	**(230,829)**
Other operating costs	(140,281)	(1,274)	791	**(142,346)**	(142,032)	(2,317)	1,687	**(146,036)**
Revenue from patient care activities	345,713	0	0	**345,713**	344,217	0	0	**344,217**
Other Operating revenue	24,512	980	(791)	**26,283**	25,627	483	(1,687)	**27,797**
Operating surplus/(deficit)	(6,722)	(294)	0	**(7,016)**	(3,017)	(1,834)	0	**(4,851)**
Investment revenue	36	239	0	**275**	31	275	0	**306**
Other gains and (losses)	227	0	0	**227**	(44)	0	0	**(44)**
Finance costs	(12,642)	0	0	**(12,642)**	(12,091)	0	0	**(12,091)**
Surplus/(deficit) for the financial year	(19,101)	(55)	0	**(19,156)**	(15,121)	(1,559)	0	**(16,680)**
Public dividend capital dividends payable	(5,507)	0	0	**(5,507)**	(6,004)	0	0	**(6,004)**
Retained surplus/(deficit) for the year	(24,608)	(55)	0	**(24,663)**	(21,125)	(1,559)	0	**(22,684)**

Other Comprehensive Income	2015-16				2014-15			
	Trust Only £'000	Charity Only £'000	Inter - Company £'000	**Consolidated £'000**	Trust Only £'000	Charity Only £'000	Inter - Company £'000	**Consolidated £'000**
Net gain/(loss) on revaluation of property, plant & equipment	1,454	0	0	**1,454**	(7,029)	0	0	**(7,029)**
Net gain/(loss) on revaluation of financial assets	0	(357)	0	**(357)**	0	241	0	**241**
Total Comprehensive Income for the year*	(23,154)	(412)	0	**(23,566)**	(28,154)	(1,318)	0	**(29,472)**

*Retained surplus/(deficit) plus Other Comprehensive Income

** Inter-Company transactions relate to the purchase of assets donated to the Trust and the governance costs of the Charity. These transactions are shown as expenditure in one set of Accounts and revenue in the other. For this reason the impact must be removed.

38.2 Group Statement of Financial Position

	2015-16				2014-15			
	Trust Only £'000	Charity Only £'000	Inter - Company* £'000	**Consolidated £000s**	Trust Only £'000	Charity Only £'000	Inter - Company* £'000	**Consolidated £'000**
Non-current assets:								
Property, plant and equipment	259,309	0	0	259,309	267,812	0	0	267,812
Intangible assets	733	0	0	733	994	0	0	994
Other Investments - Charitable	0	7,380	0	7,380		8,036	0	8,036
Trade and other receivables	2,005	0	0	2,005	2,182	0	0	2,182
Total non-current assets	262,047	7,380	0	269,427	270,988	8,036	0	279,024
Current assets:								
Inventories	5,903	2	0	5,905	5,693	7	0	5,700
Trade and other receivables	29,152	676	216	29,612	29,719	271	206	29,784
Other current assets	163	0	0	163	163	0	0	163
Cash and cash equivalents	7,531	849	0	8,380	1,769	1,238	0	3,007
Total current assets	42,749	1,527	216	44,060	37,344	1,516	206	38,654
Non-current assets held for sale	325			325	0			
Total current assets	43,074	1,527	216	44,385	37,344	1,516	206	38,654
Total assets	305,121	8,907	216	313,812	308,332	9,552	206	317,678
Current liabilities								
Trade and other payables	(30,228)	(220)	(216)	(30,232)	(37,285)	(439)	(206)	(37,518)
Other liabilities	(165)	0	0	(165)	(25)	0	0	(25)
Provisions	(437)	0	0	(437)	(430)	0	0	(430)
Borrowings	(2,904)	0	0	(2,904)	(2,834)	0	0	(2,834)
Working capital loan from Department	(1,142)	0	0	(1,142)	(1,142)	0	0	(1,142)
Capital loan from Department	(723)	0	0	(723)	0	0	0	0
Total current liabilities	(35,599)	(220)	(216)	(35,603)	(41,716)	(439)	(206)	(41,949)
Net current assets/(liabilities)	7,475	1,307	0	8,782	(4,372)	1,077	0	(3,295)
Non-current assets plus/less net current assets/liabilities	269,522	8,687	0	278,209	266,616	9,113	0	275,729
Non-current liabilities								
Trade and other payables	(624)	0	0	(624)	(936)	0	0	(936)
Other Liabilities	(338)	0	0	(338)	(361)	0	0	(361)
Provisions	(1,286)	0	0	(1,286)	(1,352)	0	0	(1,352)
Borrowings	(61,543)	0	0	(61,543)	(63,762)	0	0	(63,762)
Working capital loan from Department	(30,532)	0	0	(30,532)	(4,574)	0	0	(4,574)
Capital loan from Department	(5,777)	0	0	(5,777)	(3,100)	0	0	(3,100)
Total non-current liabilities	(100,100)	0	0	(100,100)	(74,085)	0	0	(74,085)
Total Assets Employed:	169,422	8,687	0	178,109	192,531	9,113	0	201,644
FINANCED BY:								
TAXPAYERS' EQUITY								
Public Dividend Capital	181,951		0	181,951	181,917		0	181,917
Retained earnings	(50,367)		0	(50,367)	(25,806)		0	(25,806)
Revaluation reserve	37,838		0	37,838	36,420		0	36,420
Charitable Funds Reserve	0	8,687	0	8,687	0	9,113	0	9,113
Total Taxpayers' Equity:	169,422	8,687	0	178,109	192,531	9,113	0	201,644

*Inter-company transactions relate to Receivables and Payables between the Trust and the Charity that had not been settled by the year end. They are not more than 30 days old.

INDEPENDENT AUDITOR'S REPORT TO THE DIRECTORS OF BUCKINGHAMSHIRE HEALTHCARE NHS TRUST

We have audited the financial statements of Buckinghamshire Healthcare NHS Trust for the year ended 31 March 2016 under the Local Audit and Accountability Act 2014. The financial statements comprise the Trust and Group's Statement of Comprehensive Income, the Trust and Group's Statement of Financial Position, the Trust and Group's Statement of Changes in Taxpayers' Equity, the Trust and Group's Statement of Cash Flows and the related notes 1 to 38. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the 2015-16 Government Financial Reporting Manual (the 2015-16 FReM) as contained in the Department of Health Group Manual for Accounts 2015-16 and the Accounts Direction issued by the Secretary of State with the approval of HM Treasury as relevant to the National Health Service in England (the Accounts Direction).

We have also audited the information in the Remuneration and Staff Report that is subject to audit, being:

- the table of salaries and allowances of senior managers and related narrative notes on page (53) ;
- the table of pension benefits of senior managers and related narrative notes on page (54);
- the tables of exit packages and related notes on page (60); and
- the table of pay multiples and related narrative notes on page (54).

This report is made solely to the Board of Directors of Buckinghamshire Healthcare NHS Trust, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014 and as set out in paragraph 43 of the Statement of Responsibilities of Auditors and Audited Bodies published by Public Sector Audit Appointments Limited. Our audit work has been undertaken so that we might state to the Directors of the Trust those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Directors, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of Directors, the Accountable Officer and auditor

As explained more fully in the Statement of Directors' Responsibilities in respect of the Accounts, set out on page 64, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards also require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

As explained in the statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, the Accountable Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the Trust's resources.

We are required under section 21(3)(c), as amended by schedule 13 paragraph 10(a), of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Section 21(5)(b) of the Local Audit and Accountability Act 2014 requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of:

- whether the accounting policies are appropriate to the Trust and Group's circumstances and have been consistently applied and adequately disclosed;
- the reasonableness of significant accounting estimates made by the directors; and
- the overall presentation of the financial statements.

In addition we read all the financial and non-financial information in the annual report and accounts to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2015, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Opinion on the financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of Buckinghamshire Healthcare NHS Trust as at 31 March 2016 and of its expenditure and income for the year then ended; and
- have been prepared properly in accordance with the National Health Service Act 2006 and the Accounts Directions issued thereunder.

Opinion on other matters

In our opinion:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the Accounts Direction made under the National Health Service Act 2006; and
- the other information published together with the audited financial statements in the annual report and accounts is consistent with the financial statements.

Matters on which we are required to report by exception

We have nothing to report in respect of the following matters:

- in our opinion the governance statement does not comply with the NHS Trust Development Authority's guidance; or
- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under section 24 of the Local Audit and Accountability Act 2014.

In respect of the following we have matters to report by exception:

- Referral to the Secretary of State

On 4 April 2016, we referred a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014, as in reporting a deficit for the financial year ended 31 March 2016 the Trust had breached its breakeven duty as set out in Paragraph 2(1) of Schedule 5 to the National Health Service Act 2006 as interpreted by the Department of Health in its detailed guidance on breakeven duties.

- Proper arrangements to secure economy, efficiency and effectiveness

We report to you by exception, if we are not satisfied that the Trust has put in place proper arrangements to secure economy efficiency and effectiveness in its use of resources.

Basis for qualified conclusion on reporting by exception

The Trust planned a surplus of £3.6million for the year ended 31 March 2016 but reported a deficit of £10.9 million in its financial statements for the year then ended. The Trust has not yet succeeded in addressing the underlying deficit in its budget and is forecasting a further deficit of £8.8million for 2016/17 which is dependent upon achieving a £14.6 million cost improvement plan.

This issue is evidence of weaknesses in proper arrangements for planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions.

Qualified conclusion on reporting by exception

On the basis of our work, having regard to the guidance issued by the Comptroller and Auditor General in November 2015, with the exception of the matter(s) reported in the basis for qualified conclusion paragraph above, we are satisfied that, in all significant respects, Buckinghamshire Healthcare NHS Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016.

Certificate

We certify that we have completed the audit of the accounts of Buckinghamshire Healthcare NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Neil Harris
for and on behalf of Ernst & Young LLP
Luton
31 May 2016

Annual Governance Statement 2015/16

Name of organisation: Buckinghamshire Healthcare NHS Trust

Organisation Code: RXQ

1. SCOPE OF RESPONSIBILITY

As Accountable Officer, and Chief Executive of Buckinghamshire Healthcare NHS Trust (referred to in the rest of the Statement as 'the Trust'), I am responsible for the propriety and regularity of the finances of the organisation; for the keeping of proper accounts; for prudent and economical administration; for achieving value for money from the resources available avoiding of waste and extravagance; and for the efficient and effective use of all the resources in my charge.

I am accountable to the Board of the Trust and to the Secretary of State as set out in the Accountable Officer Memorandum.

It is my responsibility to put in place effective management systems which safeguard public funds and to implement the requirements of corporate governance. I do this through maintaining a sound system of internal control that supports the achievement of the Trust's policies, aims and objectives whilst safeguarding quality standards and public funds.

To enable the delivery of this system of internal control I have managers in place who have a clear view of their objectives and the means to assess achievements in relation to those objectives; who are assigned well-defined responsibilities for making the best use of resources; who have the information, training and access to the expert advice they need to exercise their responsibilities effectively; and who are appraised on an annual basis and held to account for the responsibilities assigned to them.

