Buckinghamshire Healthcare NHS Trust

Buckinghamshire Healthcare NHS Trust Annual Report 2016/17

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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. Our highly trained doctors, nurses, midwives, health visitors, therapists, healthcare scientists and other support staff deliver this care.
We deliver our services from a network of facilities including:

- A range of community settings - health centres, schools and patients' own homes
- Five community hospitals in Amersham, Buckingham, Chalfonts & Gerrards Cross, Marlow and Thame
- Two acute hospitals located in the two most densely populated areas of Buckinghamshire - Wycombe and Stoke Mandeville, Aylesbury.

Over 5,900 members of staff provide care to approximately half a million people, including the dispersed population of Buckinghamshire and the surrounding areas of Thame (Oxfordshire), Tring (Hertfordshire) and Leighton Buzzard (Bedfordshire). We are recognised nationally for our urology and skin cancer services and are a regional specialist centre for burns care, plastic surgery, stroke and cardiac services and dermatology.

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

Our vision is to become one of the safest healthcare systems in the country. We are proud of the progress we have made this year against our three strategic priorities – quality, people and money. This wouldn't have been possible without the commitment of our staff. We recognise our partners, who have supported us to develop services, redesign care and nurture innovation. We are committed to the communities that we serve and our patients will be at the centre of our plans as we strive towards becoming outstanding.

Our strategy is being delivered *the BHT way*:

- *empowering our patients* - encouraging people to be partners in decision-making about their own treatment and care
- *engaging and involving our communities and partners* – joining-up social care, primary and secondary care as well as physical and mental health services to give our patients and service users better outcomes and a better experience
- *enabling our staff and leaders* - building morale, developing culture and enabling teams to make improvements in the way they provide services.

Progress against our three strategic priorities

Quality: We have been unwavering in our work to improve our patient care and experience. With a focus on seeking out harm and learning from best practice, we have demonstrated further year-on-year positive shifts in outcomes including sepsis screening, hospital mortality and avoidable pressure ulcers. We have also sustained our patient experience rating, with over 95% of people recommending the Trust as a place for care or treatment. An unannounced inspection by the Care Quality Commission last September also noted significant improvements with 21 out of 35 inspection areas rated as 'good' (up from 7 at our previous inspection). Our overall rating remained at 'requires improvement', which is why we are striving for outstanding.

People: High staff engagement leads to better outcomes for patients, which is why we want to be a great place to work. We are proud to have seen a rapid improvement in our engagement scores for the second year running; 92% of staff believed their role made a difference to patients and service users over the past year and we saw a further improvement in the number of staff recommending us as a place to work or receive treatment. Leadership is the key and to that end we have continued to invest in our people with over 130 clinical and non-clinical managers going through our development programme and over 200 participating in our *BHT way* quarterly leadership sessions and annual conference. This investment is helping to shape strategy and develop our future leaders. To broaden our approach we have also introduced *Feedback Friday* where the executive team and divisional leaders shadow and learn from different teams and departments each month.

Money: We have been open about our underlying financial position and realistic about how we will get to a sustainable financial position within three years. We have reduced this historic deficit by a third, ending the year with a £1.8m deficit compared to £10.9m in 15/16. Our approach has ensured the money has not been tackled in isolation, with clinical teams leading our quality and financial improvements, saving £17.4m through a range of schemes. This included substantively recruiting staff to reduce agency costs by 30%, improving our purchasing of goods and services, reducing travel costs by introducing a new tongue-tie

clinic, and improving the way we work in our operating theatres which led to fewer patient cancellations and saved over £1m.

Our achievements

We are proud of the improvements we have made, but to face the challenges of the future and meet our own aspirations and expectations we must develop, redesign and innovate. As an integrated acute and community provider, we are in a unique position to do this.

We are developing services …

Our award-winning stroke service has expanded at Wycombe Hospital to provide access for an additional 400 patients from East Berkshire. The service retained its 'A' rating by the Royal College of Physicians for the seventh consecutive time placing it in the top 12% in the country. In addition, we are expanding cardiac services with a £1.1m investment in a second cardiac catheter laboratory to help 700 more patients to come to straight to Wycombe for procedures such as angiograms and pacemaker fittings.

Last summer we opened a new state-of-the-art clinic at Amersham Hospital to treat age-related macular degeneration, an eye condition mainly affecting older people. This dedicated one-stop clinic has significantly reduced the number of hospital visits each patient needs to make.

We were delighted to secure five-year contracts to provide the Buckinghamshire healthy child programme and children and young people's integrated therapies. Our aim is to join-up services provided to patients and their families in order to give every child in Buckinghamshire the best start in life.

We are redesigning care …

We have invested an additional £1m in out-of-hospital care. Following public engagement during 2016 we have begun developing community hubs, expanding the range of outpatient, diagnostic and one-stop services we offer. We are piloting community hubs in Thame and Marlow hospitals, working with GPs, social care and the voluntary sector to bridge the gap between home and hospital to over 3000 people and reduce hospital admissions by seeing 350 people through a new community assessment and treatment service.

We have strengthened our links with GPs and mental health services in Buckinghamshire by forming a collaborative with Bucks GP Federation and Oxford Health to focus on improving - in the first instance – urgent care, frail older people, diabetes and mental health. Also due to launch in 2017 is a new and integrated musculoskeletal (MSK) service, having been co-designed by clinicians and patients during the past year and which we are leading, supported by other MSK providers in Buckinghamshire.

We are nurturing innovation …

We were delighted to secure £1.3m for a new Life Sciences Innovation Centre in partnership with Bucks New University, the county council and Oxford Academic Health Science Network. The centre, which will have bases at Stoke Mandeville Hospital and Bucks New University campus in Wycombe, is due to open later in 2017 and will support the development of innovative products with a strong emphasis on supporting people to better manage their health and wellbeing.

Linked to this, we have progressed plans to develop a laboratory in the National Spinal Injuries Centre that will enable our patients to benefit from and participate in testing new innovations and technology to help arm strength and mobility.

Looking ahead

We are proud of how much has been realised in 2016/17. All the more so when considered against a backdrop of what has been one of the most challenging years for the NHS, with increasing demand on all parts of the service. Whilst we have continued to demonstrate improvements we know there is a way to go if we are to realise our ambition of becoming one of the safest healthcare systems in the country.

Our strategy and priorities will remain the same, yet in the coming year we will also focus on five impact areas to ensure we maintain our rate of improvement to become outstanding:

1. patient-led transformation – investing in our systems, working with partners and delivering the changes our patients have asked for
2. organisational development – removing bureaucracy, streamlining our ways of working, and empowering our staff to make decisions
3. investment in leadership - continue to grow and develop our talent, strengthening support to line managers
4. improvement and innovation – developing a single methodology, accelerating ideas and spreading good practice for the benefit of our staff and patients
5. shaping the environment – leading and supporting change within the county and through the development and delivery of our local sustainability and transformation plans.

Our gratitude and thanks go to all the staff and volunteers who have worked so hard to support our patients and service users over the past year. They are what makes BHT a great place to work and we are proud of everything they have achieved. Our thanks also go to our partners, key stakeholders and local communities for your continued support and encouragement.

Hattie Llewelyn-Davies, Chair

Neil Dardis, CEO

4. STRATEGIC REPORT – Our mission and strategy

4.1. The BHT Way

Throughout 2016/17 we continued to embed BHT's Mission, Vision and Five Year Strategy, as the BHT Way, throughout the organisation.

Our Mission – safe and compassionate care, every time.

Our Vision – to be one of the safest healthcare systems in the country

Our Values – CARE (Collaborate, Aspire, Respect, Enable)

The hallmarks of the 'BHT Way' are being known for excellence in quality, being a great place to work and leading the way in joining up with partners. We do this by empowering patients, engaging and involving communities and partners, and enabling staff and leaders. We recognise that more engaged staff leads to better outcomes for patients.

Our three Strategic Priorities:

Quality - we will offer high quality safe and compassionate care in patients' homes, in the community or in one of our hospitals, and patient outcomes and experience will be amongst the best in the country. The BHT Way helps patients to manage their own health whilst BHT takes the lead in joining up the work between hospitals, the community, GPs, social care and the voluntary sector.

People – we will be a great place to work where our people have the right skills and values to deliver excellence in care. The BHT Way helps our inspirational leaders to develop strong teams that are enabled to innovate and develop their services. People want to work at BHT and so we will attract and retain high calibre and engaged people who will pioneer new ways of working across sites, services and organisations.

Money – we will be financially sustainable, will make the best use of our buildings and be at the forefront of innovation and technology. The BHT Way helps us to be more efficient so that we can ensure income and expenditure remain in balance. Health and care hubs will support more people in their communities and specialist services will be at the forefront of research and innovation on our journey to an IT-enabled 'paperless' organisation.

4.2. Sustainability and Transformation Partnership – our role

NHS England has asked every health and social care system to work together to create an ambitious local blueprint for the delivery of the Five Year Forward View, to be known as Sustainability and Transformation Partnerships (STP)

The Buckinghamshire health and social care system is part of the Berkshire West, Oxford and Buckinghamshire (BOB) Sustainability and Transformation Partnership. The goal as one of the 44 STP footprints set up across England is to become more efficient and use our resources to improve the quality of care and the health of our population while managing increasing demand.

We believe that effective leadership is vital if we are going to see effective and long-lasting transformation and change and so BHT has taken an active role in leading workstreams on behalf of the BOB STP in areas such as workforce, maternity and acute paediatrics.

We know that as an organisation we cannot achieve our ambition for our patients on our own and we recognize the importance of partnership working. At the Buckinghamshire level the health and social care system has a long-standing history of partnership working across public services, particularly between the NHS and the County Council's Communities, Health & Adult Social Care and Children's Directorates to deliver improvements in health and care services.

The partners that provide strong collaborative leadership, through the *Healthy Bucks Leadership Group*, to the Buckinghamshire health and care system are as follows:

- Buckinghamshire Healthcare NHS Trust
- NHS Chiltern Clinical Commissioning Group and NHS Aylesbury Vale Clinical Commissioning Group
- Buckinghamshire County Council
- Oxford Health NHS Foundation Trust – the principal provider of mental health services in Buckinghamshire
- South Central Ambulance Services NHS Foundation Trust
- The Oxford Academic Health Sciences Network

We have a programme governance structure to drive the operational efficiencies and transformation that is required to address the areas in health & wellbeing, care and quality, and finance & efficiency that need to change.

The overarching principles supporting the partnership working are:

- All partners working to the common goal of ensuring the people of Buckinghamshire have happy and healthier lives

- The focus to be on reducing health inequalities between and within communities
- Total transparency between organisations in sharing service, quality and financial plans and performance against these
- Parity of esteem between mental and physical health is a key aim of all partners.

There are our three key challenges:

- To prevent avoidable physical and mental ill health
- To ensure that services are as operationally efficient as possible to reduce infrastructure costs; and
- To transform services in a way that maintains and improves the quality of care, reduces costs but at the same time improves access in more local settings where appropriate.

We recognise that further benefits can be provided on a strategic level at scale. We are leading and working collaboratively with our partners within the STP to harness the skills and expertise within our STP to drive improvements across:

- Integrated Care
- Estates
- Workforce
- Acute Services
- Maternity
- Acute Paediatrics
- Pathology

These areas need the wider collective impact that BOB offers to deliver at scale.

4.3. Corporate Objectives

The following corporate objectives have been agreed by the Board for the year ahead**.**

Strategic Priorities	Outcome - Key Performance Indicator
1. Quality	
1.1 Sustain HSMR	• HSMR < 90 • 75% of patients meet 1 hour door to needle time presenting with sepsis in ED • 80% of fracture neck of femur patients meet 36 hour standard for emergency surgery • 75% of patients on the fragility pathway are assessed with an appropriate tool
1.2 No avoidable harm in grade 3 or 4 pressure ulcers, with a further reduction in avoidable grade 2 pressure ulcers. Further reduction in avoidable falls.	• Avoidable grade 2 pressure ulcers – no more than 5 per month (60 in total) • Avoidable falls with harm – no higher than • 100 per month. • Falls with moderate or severe harm – no more than 15 (2016/17 baseline – 21).
1.3 Meet infection control targets in MRSA and avoidable C difficile.	• MRSA - 0 • C.diff - 32 • Reduction in gram negative infection - **1**0%

1.4 Sustain Friends and Family Test (F&FT) approval rating and increase response rate. Increase the number of complaints answered within 28 days.	• Friends and Family Test approval rating > 95% • Response rate > 40% • Improvements in patient experience in outpatients, urgent Care, discharge and children's services • Complaints response >85% • Increase number of complaints resolved through local resolution by 10%
1.5 Increase patient engagement numbers across key initiatives.	• 10% increase per annum from 2016/17 baseline.
1.6 Consistently meet the NHS Constitution standards	• A& E - deliver 2017/18 improvement trajectory towards 95% standard. • Referral to Treatment Time - 92% referral to treatment within 18 weeks. • Meet cancer waiting times for diagnosis and treatment.
2. People	
2.1 Improve staff engagement score	• Upper decile nationally in the 2017/18 staff survey. • Improve medical engagement score
2.2 Reduce nurse vacancies and total agency spend for 2017-18	• Monthly cap of £750k • Annual cap - £8m • 7% nurse vacancy level
2.3 Achieve statutory and mandatory training, and appraisal completion rates.	• 90% monthly achievement
2.4 Ensure all staff have a Personal Development Plan	• At least three days of development annually for each member of staff
2.5 Formally assess leadership development programme and implement talent management structure to monitor output/improvement.	• Complete review and implement talent management structure
3. Money	
3.1 Deliver our control surplus.	• No less than £6.5m surplus
3.2 Deliver our transformation programme	• CIP delivery of 4.4%
3.3 Deliver a capital programme to ensure safe services, progress digital interoperability and improve our estate.	• Delivery of £16.4m capital programme
3.4 Deliver five year BOB Sustainability and Transformation Plan, including Buckinghamshire and BOB components.	• Monitor monthly delivery against milestones through Buckinghamshire Transformation Delivery Group

Strategic Drivers	Outcome - Key Performance Indicator
4. Urgent Care	
4.1 Expand stroke services at Wycombe Hospital to cover the East Berkshire and South Bucks population.	• Quality – maintain Trust stroke standards at 'A' grade with an additional 330 patients per annum. • Money – achieve net margin of £277k per annum.
4.2 Open a 2nd Catheter Laboratory expanding our catchment area for cardiac care and repatriating Buckinghamshire patients from London Hospitals.	• Quality – maintain Cardiac standards for an additional 350 patients per annum • Money – achieve net margin of £187k per annum
4.3 Introduce improvements to the urgent and emergency care pathways for both specialist hospital care and at locality level through integration with primary care	• Quality – reduce mortality rate and emergency readmission rates; seven day service compliance with four key clinical standards • Money – £1m transformation via bed productivity.
4.4 Create an integrated urgent care (IUC) system in Buckinghamshire working with partners across Thames Valley in redesigning NHS 111 and primary care out of hours services.	• Quality – support access to ambulatory and primary care within 3 hours for urgent care and within 48 hours for routine primary care appointments.
5. Integrated Care	
5.1.1 Integrate providers in Buckinghamshire into a new model of care – A Primary and Acute Care System.	• Quality - reduce non-elective demand through faster and more local access to expert support for patients with chronic or frailty conditions. Focusing on diabetes, mental health, urgent care and integrated care as priorities • Improving patient experience by reducing fragmentation of services in areas such as musculo-skeletal care • Money –reduce rising demand and cost of hospital based care.
5.1.2 Implement a single point of access for all referrals into community services.	• Quality - improving patient experience – clearer access into community services • Money - reducing transfer of care delays, creating service efficiencies
5.1.3 Pilot community hubs in Thame and Marlow to deliver expanded diagnostic, outpatient, health and well-being and ambulatory care services for local people.	• Quality – local access for high volume community services • Money - £650k transformation contribution for 2017/18.
5.2.1 Implement the integration of children's services in line with the new BCC service specifications for the Healthy Child Programme (HCP) and integrated therapies.	• Quality – meet Key Performance Indicators linked to the specifications. • Money – secure £300k contribution per annum for HCP, and contribution of £140k per annum by 2018/19 for integrated

	therapies. • People – fixed five year and three year contracts support improved recruitment and retention of staff.
6. Specialist	
6.1 Complete an appraisal of pathology services assessing collaboration options with neighbouring providers	• Money – deliver a service at less than 1.6% of overall expenditure.
6.2 Complete an option appraisal of maternity services to meet the needs of the population in the future	• Outline Business Case to demonstrate quality, people and clear financial benefits.
7 Planned	
7.1 Introduce a new model of care for musculo-skeletal services in alliance with our partners.	• Quality – improve 'Visual Analogue Score (VAS) pain scores' pre and post treatment, improve patient involvement in shared decision making. • Money – increase market share, reduce Bucks activity by 5.4% over predicted increase in 5 years, reduce duplication of outpatient and diagnostic tests.
7.2 Outpatients – transform the delivery of outpatient services	• Quality – improved patient experience and access through reduction in complaints by 20%, and meet RTT targets. • Money- contribution of £1m transformation contribution.
7.3 Theatres - transform the delivery of theatres	• Quality – improve patient experience and outcomes and reduce errors and delays. • Money- £1.5m transformation contribution. • People - transform leadership and culture.
7.4 Implement a new model for Diabetes services.	• Quality – improved patient experience through increased number of patient contacts in the community. • Money – reduce demand for secondary care services
8. Technology	
8.1 Launch a Buckinghamshire Lifesciences Innovation Hub supporting businesses to develop their healthcare products and services in conjunction with our patients and clinicians	• Quality – supports a culture of innovation to access new services and products for patients; target 30 innovation and enterprise links in the first year. • People - build reputation to aid recruitment and retention. •
8.2 Continue to drive back office efficiencies with partners.	• Money - £1.3m cost transformation per annum; meet Carter target of no more than 7% of operating costs on administration.
8.3 Drive IT Interoperability and implement a new E-Observation system across all wards.	• Quality – 100% escalation and action recorded for deteriorating patients.

	• Money – deliver efficiencies in medical and workforce productivity through the use of IT and technology.
9. Estates	
9.1 Deliver robust costed and affordable estates strategy as part of five year Long Term Financial Model.	• Five year estate strategy included in Long Term Financial Model (LTFM) addressing service developments and prioritised backlog. • Ensure business case support and delivery of theatres, and an acute care hub on the Stoke Mandeville site • . • Prioritise estates backlog and implement plans to address.
10. Organisational Development	
10.1 Delivery of board development programme that is well evaluated and covers key strategic and functional elements.	• People - All posts on the Board filled. • Board development programme in place for the year. • 360 degree appraisals for every board member. • Board self-review and assessment
10.2 Implement Year One of the Communications and Engagement Strategy	• Improve performance scores in Trust stakeholder and staff surveys
10.3 Implement BHT Improvement Methodology and priorities for change and link for innovation.	• Quality – number of rapid improvement projects complete – 15 • Trust wide methodology introduced • People- staff award for innovation created
10.4 Develop GP relationships and education to improve pathways of care	• Money – sustain and increase GP referrals in selected specialities • Quality – reduce fragmentation and duplication of care for patients between GPs and Trust specialties
10.5 Develop OD programme to support people agenda with a focus on IT and business intelligence, approvals and contract management and meetings structure.	• People- Complete analysis and agree prioritised plan
10.6 Deliver a clinical strategy framework to ensure vision and plan for all SDUs.	• Complete service strategy for all Service Delivery Units (SDU)