I have various mechanisms available to me to monitor effectiveness of control systems including external auditors (Ernst & Young) and internal auditors (RSM).

Effective and sound financial management and information are the operational responsibility of the Director of Finance, but I hold the primary duty to see that these functions are properly discharged.

2. PREPARING THE ANNUAL GOVERNANCE STATEMENT

This Annual Governance Statement reflects a range of informed views comprising a number of key elements.

The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the controls reviewed as part of Internal Audit's work programme.

Executive directors within the organisation who have responsibility for the development and maintenance of the system of internal control provide me through the year with assurance that the controls are in place.

The regular review of controls, assurance and risk through the Board Assurance Framework provides me with information about the effectiveness of controls throughout the year. There is a wide range of assurance referenced within the Board Assurance Framework much of which is individually presented to the Board and its Committees for scrutiny and review. For example, assurance is provided through monthly performance reports relating to delivery of operational requirements as set out in the Operating Plan, delivery of financial requirements, and delivery of quality and workforce objectives.

My review is also informed by:

- The key findings and action plan arising from the Chief Inspector of Hospitals' inspection of community services in March 2015 as reported at a Quality Summit held on 6 August 2015.
- External reviews from other sources such as the Deanery, clinical networks, and the Health and Adult Social Care Select Committee for Buckinghamshire County Council, local Clinical Commissioning Groups (Chiltern and Aylesbury Vale) and Healthwatch.
- The annual report of the Trust's external auditors and regular reports from the Trust's internal auditors.
- A comprehensive programme of clinical audit as reported in the Quality Accounts
- Divisional and Service Delivery Unit performance dashboards.
- Trust Development Authority monitoring and other benchmarking.

My review of the effectiveness of internal control has also taken into consideration feedback from the Quality Committee, Finance and Business Performance Committee, Audit Committee and Trust Board. A system of continuous improvement is in place with in-depth focused work triggered by identification of risks.

The following sections describe the system of internal control and the corporate governance mechanisms. I provide an analysis of their effectiveness and give consideration to any potential 'Significant Issues'.

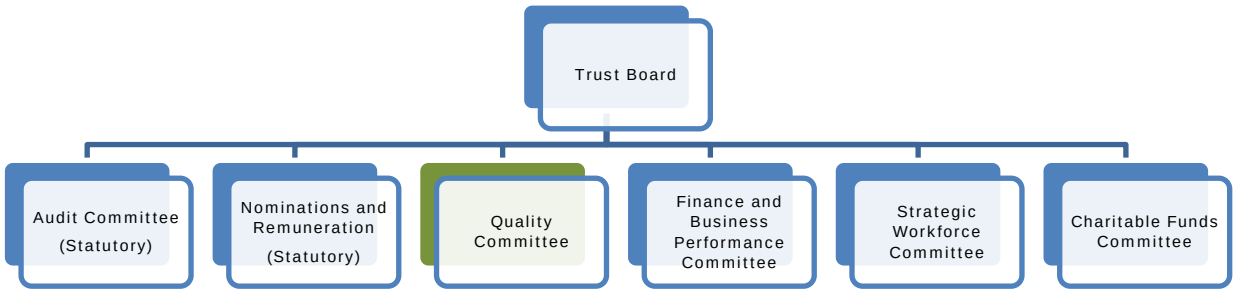
3. THE GOVERNANCE FRAMEWORK OF THE ORGANISATION

The Trust Board operates an integrated governance approach covering the full range of corporate, financial, clinical, information and research governance. In line with the Code of Accountability the Trust has adopted Standing Orders for the regulation of its proceedings and business with integral Standing Financial Instructions.

The Trust Board comprises a Chair appointed by the NHS Trust Development Authority (TDA), five non-executive directors appointed by the TDA and 5 executive directors including the Chief Executive Officer and the Director of Finance. The Board is supported in the delivery of its duties by three associate non-executive directors (non-voting) and two non-voting executive directors.

The Board has formally established six Committees in support of its function. The Committee structure is shown in Figure 1 below. The Board working arrangements, including composition of the Executive and Non-Executive membership, the committee structure and membership, and the Board development plan are in line with the Code of Governance expected of NHS Trusts and the guidance contained within 'The Healthy NHS Board'.

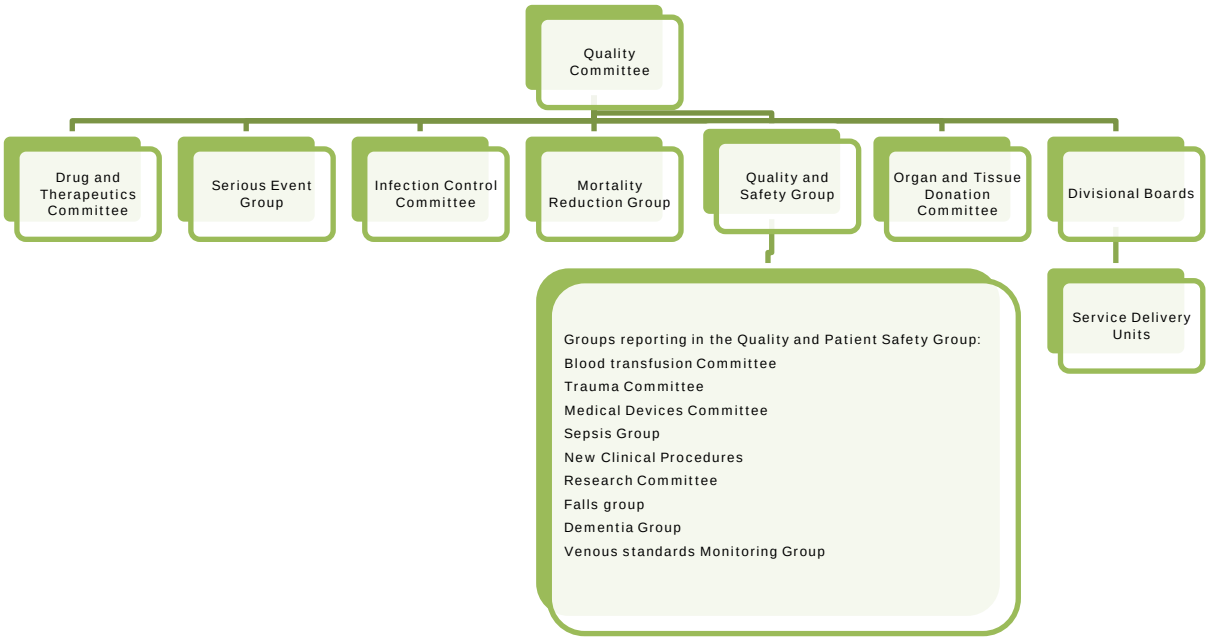
Figure 1 Board of Directors Committee Structure



The Board Committees support the Board in meeting its duty to set strategy and monitor the delivery of the organisation's objectives. A governance framework and processes are in place across the organisation to ensure that information flows clearly to the Board providing assurance where possible and highlighting risk identified through gaps in control or gaps in assurance.

In addition to the Board Committees there are a number of sub-committees reporting to the Quality Committee as shown in Figure 2 below:

Figure 2 Quality Committee and sub-committees



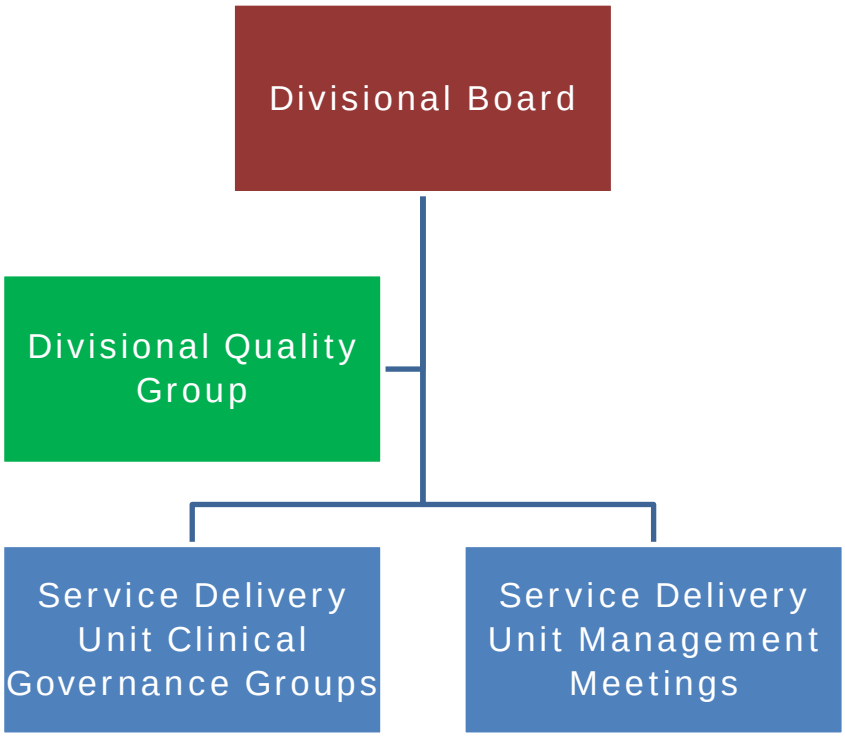
Also important to the governance process are the Executive Management Committee and its sub-committees as shown in Figure 3 below. Of particular note from the sub-committees are the Health and Safety Committee chaired by the Director of Human Resources, and the Information Governance Committee chaired by the Caldicott Guardian.

Figure 3 Executive Management Committee and sub-committees

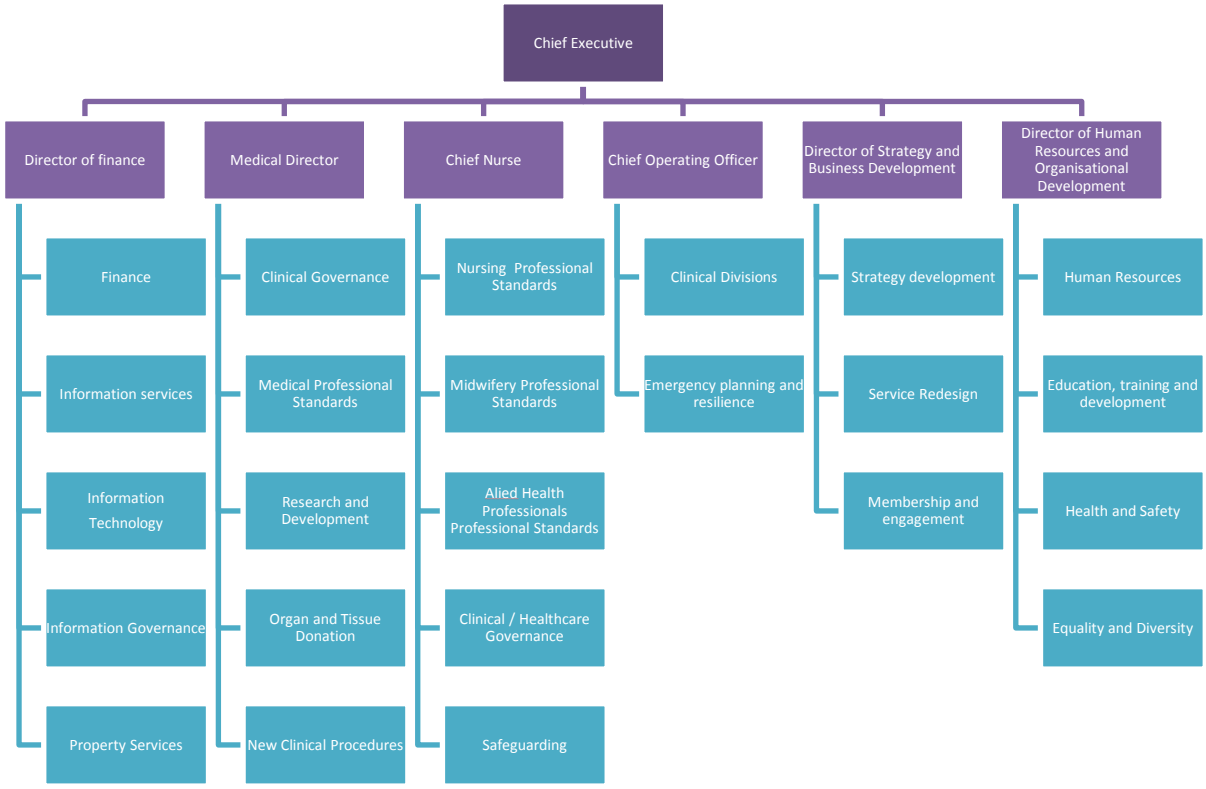
The clinical services are delivered through five clinical divisions each led by a Consultant Doctor, Divisional Director and Associate Chief Nurse. The five Divisions are the Division of Surgery and Critical Care, the Division of Women and Children, the Division of Specialist

Services, the Division of Integrated Medicine and the Division of Integrated Elderly and Community. Each of the Divisions has its own management and governance structure through which performance is monitored at service level, and which links to the Divisional performance meetings. The Divisional governance structure is shown in Figure 4 below.

Figure 4: Governance at Divisional Level



Each executive director is responsible for a portfolio of corporate services and has governance mechanisms in place for the delivery of that service. These mechanisms include policies and procedures, performance meetings and various audits. The executive director portfolios are shown below:



All these portfolios are supported by the Director for Governance and the Assistant Director of Communications.

3.1 Description of Board and Committees

3.1.1 Board of Directors

The Board of Directors has responsibility for setting the overall direction, agreeing the Trust's principal objectives, assessing and managing strategic risks to the delivery of those objectives, and monitoring progress through regular performance monitoring reports.

The Board has delegated scrutiny of assurance processes, workforce, quality, and finance and information to four of its committees, namely the Audit Committee, Finance and Business Performance Committee, the Quality Committee and the Strategic Workforce Committee. The Strategic Workforce Committee is a new Committee and first met in February 2016. The committees work together to deliver an integrated approach to governance. All of these committees have a non-executive chair and membership. There is a significant common membership across the four committees. Each has terms of reference which have been reviewed in the year and an annual work plan.

3.1.2 Audit Committee

The Audit Committee is responsible on behalf of the Board for reviewing the establishment and maintenance of an effective internal control and risk management process across the whole of the Trust's activities that supports the achievement of the Trust's objectives and monitors:

- The integrity of the financial statements of the Trust;
- The independent auditors' qualifications, independence and performance;
- The performance of the Trust's Internal Audit function and Local Counter Fraud provision
- Compliance by the Trust with legal and regulatory requirements

There was a rotation of Non-Executive Directors during 2015/16 which meant that for some meetings there were not four appointed members in place.

Meeting Date	**Number of members attending**
20th April 2015 (Extraordinary)	2
14th May 2015	3
2nd June 2015 (Extraordinary)	2
16th July 2015	3
17th September 2015	3
12th November 2015	4
7th January 2016	2
17th March 2016	3
30th March 2016 (Workshop)	3

The meetings that each member was eligible to attend, together with actual attendances, is shown below:

Member	**Number of meetings eligible to attend**	**Number of meetings attended**
Les Broude (Chair)	9	9
John Pulsinelli	2	1
Graeme Johnston	9	7
Rajiv Jaitly	6	5
David Garmon-Jones	6	3

The Committee has an annual work plan with meetings timed to consider and act on specific issues within that plan. The Committee Chair reports to the Trust Board following each meeting.

The terms of reference of the Committee are reviewed annually and were last reviewed in September 2015.

The Audit Committee has received updates on the Board Assurance Framework at every meeting in 2015/16, and has been provided with a full BAF at least every other meeting, as required by its Workplan. The Committee is satisfied that it covers the full range of risks to achieving the objectives of the Trust. Assurances used to populate the framework have also been reviewed through the attendance of senior managers at Audit Committee and through the Internal Audit work plan. In particular, the Committee has instigated a process in year where Executive Directors provide 'deep dive' information into selected BAF risks, assurances, controls and actions. In year, BAF risks relating to the delivery of financial plans, replacement of the Patient Administration System, recruitment and retention of staff and delivering alternatives to A&E were the subject of deep dives presented by the relevant Executive Directors. The Committee has requested more detailed Board consideration of individual BAF scores where it has considered necessary as part of its reporting to the Board.

In year, the Director for Governance has met with Audit Committee members to discuss improvements to BAF reporting, and this will form a key item of focus in 2016/17.

Review of the highest risks on the corporate risk register has allowed the Committee to assured itself the system of risk management is adequately identifying risks and allowing the Board to understand the appropriate management of these risks. The Committee has also reviewed the risk register for consistency with risks identified to Trust objectives through the Board Assurance Framework.

The Audit Committee has monitored the work of the Finance and Business Performance Committee and Quality Committee through shared membership and reports from the Chairs of the Committees. The Audit Committee concludes overall that there are no areas of significant duplication or omission in the Trust's governance systems that have come to its attention and are not adequately resolved.

The Audit Committee has reviewed the process for the preparation and approval of the Annual Governance Statement for 2015/16 at the March meeting, and were provided with an opportunity to comment on its contents. The Committee members have concluded that it is consistent with the view of the Committee on the organisation's system of internal control and, subject to approval of the final version at the May meeting, accordingly supported the Board's approval of the AGS.

The Committee has also reviewed, through Internal Audit, the process used by the Trust to carry out the self-assessment against the Care Quality Commission regulations. This provides assurance of compliance to the Board on an annual basis. The Committee is satisfied that the process is robust.

The Committee has reviewed the process for the approval of policies and protocols covering financial matters to obtain assurance that the process provides for financial controls to meet all relevant regulatory, legal and code of conduct requirements.

The internal audit work plan is developed using a risk based approach. RSM have a three year internal audit strategy, which has been formulated from meeting with Executive Directors, reviewing the Board Assurance Framework and Corporate Risk Register and focussing on areas of the Trust's operations which are either high risk or have not been recently reviewed as part of the regular audit cycle. This was used to populate the Plan for 2015/16. Prior to agreeing the Internal Audit plan the Committee reviewed it and contributed to its development

The Committee invites the Counter Fraud Specialist to attend to present reports on progress with this programme of work and has received the annual report on counter fraud services. The report highlighted work undertaken to embed an anti-fraud culture through deterrence, prevention, detection and counter-fraud management.

During 2015/16 the Committee has had the opportunity to put in place meetings between internal audit and the Committee members, these meetings have taken place where considered necessary after a meeting of the Audit Committee.

The Committee approved the External Audit Plan at the start of the financial year and received regular updates on the progress of work. In addition, reports and briefings were received from the External Auditors.

During 2015/16 the Committee has had the opportunity to put in place private meetings between external audit and the Committee members where considered necessary, following Audit Committee meetings.

The Trust will need to appoint its own external auditor for the 2017/18 financial statements and the Board have ratified the decision that the Audit Committee should be the panel to lead on the procurement for this function.

During the year, members who were new to the Committee were provided with training and support on the Committee's responsibilities and processes. Committee members will carry out a self-assessment in May 2016 for 2015/16 replying to questions based on criteria set out in the NHS Audit Handbook 2014.

The Committee is due to have 6 standard meetings in 2016/17 plus an extraordinary meeting to undertake self-review and development activities. A Workplan based on the model example in the NHS Audit Committee Handbook 2014 has been agreed by the Committee for 2016/17.

The Committee will continue to review the assurances provided by the other sub-Committees of the Board, and receive 'deep dives' into BAF risks.

A key focus of the Committee in 2016/17 will be to ensure that BAF and CRR reporting provides an appropriate degree of transparency in an effective way to ensure that the

Board can take assurance that they have sufficient information and evidence on the risks facing its strategic and operational objectives.

In addition, the Committee will continue to review the timeliness and robustness of the organisation's responses to Internal Audit reports and recommendations. Where gaps and weaknesses have been identified in the internal control framework, the organisation needs to consider these and take the appropriate level of action in a timely way.

3.1.3 Quality Committee

The Quality Committee provides the Board with assurance concerning all aspects of quality relating to the provision of care and services in support of getting the best clinical outcomes, ensuring safety, and providing the best experience for patients. It assures the Board directly and through consultation with the Audit Committee that the structures, systems and processes are in place and functioning to support an environment for the provision and delivery of excellent quality health services. It also assures the Board that where risks and issues exist that may jeopardise the Trust's ability to deliver excellent quality healthcare, these are being managed in a controlled and timely way.

The Committee has focused in 15/16 particularly on progress against actions within the Quality Improvement Plan to deliver the Quality Improvement Strategy. A number of these actions were agreed as part of the Quality Summit with the Care Quality Commission in August 2015. The Committee has seen significant progress with the actions in the plan and has noted improvement in indicators relating to mortality, falls and pressure ulcers.

The annual review of the Terms of Reference resulted in a number of changes as follows:

- Increased frequency of meetings to a monthly meeting from January 2016. The meetings alternate between an overview of quality related topics and an in-depth quality review of each Division on a rotational basis.
- Membership has been revised in order to promote assurance based discussion.
- In terms of monitoring quality priorities a dashboard has been developed to show progress against outcome measures associated with the Quality Improvement Strategy and Quality Improvement Plan. This is in addition to the assurance report around completion of actions within the Quality Improvement Plan.
- The Committee scheduling now includes a greater focus both on Serious Incidents and on clinical audit.

3.1.4 Finance and Business Performance Committee

The purpose of the Finance and Business Performance Committee is to provide the Board with assurance concerning all aspects of finance, workforce and operational performance relating to the provision of care and services in support of getting the best clinical outcomes and experience for patients. On behalf of the Trust Board, the Finance and Business Performance Committee oversees all aspects of the financial arrangements of the Trust. It provides the Trust Board with assurance that the financial issues of the Trust are being appropriately addressed, and provides the Board with information and advice on key issues. The Committee also has oversight of the Trust's performance management framework and, as required, focuses on specific issues where the Trust's performance is deteriorating or there are matters of concern.

The Committee reviews in detail every business case above the value of £1m.