4.4. Partners and Stakeholders

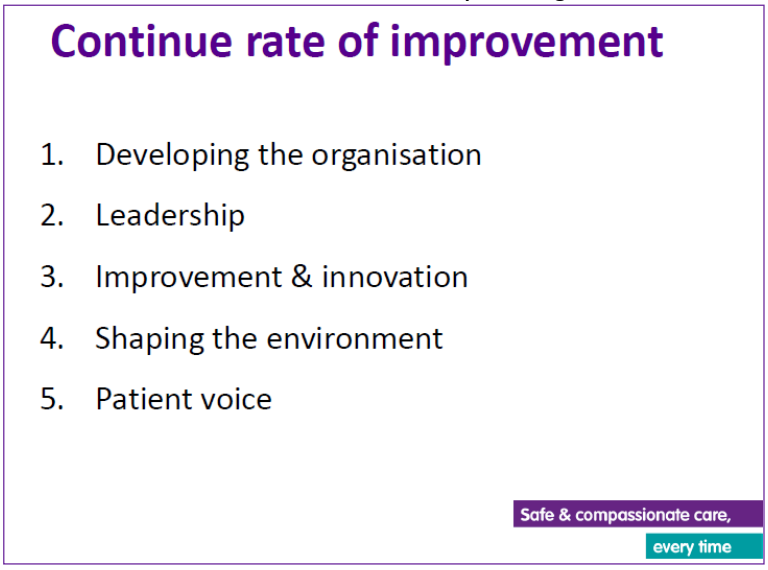
16/17 has been a year of working and engaging with external partners and stakeholders to shape health and care services in Buckinghamshire. Our work has included:

- System leadership:
  - the Chief Executive is a member of and participates in the Bucks Healthy Leaders Group and sits on the BOB STP Delivery Board
  - The Trust leads STP-wide initiatives in Maternity, Paediatrics and Workforce
  - A strong partnership with Oxford Academic Health Science Network (AHSN); the Chief Executive chairs the Clinical Innovation Group
  - A 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.
- We have developed an Executive Lead for each of the seven GP localities in Buckinghamshire to enhance communication and responsiveness to primary care. We are working with Bucks Carers, Alzheimer's Society and Age Concern to develop voluntary services in our community hubs
- 'Your community, Your care' – a system-wide engagement programme with patients and public to design the future of primary and community services was launched in Spring 2016 and further public engagement over the future provision of some community services took place in Autumn 2016. A community hubs pilot in Thame and Marlow commenced in April 2017.

4.5. Key focus in 17/18

When reviewing our quality and people metrics it is clear that we benchmark as average. In relation to finance we have set ourselves goals and met them, although did not achieve the control total in 16/17. To maintain this rate of improvement we will have to do things differently. Our vision is to be one of the safest healthcare systems in the county and we have identified through our work with other organisations and key stakeholders the following priorities for improvement that will see us reach our ambition.

The key areas of focus to enable us to make a step change are shown below:



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 16/17.

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.

5. Performance Highlights and Challenges

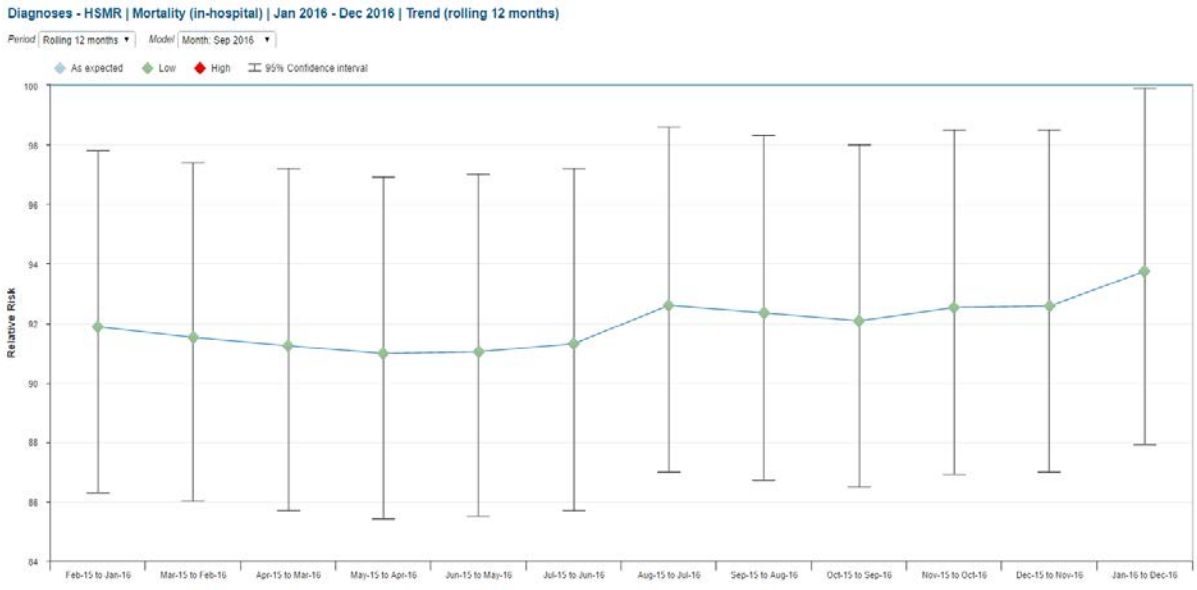
This section of the report provides information about our performance including how we have done against the national indicators set out in the Operating Framework for 16/17. More detailed information about quality performance can be found in the Trust Quality Accounts 2016/17 published on the Trust 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.

5.1. Quality Performance

5.1.1. Reducing Mortality

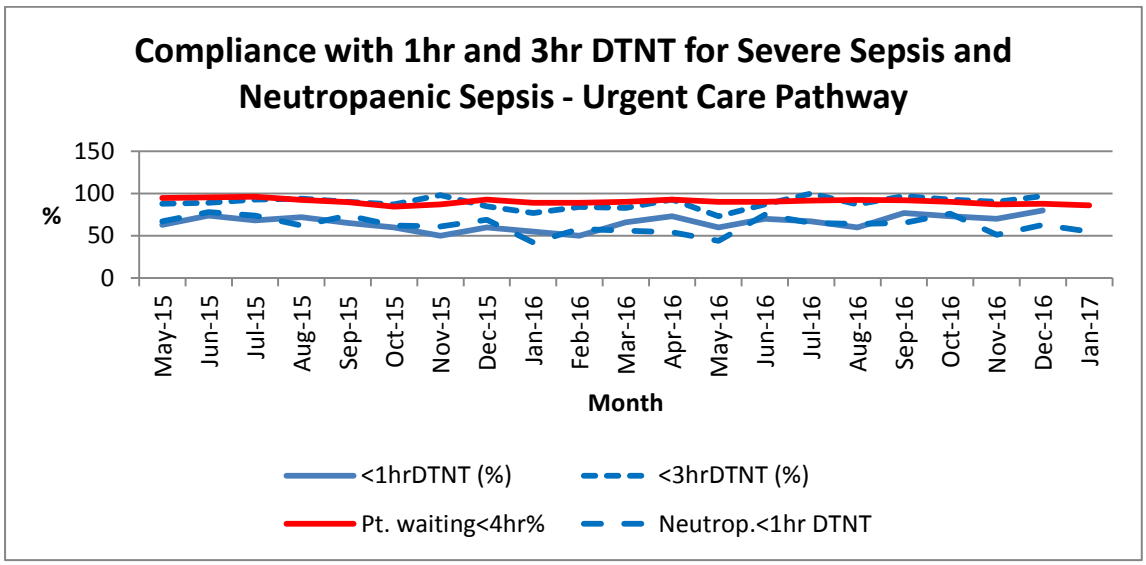
For the year January to December 2016 the rolling HSMR was 92 meaning that we achieved the target set at the beginning of the year.

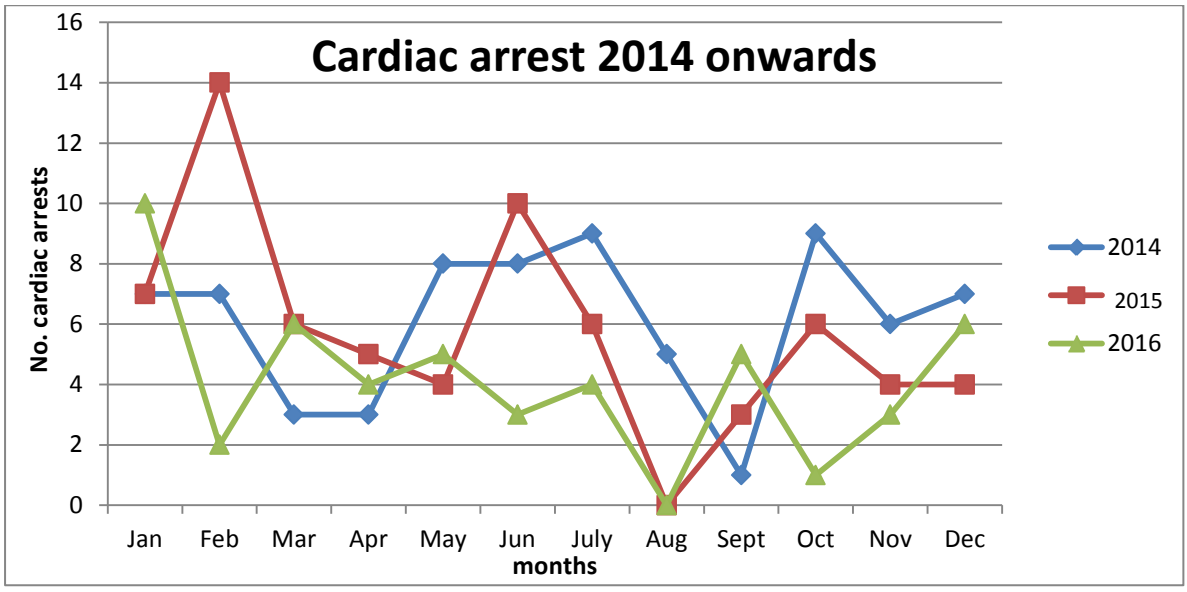


We continue to be fully committed to reducing our HSMR by continued focus on delivering the actions described below:

- The Mortality review process has been successfully embedded with the clinical teams with over 95% of deaths reviewed monthly within the trust. As a result of the new national initiatives, this will be reviewed in the near future.

We have been concentrating on reducing mortality through better care of patients with sepsis. We have been working to ensure patients with sepsis receive their antibiotics as soon as the condition is recognised (one hour and three hour door to needle time (DTNT) monitored) with a year end achievement of 80% of patients receiving their antibiotics within one hour which is above the national standard set. We have also focused on reducing the number of cardiac arrests across the trust through sharing learning and a programme of education. We set a 10% reduction last year from 60 to 54. We achieved a 28.3% reduction from 60 to 43.





5.1.2. Sign up to Safety (Falls Reduction)

Our quality and safety programme is central to achieving our ambition of being the safest healthcare system in the country. A number of our safety priorities have been shaped through the national Sign up to Safety Campaign. Sign up to Safety aims to make the NHS the safest healthcare system in the world. The campaign have negotiated with the NHS Litigation Authority (NHSLA [re-named NHS Resolution since 1 April 2017]) a one off incentive scheme inviting NHS organisations to bid for patient safety improvement monies. BHT was successful in its bid, securing £500,000 in support of our patient falls reduction project.

We have implemented our second year of the 3 year funding. The funding was to:

- Improve outcomes for patients by reducing the severity of harm from a fall
- Reducing the overall numbers of patients who fall

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.

Outcomes:

- Comparing the number of falls between 2015/16 up to 2016/17 per occupied bed-days indicates a 23.8% reduction.
- We have zero falls that resulted in severe harm, which is a considerable achievement and reduction from 7 falls with severe harm last year.

5.1.3. Dementia and Delirium

In 2016/17 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 expanded our portfolio of teaching programmes to include the needs of Carers for people with Dementia (John's Campaign) and also for those with Young Onset Dementia.

We have participated in the National Dementia Audit and we are using our data to drive improvements.

We continue to develop our teaching on delirium and ensuring our clinical environments are equipped for the needs of this population.

5.1.4. Pressure Ulcers

Our aim for 2016/17 was to reduce Grade 2 avoidable pressure ulcers. As we did not have a baseline we set the baseline in this year to enable further work in 2017/18. We have recorded 246 grade 2 avoidable pressure ulcers and will aim to reduce this to no more than 5 per month (60 in the year).

We had set ourselves a target to achieve 50% reduction in avoidable Grade 3 and 4 pressure ulcers over a 2 year period commencing 2014/15 and achieved the following:

- We over reached on our 25% target reduction in year one by achieving overall reduction of 33% (2014/15)
- In year two, 2015/16- we have again overreached our 25% target by achieving a 70% reduction.
- In 2016/17 – we have recorded 43% reduction in Grade 3 and 4 pressure ulcers

5.1.5. Medicines management

The Care Quality Commission report published in 2016/17 drew attention to a number of issues relating to medicines management and we have been working to address these.

Our Medication errors sub group has focussed on improving the overall management of medicines, including improved systems for controlled drugs destruction, 15 Steps to Medicines optimisation and optimising drug fridge management. As a result we have

introduced ward pharmacy diaries to improve communication between the ward staff and pharmacy staff. This has shown to be highly successful with improvement in stock management and more effective patient management. We have also standardised information about pharmacy, out of hours support and general ward stock.

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.

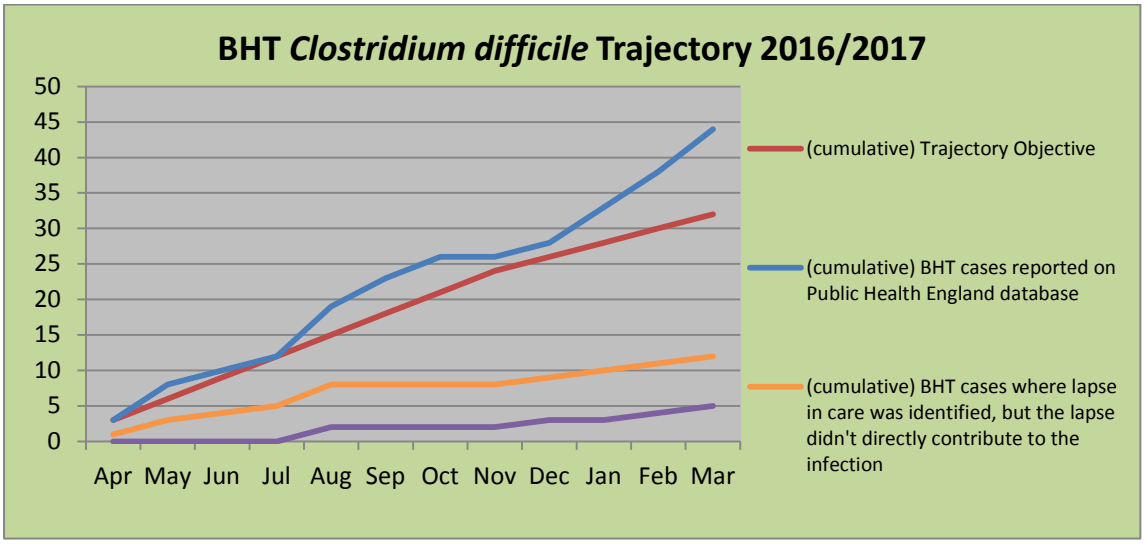
To support education, training and self-management of diabetes, we have appointed new Diabetic Specialist Nurses which has proved very successful in supporting the Diabetes transformation work. Our seven day a week clinical pharmacy service has been successful and we have reduced unnecessary delays in 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.

5.1.6. Infection Control

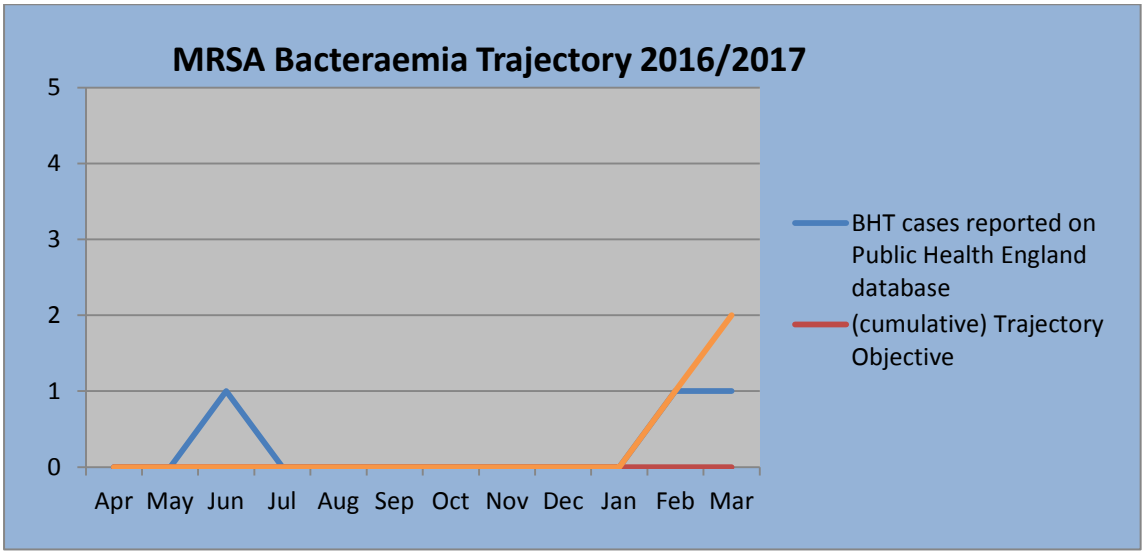
We continue to participate in the mandatory reporting of *Clostridium difficile* Infection. The graph below show our *Clostridium difficile* figures for the year. Our limit for the year was 32. Our year end numbers were 44 cases reported to Public Health England (PHE). Lapses in care which contributed to infection were noted in 5 cases. A root cause analysis was undertaken for each case and identified the following findings:

- 3 cases highlight antimicrobial use as a factor.
- 2 related to a small outbreak at one of our Community Hospitals.

For 2017/18 a Clostridium Difficile Infection (CDI) reduction plan has been developed to focus on the aspects of learning identified from our 2016/17 cases. The plan will be monitored by the Infection prevention team and progress against it will form part of the Infection prevention & Control committee.



Mandatory reporting of MRSA bacteraemia continues. The limit was set at 0 avoidable cases. 3 cases were reported to PHE.



5.1.7. Safer staffing (specific to nursing)

We have reviewed our staffing requirements across acute ward areas, community services and health visiting, including Emergency Department and Critical Care units, to support us in setting appropriate ward staffing establishments.

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 continue to 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 particular needs of the patients on the day. 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 2016/17 we were the national pilot site nominated to design and implement a ward resource planning tool as part of the Lord Carter initiative. We co-designed a tool with 'Netcare' 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 tool supports derivation of Care hour per patient day using an acuity model.

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.

5.1.8. Safeguarding

Safeguarding continues to be a high national priority and scrutiny of safeguarding within health organisations is increasing. The Trust takes seriously its safeguarding responsibilities and has in place a robust governance structure to monitor all aspects of safeguarding activity in order to ensure that its statutory duties to safeguard adults and children are upheld.

Working in partnership with all other local agencies continues to be a high priority and the Trust's commitment to this has been noted. This is demonstrated through our regular attendance at the Local Safeguarding Children and Adult Board meetings and sub group meetings. In addition the provision of staff resource to the children's and adult multi agency safeguarding hubs (MASH) and to SWAN unit further demonstrates that commitment.