The Committee has been very focused in 15/16 on understanding the underlying financial position, working to achieve the best possible out-turn for the year, planning the financial strategy for 16/17 and reviewing the recommendations published in the Carter review.

There is now an established process of divisional deep dives to provide assurance on granularity of risk management and improvements at divisional and service line level.

The annual review of the Terms of Reference resulted in an increase of the non-executive director quorum from one to two.

3.1.5 Strategic Workforce Committee

This is a newly formed Committee which first met in February 2016. The purpose of the Strategic Workforce Committee is to provide the Board with assurance regarding delivery of the People Strategy and Organisational Development Plan. On behalf of the Trust Board, the Strategic Workforce Committee oversees all aspects of the workforce and organisational development arrangements of the Trust. It provides the Trust Board with assurance that the workforce and organisational development issues of the Trust are being appropriately addressed, and will provide the Board with information and advice on key issues.

3.1.6 Nominations and Remuneration Committee

The Nominations and Remuneration Committee oversees:

- The formal, rigorous and transparent procedures in place for the appointment of executive directors to the Board;
- The remuneration policy and performance management framework.
- Restructuring and redundancy

3.1.7 The Charitable Funds Committee

The overall purpose of the Charitable Funds Committee is to assist the Board in its role as Corporate Trustee of the charity in the performance of its duties. This is through providing assurance that the Trust's charitable activities are within the law and regulations set by the Charity Commissioners for England and Wales. The Committee approves charitable funds expenditure in accordance with standing orders and standing financial instructions as well as approving investment policy and monitoring investments on a regular basis.

3.2 Board Membership and Development

The Board of Directors has seen significant change in 15/16. Changes are set out below.

Directors who have left the Board

Name	Post	Leaving date
Mr John Pulsinelli	Non-Executive Director	May 2015
Mr Mike Naylor	Director of Finance	December 2015

Directors who have joined the Board

Name	Post	Date
Mr Neil Dardis	Chief Executive Officer (interim)	Commenced April 2015
Mr Neil Macdonald	Chief Operating Officer (interim)	Commenced April 2015
Mr Rajiv Jaitly	Non-Executive Director	Commenced June 2015
Dr Dipti Amin	Non-Executive Director	Commenced June 2015

Other Directors in non-voting roles who have joined the Board in 15/16 are as follows:

Name	Post	Date
Mr Ian Anderson	Director of Human Resources and Organisational Development	Commenced April 2015
Mr David Garmon-Jones	Non-Executive Director Designate	Commenced June 2015
Mrs Rachel Devonshire	Associate Non-Executive Director	Commenced in December 2015 (previously a trainee NED from June 2015)
Mr Dominic Tkaczyk	Interim Director of Finance	Commenced in January 2016

There has been a comprehensive externally facilitated Board Development Programme in place through the year. The programme has considered the technical knowledge requirements of the Board, the strategic knowledge some of which has been provided by partners in the health economy, and has included work on the Board behaviour required for top performing Boards.

3.3 Board Performance

In July 2016 the Trust Development Authority reviewed the Board processes through observations of Board and its Committees and through interviews with individual Board members. There were a significant number of elements of good practice identified including

- Improved engagement and visibility
- Growing confidence in leadership
- Good alignment on risk within Board and effective risk identification
- Effective challenge at Board level
- Transformational approach to OD and organisational values

The TDA also made recommendations for improvement and since their feedback the following changes have been made:

- Executive summaries are provided for Board and Committee papers to highlight the key messages
- A programme of work for the Board and its Committees has been prepared for 16/17 to ensure they are aligned in their work and complement each other in terms of function. This programme is under the oversight of the Director for Governance who also provides guidance and support for Committee Chairs

The externally facilitated board development sessions enabled the Board to reflect on its own effectiveness confirming the areas for further development. A Board Agreement has been put in place summarising the Board's expectations of itself and there is an opportunity for the Board to reflect on its effectiveness at the end of every meeting. These reflections are recorded in the Board minutes. The Committee Chairs meet on a quarterly basis to facilitate a joined up approach to the review of assurance.

The Board has also reviewed its performance using the Well-led Framework tool and put in place actions to strengthen its performance, for example developing a clearly articulated strategy and introducing a Strategic Workforce Committee.

3.4 Board Attendance

A review of attendance by Board members at Board meetings, seminars and sub-committees shows great commitment from all the current Board members. The attendance record is reviewed at each Trust Board meeting in public.

3.5 Corporate Governance Code

The Board is compliant with all aspects of the UK Corporate Governance Code (Financial Reporting Council September 2014) which apply to an NHS Trust.

3.6 Statutory functions

Many of the statutory functions of the Board are set out in the Standing Orders and Standing Financial Instructions. These are modelled on the Department of Health 'Model Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions', March 2006. There are also a comprehensive set of policies in place setting out statutory duties such as Health and Safety compliance. Each of these policies contains a monitoring section in line with best practice.

A programme of external audit, internal audit, clinical audit and external reviews contribute to the monitoring of compliance with statutory functions including checking for any irregularities.

The Trust seeks external legal advice in relation to statutory functions as required.

3.7 Quality Governance

There are multiple mechanisms in place to provide a sound governance framework for the delivery of high quality services. These mechanisms include an electronic incident reporting system; a process for identifying, reporting, investigating and acting on Serious Incidents, including Never Events; a comprehensive clinical audit programme; and a process for responding to complaints. There are also mechanisms for feedback from staff and patients and using data to seek out assurance and risk. The processes to deliver these mechanisms are set out in policies and communicated to all levels of the organisation, initially through induction and then through a programme of annual mandatory training. Another key element of quality governance is the safeguarding process for children and adults.

Assurance and risk from these mechanisms is reported through the meeting structure and reviewed at the Quality Committee.

The organisation has assured itself with regard to the information contained in the Quality Account 2015/16 through the following measures:

- Control mechanisms within the Care Records Service application
- A programme of clinical audit, including engagement with required national audits
- Multiple reviews of the Quality Account whilst in draft by Board members, clinical leads, and contributors to the document to check for accuracy
- Provision of a draft for review by the Buckinghamshire Health and Adult Social Care Select Committee and Health Watch England.
- External audit of compliance with the Quality Account regulations and detailed review of two indicators within the report
- Consideration of the draft Quality Account by the Audit Committee prior to submission to the Board for approval
- Emphasise staff and patient feedback and Key Performance Indicators to monitor plus external review and assessment and peer challenge – listening and seeking out risk

4.0 RISK ASSESSMENT

4.1 Risk Process

The risk management process is set and monitored by the Board as part of its governance duties. The Board review of the effectiveness of the system of internal control enables them to take a clear view of the range and scale of risks facing the organisation. This is particularly evident through an agenda item at the end of each Board meeting where the Director for Governance is asked to sum up the key risks emerging from the business of the meeting and the Board agrees their understanding of these risks and how they are being managed.

The Board approves the Risk Management Strategy and Risk Management Policy which ensures that the Trust approaches the control of risk in a strategic and organised manner. The strategy describes the corporate and individual accountability for managing risk, the risk management process, the approach to training and how the success of the strategy will be monitored.

The process underpinning the core organisational risk documents is shown in Figures 5 and 6 below:

Figure 5: Risk Communication Process for Board Assurance Framework

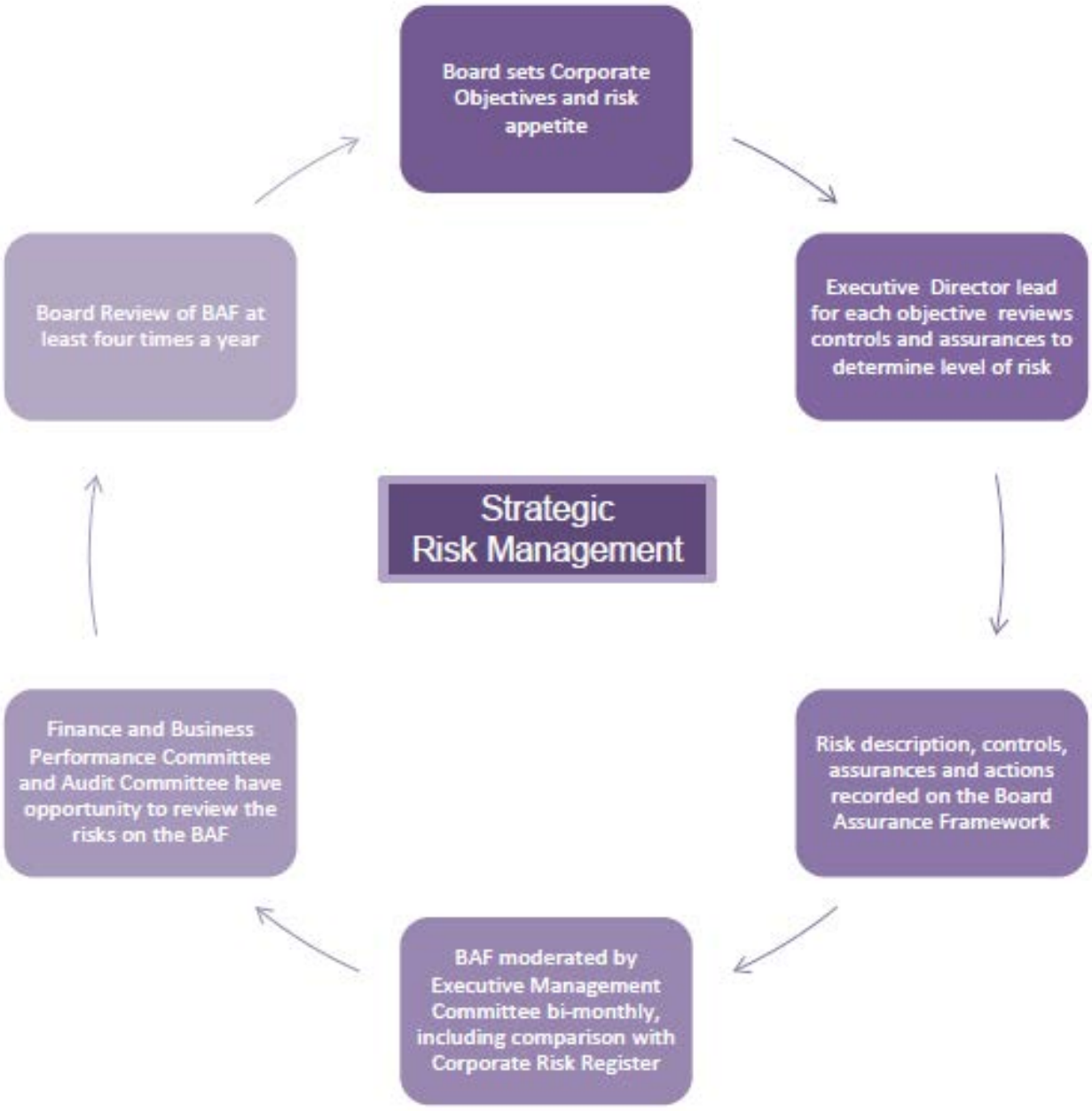
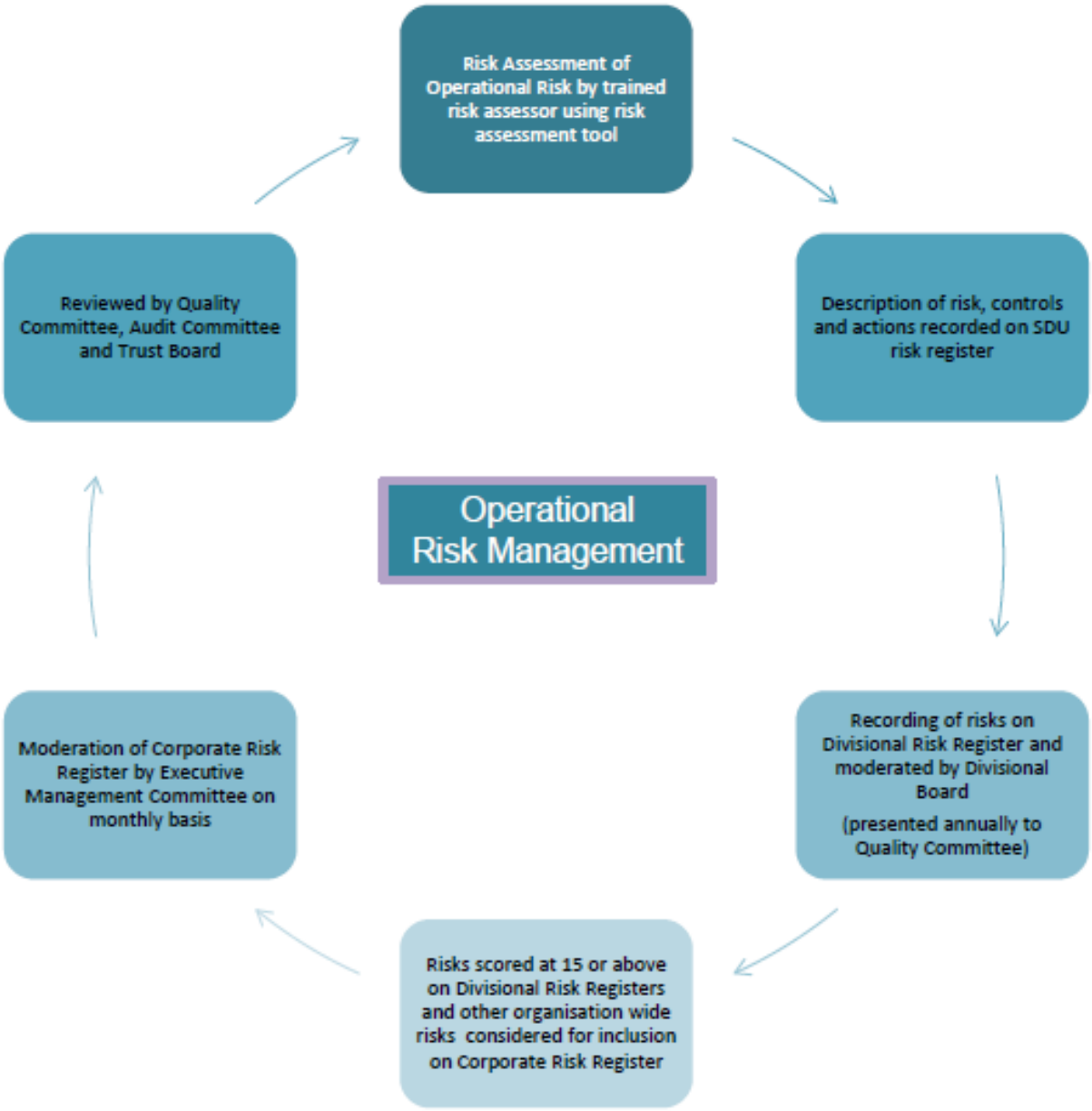