The Trust has been very influential in the development of both local safeguarding boards through participating in away days and learning events, and there is evidence of greater effectiveness and maturity of these boards which is demonstrated via improved cooperation and partnership working. The key priorities of the Safeguarding Adult and Children's Boards, as set out in their respective business plans, will form the basis of the Trust safeguarding work plan for the year 2017/18.

Mental Capacity (MCA) and Deprivation of Liberty Safeguards (DoLS) continue to be a high priority for the organisation; 85% of Trust staff have undertaken MCA training and 81.5% have been trained in DoLS. A steady increase in DoLS applications has been observed throughout 2016/17 which is indicative of greater staff awareness, however there is still room for further improvement and this will be a key area of focus throughout the coming year. Further embedding the Trust's statutory duties as et out in the Care Act 2014, especially around and "Making Safeguarding Personal" agenda continues to be a key are of focus and this will also be a key priority area for 2017/18.

Attaining the required level of safeguarding children and adult training compliance continues to be a challenge and a great deal of effort has been put into achieving this goal by the Trust Executive, Safeguarding Team and Divisional Leads. Whilst there has been a degree of success in driving up training compliance this will be a key area of focus throughout the coming year. The Trust Safeguarding Team has helped develop along with our CCG safeguarding colleagues and other partner provider Trusts, multi-agency training events for health staff, including GPs. The Team will be participating in the delivery of these training events throughout the remainder of 2017.

A significant area of success in respect of safeguarding training has been in relation to Prevent, with in excess of 91% of staff now being trained. 'Prevent' is a national strategy that provides practical help to prevent people from being drawn into terrorism and ensure they are given appropriate advice and support. Our achievement has been recognised by our CCG safeguarding commissioners and local Prevent partnerships.

Training in domestic abuse and using the approved assessment tool for assessing risks around this issue continues to be delivered to Trust staff in partnership with Women's Aid. The successful embedding of this training into practice should be demonstrated by increased referrals to the domestic abuse Multi Agency Risk Assessment Committees (MARACs), which is not currently evident. This will be further explored via an audit of case files which will be carried out in the year 2017/18 as part of the safeguarding audit programme.

In order to effectively embed learning and support staff in putting all safeguarding knowledge into practice, the Safeguarding Team is actively working towards developing closer working relationships with Trust divisions in order to raise the profile safeguarding and make it more visible in practice areas. Safeguarding leads have been allocated to each division so that they can work assertively with lead clinicians and form good working links with important practice areas.

The appointment to the new post of Associate Director for Safeguarding in August 2016 has further emphasised the Trust's commitment to its safeguarding responsibilities; this appointment will enable closer integration of the safeguarding functions within the team

and will promote the ethos of safeguarding across the lifecycle. A key area of development in this regard will be the greater awareness of risks and enhanced management of children who are transitioning from children's to adult services.

Children in care continue to be a priority for the Trust; the numbers in care within Buckinghamshire stand currently at 465 children with approximately 50% being placed outside the county. Whilst the numbers in care have remained fairly consistent with last year's data, the children's cases are becoming more complex. The rise in the numbers of asylum seeking children and young people coming into the UK, many of whom are placed within Buckinghamshire, produces particular challenges for health services, including the Trust looked after children (LAC) Team. Completing all health assessments for LAC in line with statutory timelines has been challenging, especially in relation to Initial Health Assessments (IHAs). The Trust continues to work in partnership with Local Authority colleagues and health commissioners to address this issue.

The National Child Protection Information Sharing (CP-IS) went live within the Trust in April 2017. A great deal of work has been done by the Trust Safeguarding Team, IT and A&E staff to enable this to happen and all relevant staff have now been trained in how to operate the system.

The Trust is also prepared to participate locally in the newly-introduced inquiry process into premature deaths of people with learning disabilities (LD) which started from April 2017. Evidence from research consistently points to significant health inequalities among people with LD and a higher prevalence of early mortality. It has been shown from a National Confidential Inquiry report that that whilst the median age at death for males in the UK was 65 years, men with learning disabilities died on average 13 years earlier than men in the general population. The median age at death for women was 63 years, whereas women with learning disabilities died on average 20 years earlier than women in the general population. The aim of LeDeRs is to address avoidable mortality for adults with LD through the learning and recommendations identified within robust multi-agency inquiries into all premature deaths within this cohort.

5.1.9. Patient Experience

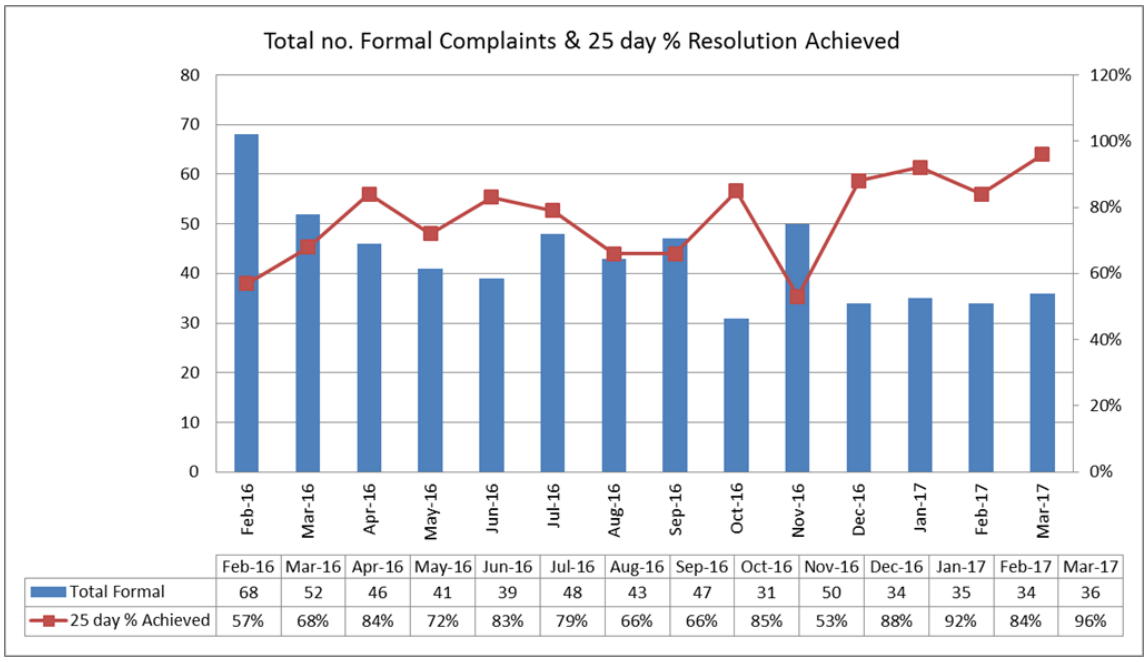
Complaints and compliments

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

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

In 2016/17 Buckinghamshire Healthcare Trust received 487 formal complaints compared to 606 formal complaints received in 2015/16. This represents a 20% reduction in complaints received when compared to the previous year.

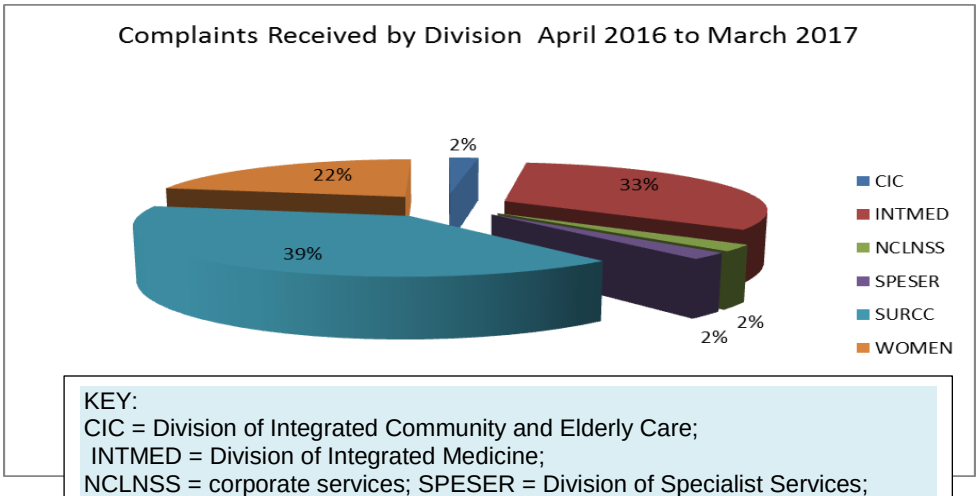
The graph below shows the number of formal complaints received each month throughout the reporting period. The Trust has set an internal target of 85% of all Grade 4 complaints to be responded to within 25 working days. Grade 4 complaints are those that cannot be immediately resolved through the PALS service, and do not cross multiple divisions or other healthcare providers. The graph below shows our performance during 2016/17. We achieved an average of 79% of our Grade 4 complaints being responded to in the specified time frame with 96% response rate within the timescales in March 2017.



	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Total Formal	68	52	46	41	39	48	43	47	31	50	34	35	34	36
25 day % Achieved	57%	68%	84%	72%	83%	79%	66%	66%	85%	53%	88%	92%	84%	96%

The number of annual complaints has fallen over recent years from 685 in 2014/15 to 487 in the same period in 2016/17. The second and third quarter remains the busiest part of the complaints year and the fourth quarter is the least busy.