Figure 6: Risk Communication Process for Corporate Risk Register



Each executive director has responsibility for specific areas of risk in addition to their corporate board responsibilities.

At a Divisional level the risk management processes are the responsibility of the Divisional Chairs, Divisional Directors and Divisional Chief Nurses.

Risk management training and awareness is included in the mandatory corporate induction programme and additional risk training is available for staff.

Guidance is also provided by specialist advisers including:

- Director of Infection Prevention and Control, and the Infection Control Team
- Head of Occupational Health
- Health and Safety Adviser
- Fire Safety Advisers
- Radiological Protection Adviser
- Chief Pharmacist
- Leads for Safeguarding Adults and Children
- Human Tissue Act Designated individuals
- Security Advisers
- Caldicott Guardian
- Information Governance Advisers

4.2 Risks Identified in 2015/16

A range of risks were identified in 2015/16 and were reported to the Board through the Board Assurance Framework and the top risks from the Corporate Risk Register.

The top strategic risks facing the organisation through the year were as follows:

4.2.1 Quality

- The Board has been apprised of the risk to patient experience resulting from waiting times for patients on the urgent care pathway particularly during times of high activity during the winter period. The actions put in place to improve waiting times have had some impact but there is more to do to achieve full compliance with the target.

4.2.2 Workforce

- One of the top risks facing the organisation has been the challenge to recruit and retain the right levels of permanent clinical staff. A reliance on the use of temporary staff as well as creating a significant cost pressure also carries with it the risk of an adverse impact on the quality of patient care. Recruitment activity has been relatively successful during the year for nursing and medical staff except for specialities where there is a national shortage. However, the recruitment of new

nursing staff has not kept pace with the attrition of nursing staff and therefore this has continued to be a challenging risk.

- Linked to the previous risk has been the risk associated with the introduction of a national cap on agency rates. The Board has been kept informed about compliance with safe staffing and the notable level of compliance with the progressive agency caps.

- In common with the rest of the NHS the Trust has dealt with risk associated with junior doctors' strikes. The arrangements to manage the organisation through the strike periods has been effective.

- The Board has recognised that with the number of director changes in 14/15 and 15/16 that there is a risk to board stability with the potential to impact on delivery of objectives. A focus on rigorous induction and delivery of a board development programme mitigates this risk.

4.2.3 Infrastructure

- The Board has received regular briefings about the introduction of a new Patient Administration System in September 2015, both before, during and after the event. The risk was managed effectively and although there have been some issues with the system after implementation these have been dealt with in a systematic way.

4.2.4 Finance

- Throughout the year the Board has monitored and managed the risk around the delivery of the annual financial plan. The Board and its Finance and Business Performance Committee has worked through the year to fully understand the underlying financial risk and to put in place a strategy to move the Trust forward from its current deficit position.

- The risk around the cash position has also been monitored and managed through the year.

4.2.5 Information risk

During 2015/16 there have been five Level 2 serious incident data breaches. Four of these were disclosures of information in error and one was a corruption of data on our Medway patient administration system. These breaches were reported to the Information Commissioner's Office (ICO) via the IG Toolkit and four of the five have been assessed and closed by the ICO with no further action required. The ICO are still in the process of investigating one incident.

All incidents were reported to the Caldicott Guardian and were thereby assessed for the level of seriousness. The incidents were then considered by the Caldicott Guardian to determine where improvements to information security and confidentiality can be made and to seek assurance that internal policies and procedures adequately reflect the rules on confidentiality. Actions were then taken in line with the Caldicott's Guardian's recommendations.

4.2.6 Deficiencies resulting in realised risk

In summary, the deficiencies resulting in realised risk in 2015/16 are as follows:

- Issues of financial control resulting in a year-end deficit. The Board has worked through the year to ensure transparency and understanding of the underlying financial position, to minimise the deficit, and to plan for 16/17 (more detail in section 6.8).
- Issues relating to patient flow on the urgent care pathway resulting in not achieving the required 4 hour target. The Trust has introduced transformational change to the urgent care pathway in 15/16 with further improvement planned in 16/17 (more detail in section 6.3).
- Although the introduction of a new Patient Administration System has happened relatively smoothly considering the pace of change there have been some post implementation issues affecting availability of key information. Additional information support has been put in place to manage these issues.
- The Trust received some requirement notices following the Care Quality Commission inspection in March 2015. The Trust worked through the year on a comprehensive Quality Improvement Plan to address all the recommendations in the report. This is considered in more detail in section 6.1

4.3 Future Risks

Many of the risks described in 15/16 will continue to be risks in 16/17, in particular delivery of the financial plan, recruitment and retention of high calibre staff, and managing the urgent care pathway in a way that optimises patient experience. These are complex risks to resolve and controls are in place to manage the current situation and to bring down the risk through focused actions.

There is both opportunity and risk in the coming year in working with partners and stakeholders on strategic transformation across the health economy.

There are clinical risks inherent in the delivery of healthcare which continue year on year and are managed through rigorous controls to prevent the risks from materialising into events that cause harm to patients. Further detail about the risk and control process is set out in the next section.

5. THE RISK AND CONTROL FRAMEWORK

The Trust's strategy for managing its risk is to:

- Adopt an integrated approach to risk management, whether the risk relates to clinical, organisation, health and safety or financial risk. Through the processes and structures detailed in the Trust's risk management strategy and its relating polices, which have all been updated during 2015/16
- Manage risk as part of normal line management responsibilities and provide funding to address 'risk' issues as part of the normal business planning process

- Undertake risk assessment on both existing, new and proposed activities to ensure that:
    - Significant risks are identified
    - Assessments are made of their potential frequency and severity
    - Risks are avoided where possible, and minimised by implementing durable and effective controls
    - Risks are recorded on the Trust's risk register
- Put in place effective deterrents to minimise the potential for deliberate breaches such as prosecution for fraud, and disciplinary policy and processes.
- Ensure that the Board reviews the significant risks identified on the Board Assurance Framework and Corporate risk Register periodically and monitors the delivery of the Trust's objectives
- Use the risk registers to inform the trust's business planning and investment decision making process so that informed decisions are made in the full knowledge of the level of risk
- Record the results of risk assessments on the Trust's risk registers and use them to ensure that any decision to accept risk is taken as an appropriate level in the Trust
- Utilise internal and external audit, the healthcare compliance assessment and other assessments by independent regulatory bodies to provide assurance that risk is being managed appropriately
- Review the impact of the actions to confirm that they are successfully reducing risk

Within each clinical division there are management teams in Service Delivery Units supported by clinical governance leads whose role is to ensure that:

- Risks within the division are identified through a process of risk assessment, prioritised, where possible eliminated, and if not, minimised.
- The importance of managing risk is communicated to all staff within the division
- The Executive Management committee is made aware of any unacceptable risks that cannot be managed within the divisions
- Data from incidents, claims and complaints etc. is reviewed to identify any trends or areas for retrospective action.
- Learning is identified and that the feedback loop is completed.

Each division also has a clinical audit lead, medical devices lead and control of infection link nurses. Managers are responsible for ensuring effective risk management within their own area.

The mechanisms within Divisions providing assurance that there are effective controls in place are through:

- SDU management and clinical governance meetings to a standard template
- Divisional Board oversight
- Monthly performance meetings chaired by the Chief Operating Officer
- Internal and external reviews

The Risk Management Strategy also requires liaison with co-employers on broader risks.