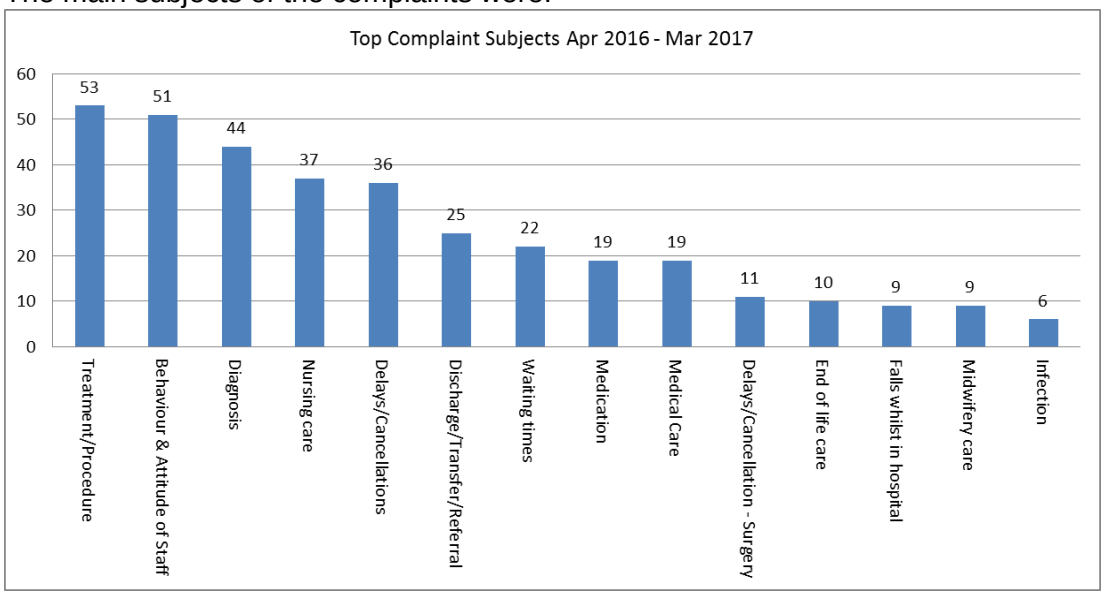
The Trust currently has 5 clinical divisions and a number of corporate services. The corporate services are categorised together in the analysis. Each clinical division has specialities within it. The graph below shows the breakdown of complaints received by each division.



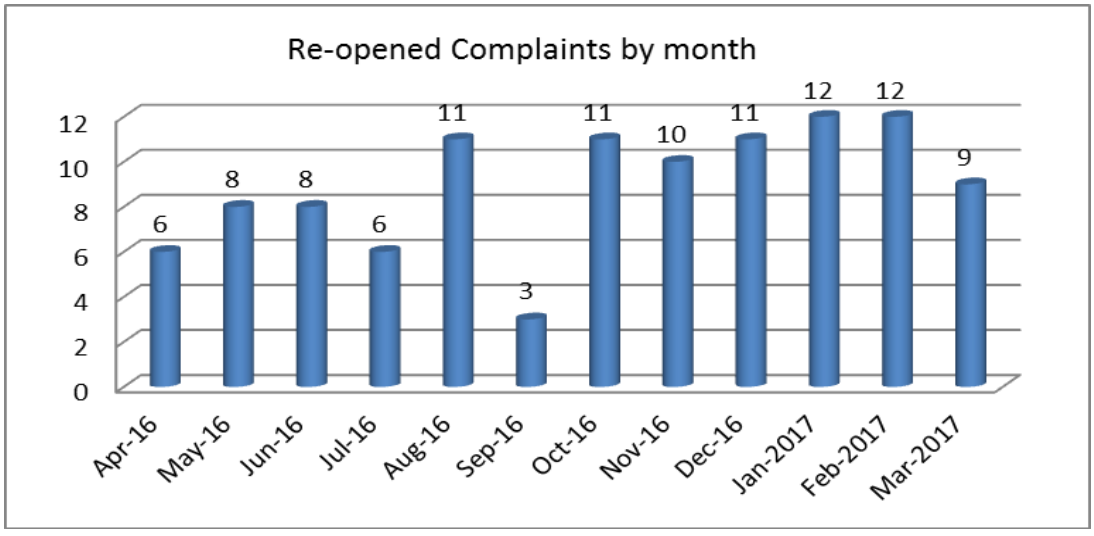
KEY:
CIC = Division of Integrated Community and Elderly Care;
INTMED = Division of Integrated Medicine;
NCLNSS = corporate services; SPESER = Division of Specialist Services;
SURCC = Division of Surgery and Critical Care;
Women = Division of Women and Children and Sexual Health

The graph below illustrates the reasons that people raised complaints against the Trust in 2016/17. Treatment and procedure, behaviour and attitude of staff were the main causes for complaints in 2016/17. Diagnosis, which includes failure to diagnose, was the third highest reason for complaints.

The main subjects of the complaints were:



Below is a graph illustrating our reopened complaints. We had an average of 9 complaints reopened each month as a result of a complainant requesting further information. In 2017/18 we will be recording and monitoring our reopened complaints so we can differentiate between reopened cases. We want to identify complaints reopened as a result of a thorough investigation that has raised additional new questions and a poor investigation that did not respond in full to the original complaint.



Learning from Complaints

The top 3 reasons for complaints in 2016/17 were:

1. Treatment and procedure
2. Behaviour and attitude of staff

3. Diagnosis - which includes failure to diagnose

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.

Behaviour and Attitude of staff - concerns highlighted about this matter have been rising since January 2016. The issue has also been recorded by the PALS service in their role as single point of access, and has also featured in the free text feedback received relating to the friends and family test. The cause for this is not confirmed but the incidents are often connected to telephone conversations or face to face conversations about access to services or appointments. Actions taken so far include:

The PALS service conducts quarterly training sessions which include techniques related to managing difficult conversations. The importance of staff attitude is further reinforced in the nursing preceptorship training. First impressions and communication is part of the patient experience presentation to the Foundation Year 1 (FY1) doctors and Foundation Year 2 (FY2) Doctors training and as part of new corporate staff induction. The importance of attitude and the perception of the patient is also being covered in the HCA training conducted by the patient experience manager.

Delays and Cancellations - Delays and cancellations have remained a recurring theme with the Trust exploring IT solutions to help mitigate the causes of enquiries in this area. Furthermore, feedback relating to access is a core theme through the complaints service. There are plans for modernisation of our Outpatient Department related access processes. Progress is being made in the modernisation program proposals in relation to Electronic Referrals (ERS).

2016/17 Complaints Test of Change:

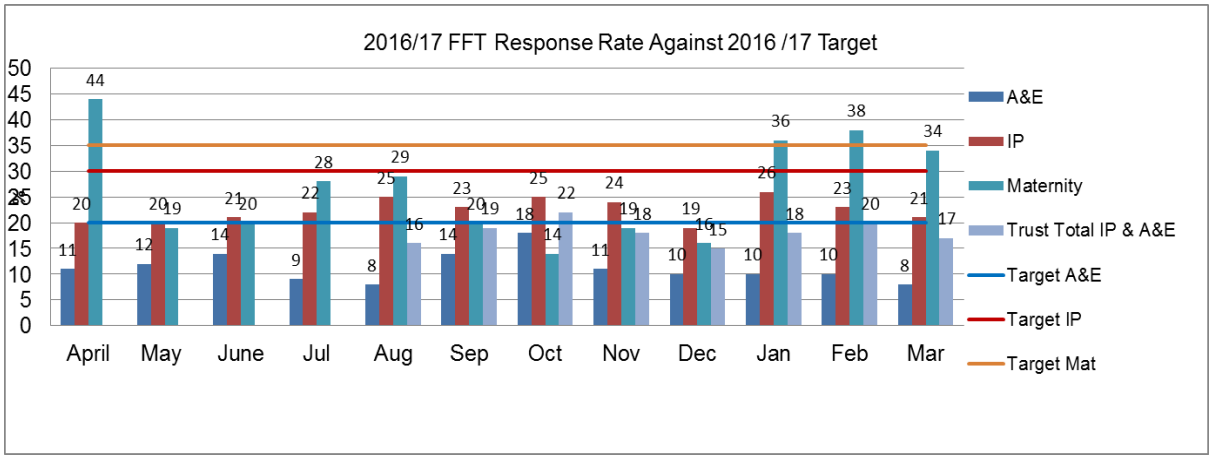
During 2016/17 the complaints team implemented some new processes for improving complaints performance. The key specific areas reviewed were:

- All investigating officers should make a contact/phone call to the complainant early in the investigation process to see if the complaint issues can be clarified with a conversation and determine an agreed timeframe for the complaint.
- Introduction of a new complaints investigation template tool. This tool focused more pointedly on the issues in the complaint and the evaluation of these issues.
- Whenever a trainee doctor is named negatively in a formal complaint no matter how trivial this will be connected to their revalidation process.
- IOs are the designated contact for the complainant during the investigation period of the complaint answering requests for updates on the progress of the complaint during the investigation period.
- Investigating officers work across services to develop a single coherent complaint response that is returned to the complaints team.

In 2016/17 there were 9 complaints referred to the Parliamentary and Health Service Ombudsman. Of the 9 cases referred, 5 were not upheld, 1 was partly upheld and 1 was upheld. We currently have 2 cases the ombudsman is deciding on whether to investigate.

Friends and Family Test (FFT)
The 2016/17 quality improvement plan target for friends and family for the Trust was set at a > 95% approval rating and a > 30% response rate for inpatient, maternity and A&E services during the reporting period.

The graph below shows Buckinghamshire Healthcare NHS Trust's FFT performance during the reported period. In 2016/17 we achieved an average approval rating of 92.4% and an average 18.6% response rate.



The Trust received compliments about our services throughout 2016/17. When combined with the accolades received as free text as a part of the friends and family responses we have received over 30,000 compliments during 2016/17.

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.