The Risk Management Strategy applies to all staff employed by Buckinghamshire Healthcare NHS Trust as well as temporary, agency and contracted staff and stresses the need to involve public stakeholders, as appropriate, in the risk management process.

The Board Assurance Framework (BAF) provides the Trust with a tool for the identification and treatment of principal risks to the achievement of the organisation's objectives. It also provides a structure for the evidence to support

(a) the annual governance statement and
(b) the statement of compliance with national healthcare regulations.

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

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

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

The Caldicott and Information Governance Committee monitors the performance of the Trust against the requirements of the Information Governance Toolkit. The Trust has self-assessed its performance on information governance requirements using Version 13 of the HSCIC Information Governance Toolkit. The Trust's end of year overall submission for 2015/16 achieved a score of 85% resulting in a 'satisfactory' rating. During 2015/16, internal Auditors RSM reviewed Version 13 of the Toolkit to provide assurance on the accuracy and quality of the submission. Detailed testing was undertaken for selected samples and the draft report suggests that areas for focus are data mapping across the organisation and establishing a comprehensive information asset register. The Board receives assurance on Information Governance through the Director of Finance.

6.0 REVIEW OF THE EFFECTIVENESS OF RISK MANAGEMENT AND INTERNAL CONTROL

This section sets out key sources of assurance to confirm that internal control mechanisms are in place and working effectively. Where weaknesses have been identified these have been addressed with timely and appropriate action.

6.1 External reviews

Chief Inspector of Hospitals' Inspection of Acute Services March 2015

In August the Care Quality Commission formally provided the results of this review into community and some acute services at a Quality Summit attended by key stakeholders.

Overall the Trust achieved a rating of 'Requires Improvement'. Overall judgements against each domain were as follows:

Are services at this Trust safe?	Requires improvement
Are services at this Trust effective?	Requires improvement
Are services at this Trust caring?	Good
Are services at this Trust responsive?	Requires improvement
Are services at this Trust well-led?	Requires improvement

The inspection team noted that the rapid pace of change in urgent and emergency care over the past 12 months had led to significant improvements. The service, which includes A&E, has moved from zero to three 'good' ratings.

The inspection team identified a number of areas of good and innovative practice across hospital and community services, including:

- 24/7 availability of community nursing and therapy teams, supporting patients in their own homes
- The award-winning integrated cardiac rehabilitation service, which is using new technology to improve patient participation
- The specialist community diabetic service offering support to non-English speaking patients and running education sessions for patients during Ramadan
- The specialist palliative care team providing a flexible service, including 24/7 support offered to children approaching the end of their life
- Providing multi-disciplinary assessments for patients covering their mobility, nutrition, pressure ulcers, and mental and emotional wellbeing amongst other things.

The report identified compliance actions (requirement notices) against six of the Care Quality Commission regulations. These predominantly related to community services and included concerns about staffing in certain areas and support of workers, respecting and involving people who use services, records management, monitoring the quality of service provision. In addition there were concerns about safety of equipment in two specific locations.

Actions to address these concerns, along with other actions were incorporated into the Quality Improvement Plan and have been closely monitored by the Quality Committee.

6.2 Internal Audit

The Head of Internal Audit has provided the following opinion for 15/16:

The organisation has an adequate and effective framework for risk management, governance and internal control.

However, our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective.

In 15/16 the Internal Audit programme issued 22 reports of which three are advisory reports. The assurance ratings are below:

Green Reports: (6)

- Board Assurance Framework
- Consultant Job Plans Process
- Savile Review
- Charitable funds
- Financial Systems – Accounts Receivable
- Accounts payable

Amber Green (6)

- Network / Data Security and Cybercrime Controls
- Human Resources – Compliance with Leave Policies
- Cost Improvement Programmes – Process and Systems
- Care Quality Commission Processes (DRAFT)
- General Ledger (DRAFT)
- Data Quality – Cancer Waits (DRAFT)

Amber Red (5)

- Divisional Governance
- Risk Management – Property Services
- Stock Management – Medical Consumables
- Payroll (DRAFT)
- Estates – PFI Contract Management Review (DRAFT)

Advisory (5)

- Information Governance – Follow Up
- Information Governance
- PAS Implementation – Position Statement
- Temporary Staffing
- Community Services - Integrated Care (DRAFT)
-

All red and amber red reports are considered in detail at Audit Committee, with Executive Directors required to present actions plans to rectify risk areas identified. Review or advisory reports are not given an assurance rating but are also considered at the Audit Committee.

6.3 Compliance with NHS Operating Framework

A comprehensive set of performance reports covering quality, finance, operational performance and workforce have been presented at each Board meeting, strengthened this year with leading indicators and improved analysis. The introduction of a new Patient Administration System in September 2015 has been challenging and any identified issues have been worked through.

The operational performance report demonstrated compliance over the year for all indicators with the following exceptions:

- The 4 hour emergency access target which achieved 93.16% against a standard of 95%

- MRSA bacteraemia, 1 recorded cases against a zero standard
- Clostridium difficile infection rate – 38 recorded cases against a standard of 33
- Admitted patients finishing their pathway – achieved 86.7% by 31 March 2015.

6.4 National Staff Survey

In 2015 we sampled all of our staff, the first time we have ever done this, and the results represent the views of 52% of the workforce, some 2875 staff members.

In 2015 we achieved 6 statistically significant improvements and just one statistically significant deterioration across the 32 key findings measured in the staff survey when compared with our 2014 results. This provides assurance that the Trust had made progress with staff engagement and it is recognised that staff satisfaction is closely linked to experience and outcomes for patients.

Improvements:

- KF1 staff recommendation of the trust as a place to work and receive treatment
- KF4 staff motivation at work
- KF8 Staff satisfaction with level of responsibility and involvement
- KF10 support from immediate managers
- KF28 percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month
- KF31 staff confidence and security in reporting unsafe clinical practice

In 2015 the Trust focused on a few key areas of priority and in all of these areas we made significant inroads, though we recognise there is more still to do in these areas. The table below documents the results compared with our results in 2014.

Priority	2015 results	2014 results
Improve our response rate to staff survey to 60%	All staff surveyed 52% response rate achieved National average was 41%	850 staff surveyed 44% response rate achieved
Improve our staff engagement score Achieve national average 3.74	3.76 National average 3.79 Ranked average	3.60 national average 3.74 Ranked worst 20% trusts
Improve our score in KF9 (now KF 10) the percentage of staff receiving support from immediate managers Achieve national average 3.65	3.71 National average 3.72 Ranked average	3.53 national average 3.65 Ranked worst 20% trusts
Improve our score in KF21 (now KF6) the percentage of staff reporting good communication between senior management and staff Achieve national average 30%	27% National average 30% Ranked below average	22% national average 30% Ranked worst 20% trusts
Improve our score in KF15 (now KF31) the percentage of staff agreeing they would feel secure raising concerns about unsafe clinical practice Achieve threshold for top 20% of trusts	3.55 National average 3.64 Ranked below average	3.42 National average (not comparable) Ranked worst 20% trusts

The only deteriorating response was KF18, the percentage of staff feeling pressure in the last 3 months to attend work when feeling unwell.

6.5 Clinical Audit

A wide range of clinical audits have been undertaken in 2015/16 which are reported in detail in the Quality Account. These provide assurance that controls are in place for clinical processes, and, where risk is identified through these audits this is escalated through the risk management system.

6.6 Never Events

The Trust has declared one Never Event in 2015. One related to an incorrect lens implanted into patient's eye during cataract surgery. The error was rectified and there are no long term consequences for the patient.

Each has been separately investigated and actions taken to minimise the risk of recurrence.

6.7 Public Sector Equality Duty

2015/16 has continued to demonstrate good progress against the Public Sector Equality duty (PSED) with the following summary of outcomes from the Equality Delivery System assessment.

Of the 16 outcomes that we can make direct comparisons with from the last assessment:

5 grades were maintained - 3 for patient and 2 for staff outcomes of these (3 green and 2 amber)

7 grades improved – 5 of these were partial improvements which is a split grade. 4 improvements were for patient outcomes and 3 for the staff/leadership outcomes This is a very positive improvement overall and demonstrates real progress in some of the areas since our last assessment.

4 were downgraded – 1 of which was a partial i.e. split grade. 1 of these was for a patient outcome and 3 were related to staff and leadership outcomes.

6.8 Finance

The Trust faced an extremely challenging year financially ending with a £10.8M deficit compared to its planned surplus of £5.5m.

Within this out-turn a Cost Improvement Plan (CIP) of £18m was achieved.

The deficit position has resulted in a Section 30 letter under the Local Audit and Accountability Act 2014. Ernst Young sent this letter to the Secretary of State on 4 April 2016.

The deficit position is also likely to result in a qualified ‘Value for Money’ audit opinion.

In Quarter 1 of the year the Board commissioned an external review of its financial position with the support of the TDA. The review identified an underlying monthly run rate deficit in the region of £1m which had been managed in previous years through short term interventions. The report also highlighted the inevitable pressure on cash as a result of the income and expenditure position.

The Finance and Business Performance Committee has been focused through the year on understanding the reasons for this deficit and the financial strategy required to resolve the situation. An action plan has commenced with the following key elements:

- Budget setting has become more formal, with an agreement of a realistic but challenging starting position. For the 2016/17 financial year all budget holders will meet, agree and sign off budgets with the Chief Operating Officer and Director of Finance
- Budgetary reporting is moving to a more balanced format that demonstrates the income and expenditure in one place, and allocates the costs of activity to the budget holders who are responsible for the spend
- The Divisional Accountants will receive a development programme to ensure they have the skills and expertise to adequately support the clinical services
- A fixed timeline will be set consistently for all divisions that outlines (and presents the correct information) on a monthly basis a formal forecasting position
- Formal training for all budget holders is now mandatory and will be pursued rapidly through the first quarter of 2016/17
- The divisions have a consistent formal escalation process for managing budgets that deviate from plan, and this is supported at a corporate level through the performance management framework
- SLR will be developed in 2016/17 in order that it will be provided to Divisions on a monthly basis. It is important that the concepts of SLR become familiar, such as why contribution is more important than surplus/loss, before the Trust considers the next step of moving to service line management system. Based on the experiences of other trusts and Monitor's guidance, it would normally take up to 18 months to reach the SLM stage

The organisation is engaged in a significant transformation programme which includes feedback from Lord Carter on where efficiencies may be achieved. It is anticipated that it will take two to three years to achieve a break-even / surplus position.

7.0 FINAL STATEMENT

With the exception of the internal control issues that I have outlined in this statement, my review confirms that Buckinghamshire Healthcare NHS Trust has a generally sound system of governance that supports the achievement of its policies, aims and objectives and that those control issues have been or are being addressed and that there are no significant internal control issues.