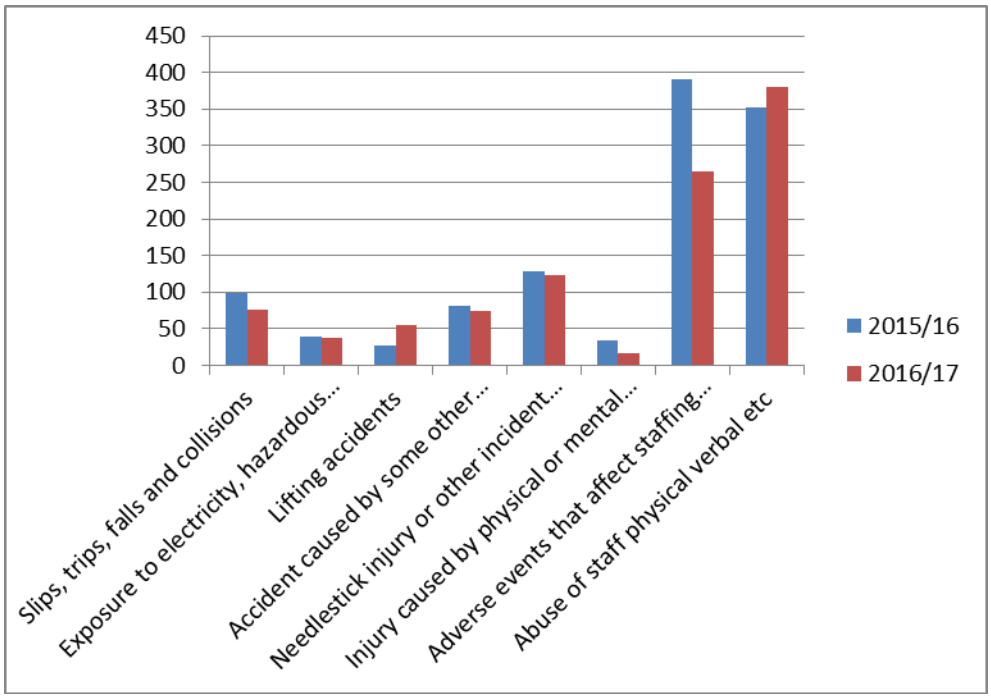
5.2. Health and Safety 2016/17

This year we have undertaken a comprehensive gap analysis of Trust Health and Safety organisation and arrangements based on the healthcare specific Workplace Health and Safety Standards Document produced by the Health and Safety Wellbeing Partnership Group which has resulted in a detailed action plan focussed on key issues for the forthcoming year.

We are strengthening our collaboration between Health and safety, Occupational Health and Wellbeing, Human Resources, Estates, Education Learning and Development (ELD) ELD and other teams, in order to achieve better integrated initiatives to further improve staff health, safety, welfare and wellbeing in the knowledge that this can then lead to improvements in patient health, safety, welfare and wellbeing outcomes.

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

Accident stats 2015-6 and 2016-7



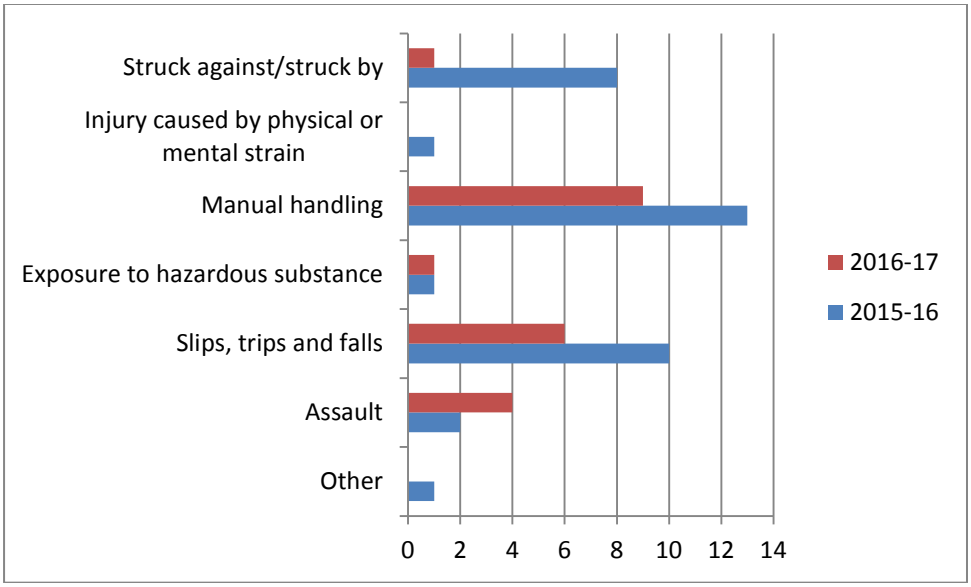
There has been an overall fall in reported incidents compared to the previous year. In all incident categories there has been a reduction with the exception of:

A) Manual handling incidents where taken together with physical or mental strain incidents there has been a small rise (analysis of “lifting accidents” and “physical or mental strain” showed that similar incidents were reported in both these categories).

B) The rise in reporting of abuse of staff we believe is partly due to raising awareness activity of the importance of reporting these incidents. We have also seen a correlation with staff survey results that also report a rise and we are addressing this through local action plans in departments where the risk is raised and at a corporate level through new training course package that address both theoretical understanding and practical de-escalation techniques.

The Trust’s Health & Safety Committee is informed of incidents reported to the Health and Safety Executive (HSE) under the Reporting of Injuries Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). All RIDDOR incidents reported to the HSE are investigated internally. The summary in the table below shows a fall in the numbers of RIDDOR incidents reported from 36 to 24.

RIDDOR Reported Incidents - Employees 2016/17 and 2015/16



No safety notices were issuesd by the Health and Safety Executive (HSE) in 16/17

The Health and Safety Committee met three times in 2016-17 under the chairmanship of the Director of OD and HR.

Health and safety projects which have taken place during 2016/17 include:

- The production of a revised health and safety risk assessment course, five sessions have been run so far. Other training sessions delivered by the Health and Safety Facilitator included Health and Safety Awareness and Corporate Induction
- The revision of Trust Health and Safety Policies relating to hazardous substances and the use of display screen equipment to simplify where possible and to take account of changes to legislation and good practice.

5.3. Progress against national standards 2016/17

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 operational performance report demonstrated compliance over the year for all indicators with the following exceptions:

- The 4 hour emergency access target which achieved 90.5% against a standard of 95%
- MRSA bacteraemia, 1 recorded cases against a zero standard
- Clostridium difficile infection rate – 44 recorded cases against a standard of 33

- Admitted patients finishing their pathway – achieved 89.89% by 31st March (full year position)

Delivery of national access standards is shown on the table below:

Standard	Performance
Urgent Care Access – 4 hour standard >95%	90.5%
Referral to Treatment (18 weeks) >92% pathways <18 weeks Zero patients >52 weeks	89.8% 3
Cancer Access 62 days > 85%	85.07% (Recovered from non-compliance in Q2 to full year compliance)
Diagnostic waits <1% greater than 6 weeks	**0.2%**
Cancelled operations 0 patients rebooked not rebooked within 28 days Urgent operations not cancelled twice	 **0** **0**

Operational performance of the organisation is managed through the 'Performance Management Framework'. Each clinical division has reported 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.

5.4. 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.

April 2016
The Aylesbury Adult Community Healthcare Team (ACHT) were runners up in the Buckinghamshire County Council's dignity and respect awards 2016.

April 2016
The Trust's National Spinal Injuries Centre (NSIC) won the 2016 Inter Spinal Unit Games.

May 2016
Maternity care assistant Julie Holland was presented with the Alison Heffernan Award at the Buckinghamshire's Maternity Services Liaison Committee (MSLC) award ceremony in recognition of her 'tireless' work in improving women's experiences of maternity care at Stoke Mandeville Hospital.

May 2016
Luke Delahunty, NSIC patient education co-ordinator, represented the UK at the Invictus Games in Orlando. Luke competed in two events at the Games finishing in 7th place in the men's hand bike time trial and joint 6th in the men's indoor rowing event.

June 2016
Ghazala Yasin, nurse angiographer, shortlisted for the nursing/allied professional investigator award run by the European Society for Cardiology.

June 2016
Spinal Rehabilitation team, Stoke Mandeville Hospital won Oxford Brookes University's 'physiotherapy placement of the year award' 2016.

June 2016

Frances Kent, Clinical Nurse Specialist Lead- Community Equipment Service, and Maye Parr, district nurse, both received Queen's Nurse awards.

October 2016

Cardiology and ophthalmology research teams both won awards at the Thames Valley Health Research Awards. The cardiology team received the award for "all-round high performing team" and the ophthalmology research team were awarded with the 'best green shoots development'.

November 2016

The Trust was shortlisted for 'most effective adoption and diffusion of best practice award' at the Health Service Journal awards in London.

March 2017

Karon Hart, health and wellbeing and occupational health manager, was shortlisted for the 'inspirational leader' award at the Thames Valley Wessex Leadership Academy (TVWLA) recognition awards.

March 2017

Consultant paediatric ophthalmologist Larry Benjamin was shortlisted for his work over 13 years with global blindness prevention charity Orbis to win a coveted humanitarian award at the Bond International Development Awards 2017.

March 2017

The communications team were shortlisted for the Association for Healthcare Communications and Marketing 'best internal communication award'.

March 2017

Dr Justin Mandeville, Consultant Intensivist and College Tutor for Critical Care, Dr Carl Morris, Consultant Anaesthetist and College Tutor and Dr Matthew Size Consultant Anaesthetist and College Tutor won the Royal College Of Anaesthetists 25th Anniversary Trainer Award.

March 2017

Thame day hospital was shortlisted for the 2017 Buckinghamshire County Council's dignity and respect awards.

6. Our staff

The Trust is one of the largest employers in the county with a staff headcount of just under 6,000 people. During 2016/17, our numbers of directly employed staff fluctuated between a low of 5008 (full time equivalents (FTE)) at 31 July 2016 to a high of 5122 (FTE) at 31 March 2017.