Accountable Officer: Neil Dardis

Organisation: Buckinghamshire Healthcare NHS Trust

Signature: 

Date: 31 May 2016

APPENDICES

Appendix 1 - Become a member of the Trust

We would like to invite you to become a member of the Trust. To become a member you can join on our website www.buckshealthcare.nhs.uk or request information from us at:

Membership office

Buckinghamshire Healthcare NHS Trust

Amersham Hospital

Whielden Street

Amersham Bucks

HP7 0JD

Appendix 2 - Feedback on the annual report 2015/16

It is important our annual report is easy to read and understand, and it is available in a variety of versions, including in other languages and as an audio book, on request. In producing ours we have used guidance on content from the Department of Health, as well as learning from reports produced by other NHS trusts.

We value feedback on this year's report – please complete the feedback form below and post the page to the address shown. Alternatively, you may email your comments to communications@buckshealthcare.nhs.uk.

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
The information in this annual report was easy to understand					
There was enough information about the Trust and its services					
There was enough information about the Trust's achievements					
There was enough information about the Trust's finances					
The layout of the document was clear					

Please post feedback to:

Communications

Buckinghamshire Healthcare NHS Trust

Amersham Hospital

Whielden Street

Amersham Bucks

HP7 0JD

Or telephone: 01494 734959

Or email: communications@buckshealthcare.nhs.uk

Appendix 3 - Glossary

Acute hospital services Medical and surgical interventions provided in hospitals.
Accruals An accounting concept. In addition to payments and receipts of cash, adjustment is made for outstanding payments, debts to be collected and stock (items bought, paid for but not yet used). This means that the accounts show all the income and expenditure that relates to the financial year.
Agenda for Change Agenda for Change is the pay system for the majority of NHS staff.
Annual governance statement The chief executive as the accounting officer is required to make an annual statement alongside the accounts of the Trust, which provides a high-level summary of the ways in which risks are identified and the control systems in place.
Assets In general, assets include land, buildings, equipment, cash and other property.
Assurance framework (and Board Assurance Framework) The assurance framework provides organisations with a simple but comprehensive method for the effective and focused management of the principal risks to meeting their objectives. It also provides a structure for the evidence to support the statement on internal control.
Better payment practice code The better payment practice code requires the Trust to aim to pay all valid non-NHS

invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

Break-even (duty)

A financial target. In its simplest form it requires the Trust to match income and expenditure.

Capital

Expenditure on the acquisition of land and premises, individual works for the provision, adaptation, renewal, replacement and demolition of buildings, items or groups of equipment and vehicles, etc. In the NHS, expenditure on an item is classified as capital if its costs exceed £5000 and its useful life expectancy is greater than one year.

Care pathway

This is the route and interactions with healthcare services that a patient will take from their initial meeting with a GP to completion of their treatment.

Care Quality Commission(CQC)

The Care Quality Commission provides an independent assessment of the standards of healthcare services, whether provided by the NHS, the private sector or voluntary organisations. The CQC replaces the Healthcare Commission.

Charitable funds

Our charity, registered number 1053113 includes a general amenity fund (unrestricted), a research fund (restricted) and an endowment fund.

Choose and book

It is the government's aim to allow patients to choose the hospital they are treated in. Patients needing elective treatment are offered a choice of four or five hospitals once their GP has decided that a referral is required. These could be NHS trusts, Foundation Trusts, treatment centres, private hospitals or practitioners with a special interest operating within primary care. Choose and book is a national service that, for the first time, combines electronic booking and a choice of place, date and time for first outpatient appointments.

Clinical Commissioning Groups

Clinical commissioning groups (CCGs) are NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England. They are clinically led groups that include all of the GPs in their geographical area. The aim of this is to give GPs and other clinicians the power to influence commissioning decisions for their patients.

Clinical division

The Trust's organisation management structure is based on five clinical divisions, each led by a divisional clinical chair who is a medical consultant, a divisional director and a divisional chief nurse. The three divisions are:-

- integrated medicine
- integrated elderly and community
- surgery and critical care
- specialist services
- women and children

Clostridium difficile (C. difficile)

Clostridium difficile is a bacterium that can cause an infection of the gut and is the major infectious cause of diarrhoea that is acquired in hospitals in the UK.

Commissioning

A continuous cycle of activities that underpins and delivers on the overall strategic plan for healthcare provision and health improvement of the population. These activities include stakeholders agreeing and specifying services to be delivered over the long term through partnership working, as well as contract negotiation, target setting, providing incentives and monitoring.

Community care

Healthcare care provided in a community setting such as at home or from a community hospital.

CQUIN (Commissioning for Quality and Innovation) payment targets

These new payment targets are aimed at driving up quality in certain areas. They have been developed to support implementation of *High Quality Care for All*.

Cost improvement programme

The 'savings' plan agreed for 2015/16.

Corporate trustee

A corporate trustee is a corporation which has been appointed to act as a trustee of a charity. In the case of the NHS, the NHS Trust Board is the corporate trustee of our charitable funds.

Current assets

Debtors, stocks, cash or similar whose value is, or can be converted into, cash within the next twelve months.
Disability equality scheme The Disability Discrimination Act amended in 2005 gives the Trust 'general' and 'specific' duties to promote disability equality.
Elective inpatient activity Elective activity is where the decision to admit to hospital could be separated in time from the actual admission, i.e. planned. This covers waiting list, booked and planned admissions.
Emergency inpatient activity Emergency activity is where admission is unpredictable and at short notice because of clinical need.
Equality delivery system (EDS) The EDS was designed in 2011 as a tool to support NHS commissioners and providers to deliver better outcomes for patients and communities and better working environments for staff, which are personal, fair and diverse. The EDS is about making positive differences to healthy living and working lives.
Evolve Evolve, is a new electronic document and records management system (EDRM) which has been rolled out from Autumn 2013.
Executive directors The executive directors are senior employees of the NHS Trust who sit on the Board of Directors and will include the chief executive and finance director. Executive directors have decision-making powers and a defined set of responsibilities thus playing a key role in the day to day running of the organisation.

GDP Gross domestic product – a measure of the value of national economic activity.
Governance Governance arrangements are the 'rules' that govern the internal conduct of an organisation by defining the roles and responsibilities of key officers/groups and the relationship between them, as well as the process for due decision making and the internal accountability arrangements.
Health and Social Care Act 2012 The Health and Social Care Act 2012 is an Act of the Parliament of the UK. It is the most extensive reorganisation of the structure of the NHS in England. It abolished NHS primary care trusts and strategic health authorities from April 2013, with clinical commissioning groups made up of GPs now responsible for buying health services for their population.
Health Education Thames Valley Health Education Thames Valley is the local education and training board covering Buckinghamshire and responsible for NHS workforce planning, education and training in the area. It is a committee of Health Education England, the organisation established as part of the Health and Social Care Act 2012 to lead on workforce issues nationally.
HSMR The Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality used by the NHS that measures whether the death rate at a hospital is higher or lower than you would expect.
ICT Information and communications technology.
Integrated business plan The Trust's Integrated Business Plan (IBP) describes services provided by Buckinghamshire Healthcare. It outlines plans for the Trust to operate as a legally-constituted, financially viable and well- governed NHS Foundation Trust over a five-year period and will form part of our Foundation Trust application to the Trust

Development Authority.

Integrated care

Integrated care – also known as *coordinated care*, *comprehensive care*, *seamless care* – is a worldwide trend in health care reforms and new organisational arrangements that focuses on more coordinated services across acute, community and primary care sectors.

International Financial Reporting Standards (IFRS)

IFRS are the standards, interpretations and the framework adopted by the International Accounting Standards Board (IASB) to promote high quality financial standards globally.

Key performance indicators (KPIs)

KPIs are the nationally recognised method for calculating performance in NHS acute trusts and are defined by the NHS Information Authority. In 2009/10 the KPIs covered existing commitments and national targets set out by the Department of Health (DH) and Care Quality Commission (CQC); clinical quality, outcome and clinical efficiency indicators and activity levels, workforce and health & safety indicators.

Local health economy

The NHS organisations including GP practices, and voluntary and independent sector bodies involved in the commissioning, development and provision of health services for particular population groups.

Methicillin resistant staphylococcus aureus (MSRA)

This is a strain of a common bacterium which is resistant to an antibiotic called methicillin.

NHS foundation trust(FT)

NHS foundation trusts have been created to devolve decision-making from central government control to local organisations and communities so they are more responsive to the needs and wishes of their local people.

NHS trusts

NHS Trusts are hospitals, community health services, mental health services and ambulance services which are managed by their own boards of directors. NHS trusts are part of the NHS and provide services based on the requirements of patients as commissioned by PCTs.

Non-executive directors

Non-executive directors, including the chairman, are Trust Board members but they are not full time NHS employees. They have a majority on the Board and their role is to bring a range of varied perspectives and experiences to strategy development and decision-making, ensure effective management arrangements and an effective management team is in place and hold the executive directors to account for organisational performance.

Order communications

An electronic system for the requesting and reviewing of test results. For example, pathology results.

Outpatient attendance

An outpatient attendance is when a patient visits a consultant or other medical outpatient clinic. The attendance can be a ‘first’ or ‘follow up’.

Health and Adult Social Care Select Committee Buckinghamshire County Council (HASC)

HASCs have the power to scrutinise health services. This contributes to their wider role in health improvement and reducing health inequalities for their area and its inhabitants.

Patient administration system (PAS)

A computer system used to record information about the care provided to service users. The data can only be accessed by authorised users.

Patient Advice and Liaison Service (PALS)

All NHS trusts are required to have a Patient Advice and Liaison Service. The service

offers patients information, advice, quick solution of problems or access to the complaints procedure. PALS are designed to offer on the spot help and information, practical advice and support for patients and carers.

Payment by results (PbR)

Payment by results (PbR) aims to be a fair and transparent, rules-based system for paying NHS Trusts. It uses a national price list (tariff) linked to activity and adjusted for case complexity.

Private finance initiative (PFI)

The private finance initiative (PFI) provides a way of funding major capital investments, without immediate recourse to the public purse. Private consortia, usually involving large construction firms, are contracted to design, build, and in some cases manage new projects

Primary care

Family health services provided by family doctors, dentists, pharmacists, optometrists, and ophthalmic medical practitioners.

Protected characteristics

The Equality Act 2010 makes it unlawful to discriminate against people with a 'protected characteristic' (previously known as equality strands / grounds). The protected characteristics are Age, Disability, Gender Reassignment, Pregnancy and Maternity, Marriage and Civil Partnership, Race, Religion or belief, Sex and Sexual Orientation.

Provisions

Provisions are made when an expense is probable but there is uncertainty about how much or when payment will be required. Provisions are included in the accounts to comply with the accounting principle of prudence.

Public Sector Equality Duty (PSED)

The Equality and Human Rights Commission published new guidance in January 2013 on the public sector equality duty (PSED) under the Equality Act, to help public authorities encourage good relations, promote equality and eliminate discrimination

the workplace and in delivering public services.
Quality account From 2009/10 onwards all NHS trusts have to publish quality accounts to give information about the quality of the services being delivered.
Revenue Expenditure other than capital. For example, staff salaries and drug budgets. Also known as current expenditure.
Ring-fenced Funding specifically designated for a purpose and which can only be used for that purpose.
RiO An electronic patient records system for community health organisations.
Risk register A register of all the risks identified by the organisation, each of which is assessed to determine the likelihood of the risk occurring and the impact on the organisation if it does occur.
Secondary care Care provided in hospitals.

Tariff / national tariff The national tariff underpins the implementation of the payment by results policy by providing a national price schedule for commissioning services for patients in England. The tariff is a schedule of prices for healthcare resource groups (HRGs). These HRG's cover a range of clinical procedures, treatments and diagnoses that cover a large proportion of hospital services in England.
Tripartite agreement This is an agreement between three parties.
Trust Board The Trust Board comprises the chairman, executive and non-executive directors and is the body responsible for the operational management and conduct of a particular NHS Trust.
Whole system reform In relation to our agenda this involves looking at the whole system of NHS care in Buckinghamshire, for example the organisations and professions involved, and improving it collaboratively.
Working capital Working capital is the current assets and liabilities (debtors, stock, cash and creditors) required to facilitate the operation of an organisation.

APPENDIX 4

Sustainability Report

Introduction

Sustainability has become increasingly important as the impact of peoples' lifestyles and business choices are changing the world in which we live. In order to fulfil our responsibilities for the role we play, has the following sustainability mission statement located in our sustainable development management plan (SDMP): We acknowledge this responsibility to our patients, local communities and the environment by working hard to minimise our footprint.

Policies

In order to embed sustainability within our business it is important to explain where in our process and procedures sustainability features.

Is sustainability considered?	
Travel	Yes
Procurement (environmental)	Yes
Procurement (social impact)	No
Suppliers' impact	Yes

One of the ways in which an orgnisation can embed sustainability is through the use of a Sustainable Development Management Plan (SDMP). We will be putting together an SDMP in the near future for consideration by the board.

As an organisation that acknowledges its responsibility towards creating a sustainable future, we help acheive that goal by running awareness campaigns that promote the benefits of sustainability to our staff.

Climate change brings new challenges to our business both in direct effects to the healthcare estates, but also to patient health. Examples of recent years include the effects of heat waves, extreme temperatures and prolonged periods of cold, floods, droughts etc. Our board approved plans address the potential need to adapt the delivery the organisation's activities and infrastructure to climate change and adverse weather events

Performance

Since the 2007 baseline year, the NHS has undergone a significant restructuring process and one which is still on-going. Therefore in order to provide some organisational context, the following table may help explain how both the organisation and its performance on sustainability has changed over time.

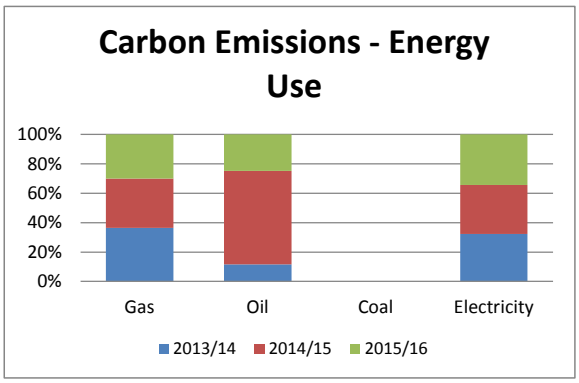
Context Info	2012/13	2013/14	2014/15	2015/16
Floor Space (m2)	138983	138477	138983	138477
Number of Staff	5800	5925	5800	5925

As a part of the NHS, it is our duty to contribute towards the goal set in 2009 of reducing the carbon footprint of the NHS by 10% (from a 2007 baseline) by 2015. It is our aim to meet this target by reducing our carbon emissions 10% by 2015 using 2007 as the baseline year. Here's how we have done:

Energy

Buckinghamshire Healthcare NHs Trust has spent £4233877.80 on energy in 2015/16, which is 9.1% increase on energy spend from last year.

Resource		2013/14	2014/2015	2015/16
Gas	Use (kWh)	61108989	56646548	50401458
	tCO_2e	12963.66093	11884.61588	10692.1653
Oil	Use (kWh)	56262	309983	120209
	tCO_2e	17.9672697	99.20057491	38.38874415
Coal	Use (kWh)		0	0
	tCO_2e		0	0
Electricity	Use (kWh)	26155176	25741523	22848738
	tCO_2e	12015.38585	12476.00214	12793.23689
Total Energy CO_2e		24997.01404	24459.8186	23523.789
Total Energy Spend		£ 4,356,889.00	£ 3,878,725.00	£ 4,233,877.80



Performance

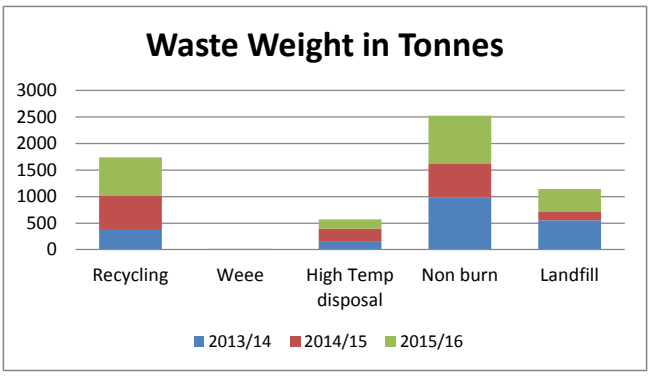
The extra spend is the result of energy increases, however these were increased by an average of 11%, therefore there was a saving of 3%. the We are on Target to reduce our emissions by 10% by 2016 using on the 2008 target base line. The were problems with the CHP last year, which resulted in the Trust taken addition energy from the grid.

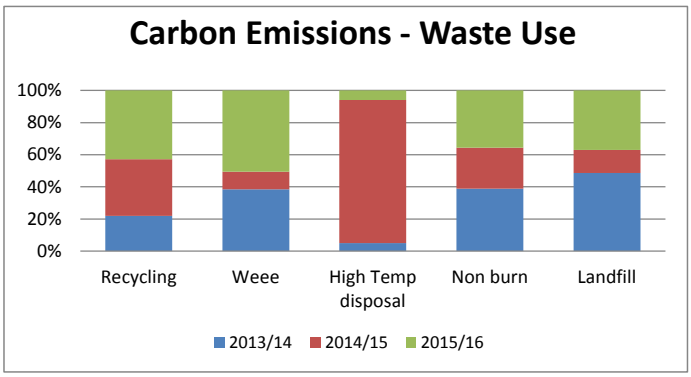
It should be noted that 0% of our electricity comes from renewable sources

Carbon Emmissions

Commentary

We are currently looking at using the CEF to finance and reduce our emissions and cost. There is a programme where lights replaced using LED.
Waste. To reduce our load on the grid and improve revenue, we are upgrading our generators to the triad scheme (run the generators when the main grid is at capacity)





Waste		2013/14	2014/15	2015/16
Recycling	(tonnes)	389	632	719
	tCO_2e	8.169	13.27	15.099
Re-use	(tonnes)	0	0	0
	tCO_2e	0	0	0
Compost	(tonnes)	0	0	0
	tCO_2e	0	0	0
WEEE	(tonnes)	5	1.5	6.6
	tCO_2e	0.105	0.03	0.1386
High Temp recovery	(tonnes)	0	0	0
	tCO_2e	0	0	0
High Temp disposal	(tonnes)	145	252	174
	tCO_2e	3.045	55.44	3.654
Non-burn disposal	(tonnes)	980	649.31	897
	tCO_2e	20.58	13.64	18.837
Landfill	(tonnes)	554	165	422
	tCO_2e	135.4074373	40.33	103.1442934
Total Waste (tonnes)		2073	1699.81	2219
% Recycled or Re-used		0.003940666	37%	0.006804416
Total Waste tCO_2e		167.3064373	122.71	140.87289

Performance

Waste has increased slightly although we have tried to reduce through induction and will continue on this path. We are introducing other methods to reduce waste by meetings and champion.

Commentary

We have recently introduced offensive waste stream across the Trust.

Water

Water		2013/14	2014/15	2015/16
Mains	m^3	169092	157232	135221
	tCO_2e	178	143	142
Water & Sewage Spend		£ 331,794	£ 286,552	£ 282,435

Performance

The use of water stays constant as we are engaged as in flushing which is part of the Trust policy. As a hospital water is critical, we are therefore installing a secondary main at Stoke Mandeville.

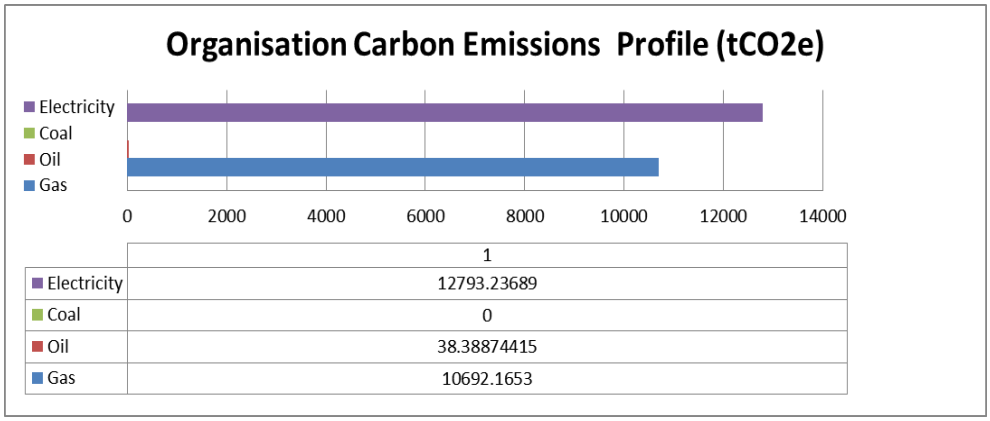
Commentary

We have regular departmental water checks, the results are logged and actions taken are in line with the our policy and L8. Installation of a secondary water main at Stoke Mandeville Hospital is now complete. All water invoices are monitored and actual reads are used.

Modelled Carbon Footprint

The information provided in the previous sections of this sustainability report uses the ERIC returns as its data source. However, we are aware that this does not reflect our entire carbon footprint. Therefore, the following information uses a scaled model based on work performed by the NHS Sustainable Development Unit (SDU) in 2009/10.

This resulted in an estimated total carbon footprint of 13636681 tonnes of equivalent carbon emissions.



	1
Electricity	12793.23689
Coal	0
Oil	38.38874415
Gas	10692.1653

CO_2 Emissions (tCO_2e) Profile	
Total	13234953.02
Anaesthetic Gases	0
Commissioning	182,309
Pharmaceuticals	544,832
Paper products	384,670
Other procurement	579,797
Other manufacture	493,435
Medical Instrument	1,930,620
Manufactured fuels	684,993
Information and cor	225,158
Freight transport	69,570
Food and catering	426,124
Construction	693,999
Business services	867,541
Capital spend	5,844,603
Water and sanitatio	142
Waste products and	141
Travel	283495
Imported Heat/Stea	0
Electricity	12793.23689
Coal	0
Oil	38.38874415
Gas	10692.1653