6.1. Recruitment and retention

We are committed to recruiting and retaining the highest calibre of staff in all areas. At the end of the financial year, the numbers of staff employed were the highest during the year. This reflects a strong focus on recruitment – just over 1,000 staff (excluding junior doctors on rotation) joined the organisation in 2016/17. However, during the year, we have faced challenges in retention of staff, particularly in nursing - the annual rolling turnover figure stood at 14.0% in March 2017; the average rate during the year was 14.5%, above the Trust target level for the year of 12%.

Maintaining levels of high quality, registered nursing staff was a particular priority during the year. As at 31 March 2017, our nurse vacancy rate stood at 16.2% and there were 1700 registered nurses in post. The vacancy figure reflects our retention challenges, which are seen across much of the country; the Human Resources team led the Trust's work to address these challenges through a task and finish group approach. We have seen some successes, for example providing staff with access to individual careers and education advice. The recruitment market for UK qualified nurses remained highly competitive, as demand from NHS organisations out-stripped supply; in addition, changes to the language requirements for overseas nurses introduce in January 2016, impacted during the latter half of the year on supply and registration times. Following the Brexit vote in June 2016, we have actively engaged with our EU staff to emphasise to them the value we place on their contribution to providing safe and compassionate care to our patients.

Looking forward to 2017/18, there are further changes that will impact on nursing supply:

- From September 2017, the funding of nursing, midwifery and allied health professional degrees will be through the student loan system
- The planned introduction of nurse apprenticeships, following the introduction of the apprenticeship levy in April 2017
- The piloting of a new role, the Nurse Associate role. This role, which will be regulated by the Nursing & Midwifery Council (NMC), aims to bridge the gap between healthcare assistants, who have a care certificate, and graduate registered nurses.

We will therefore continue to use a variety of recruitment strategies to supply the Trust with high quality nursing staff, including continued recruitment from within and outside the UK, reviewing the skill mix of staff, training and deploying new roles (such as nursing associates and other support roles) and developing the skills of all staff (through apprenticeships where possible and appropriate) to work at the maximum of their roles.

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

6.1.1. Equal Opportunities

The Trust values difference, and recognises the value that people from different backgrounds, with different skills and experiences bring to the workforce across our organisation. Having a diverse workforce means improved opportunities for cultural awareness, sensitivity and understanding which are of benefit to patients in the delivery of care.

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.

We publish details of the demographic profile of our workforce annually as part of our Public Sector Equality Duty monitoring; through this analysis we can compare and monitor our workforce with the demographics of our local community in Buckinghamshire. This helps us to identify any under or over representation and ensure that we are meeting our obligations as set out in law and best practice.

In 2017-18, we will publish information relating to the gender pay gap, as is now required. We will also ensure that we are prepared for the introduction of the Workforce Disability Equality Standard, which will be mandated via the NHS Standard Contract in England from April 2018.

6.2. Temporary Staffing

Managing usage and spend on agency staffing has been a priority for the organisation. During the year there were further changes to the management of temporary staffing across the NHS, driven by nationally imposed rules and caps from NHS Improvement. We have had considerable success in meeting these requirements and have led the way regionally in our management of agencies. In particular we have:

- Reduced total spend on agency staffing by circa £6million from 2015-16 to a level of £11.8m, below the ceiling of £12.1m spend set by NHS Improvement;
- Maintained our stance of only using framework agencies for nursing staffing and met the price cap and wage cap rules in all but the most specialist and hard to fill areas;
- Not used any agency healthcare assistant staff since November 2016.

Looking forward to 2017/18, we will change our provider of managed temporary staffing for our non-medical staff; following our usual tender processes, NHS Professionals (NHSP) will take over from Bank Partners as our partner from 1 May 2017. We believe that this new contract will enable us to continue to maintain high quality provision, whilst continuing to drive efficiencies, both within our own Trust and also across our STP.

6.3. Employee benefits highlights

The Trust continues to provide a range of employee benefits. These include salary sacrifice schemes for staff including childcare vouchers, for bike purchases as part of a cycle to work scheme and a lease-car scheme. The first two schemes remain unchanged for 2017/18, with the Trust lease car scheme changing to reflect changes in HMRC rules, which see only low emission cars now falling in scope.

A healthy lifestyle is crucial to our sense of wellbeing and the Health and Wellbeing service has continued to support our staff lead healthier, more balanced lives. Our healthier lifestyles team provides general wellbeing advice and specific interventions delivered by appropriately trained practitioners. Staff can access these services from the Healthier Lifestyles Hub at Stoke Mandeville or via the outreach services across all other acute and community hospitals. Services include support and advice on physical

activity, alcohol management, weight management and healthy eating and psychological services.

The staff benefits pages on the intranet provide a wide range 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.

6.4. 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 Education, Learning and Development team (which incorporates the management of the medical education team) works in close collaboration with the Health Education England - Thames Valley who provide the majority of funding for our educational activity.

The Trust's approach to the development of our people in 2016/17 was focused around five themes:

- Inter-professional Leadership and Management
- Post qualification Education including Medical Education
- Pre-qualification Education
- Vocational Learning – staff in Agenda for Change Bands 1 - 4
- Foundations for Education, Learning and Development

In 2016/17, 4969 staff members participated in educational activities managed by the Education, Learning and Development Team.

Our approach is increasingly inter-professional. A key part of this is simulation activity, which has grown significantly over the past 2 years. We have a dedicated Clinical Skills Suite at Wycombe Hospital and a high fidelity simulation suite at Stoke Mandeville Hospital.

Our approach to learning and development has been recognised by HEE-TV. The outcome of a visit by their senior leadership team in February 2017 was a conclusion that "the Trust is clearly committed to its learners and its learning environment".
In 2017/18, there will be significant changes to the funding of education across the Trust and the NHS more widely following the introduction of the apprenticeship levy in April 2017. Apprenticeship standards continue to be developed; as they are approved, we will work closely with local higher education institutes, other local Trusts and the Health Education England Thames Valley (HEE-TV) to deliver education through these.

6.4.1. Trust Library

Our Library Services continue to deliver new and innovative enhancements to improve their existing services. Following a peer-review of our Library Quality Assurance Framework (LQAF) submission, our compliance score was revised upwards from 94% to 98%. The overall score places the Trust library service among some of the top performing NHS library services nationally. Compliance with the metric, demonstrating the positive impact of library services, was improved following the submission of supporting evidence.

The library has reviewed and improved the range of electronic resources on offer: Clinical evidence can be accessed via an App on mobile devices; new online exam revision tools have been made available to junior doctors to aid in exam preparation and on-line journal resources have been improved for nursing staff.

We have the highest proportion of trust staff NHS Athens holders at 34% compared to the regional average of 22%. (NHS Athens is a system which provides access to a range of academic and healthcare journals and resources.)

6.4.2. Leadership and Management

Increasing the skills and competences of our leaders has been a key part of the Trust's Organisational Development Plan for the past two financial years. During 2016/17, we continue to roll out our bespoke inter-professional Leadership Pathway, with c120 senior managers, a third of whom are Consultants participating. Our coaching programme for middle managers, "Coaching to Promote Positive Behaviours" has been rolled out to c 200 band 6 and 7 employees. Bite-size Leadership and Management Modules are available for employees including junior doctors seeking development within specific areas.

6.4.3. Lessons Learnt Feedback Sessions

The 2016/17 Lessons Learnt sessions (open to all staff) have been held across the 3 hospital sites; 440 people have attended and the sessions are then available on the Trust intranet. 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.

6.4.4. Medical Education

We continue to provide wide-ranging support to our medical education leads to ensure they provide the best education to our junior doctors. Highlights for 2016/17 include:

- Excellence Grading: Anaesthetics and Radiology were graded 'excellent' as a learning environment by HEE-TV for 2016-17. It is the second year in the row for both of them with anaesthetics being the only training centre in the region graded excellent
- Orthopaedic Away Day: A multidisciplinary away day was held at the Clare foundation on 17 November for all orthopaedic staff (including physiotherapists and nursing staff). Over 60 staff and trainees attended. The event aimed to build links between different grades and disciplines, encouraging team-work through quality improvement projects
- A number of training days have been run this year for the trust educators including sessions for the Trusts Foundation Training Programme Directors and a SAS doctor's educational day
- National Roles: Our Medical Education Manager has been selected to sit on the council of 'National Association of Medical Education Management and our Director of Medical Education sits on the council of NACT UK representing all DME's in Thames Valley

6.4.5. Preceptorship & clinical skills training

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.

6.4.6. 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.

In September, 24 members of staff commenced the Foundation Degree programme for clinical staff; this is the highest number the Trust has ever supported and will have a beneficial impact on clinical environments as these students develop their clinical skills and knowledge in the workplace.

In October, the Trust held its first vocational staff conference which was aimed at all staff in bands 1-4 from all clinical disciplines. The Chief Nurse opened the conference and Non-Executive Director Professor Mary Lovegrove gave the keynote speech. The event was well attended and the feedback was very positive.

In 2016/17, we supported 94 healthcare assistants in studying a level 3 healthcare support worker apprenticeship; in 2017/18 we expect to support even more staff as we expand the programme to all new recruits to clinical posts, which will be funded through the newly introduced apprenticeship levy.

6.4.7. Nursing Associates

The Trust was successful in a HEE-TV-wide bid to secure trainee nursing associates as part of the national pilot study. The Trust has been confirmed as a 'Fast Follower' and has 10 places on the programme which will commence in April 2017.

Nursing associates will bridge the gap between health and care support workers - who have a care certificate - and graduate registered nurses and the role opens up greater opportunities for health care assistants to transition into nursing roles. A draft curriculum, assessment criteria and trainee job descriptions have now been published and work has commenced on framework matching and post qualifying job description.

6.4.8. Statutory Training

At the end of the financial year, statutory training levels were at 83%, against an overall Trust target of 90%. In order to meet this challenging target set by the Trust - operational managers and the HR Team have worked collaboratively - 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.

6.5. Values Roll Out

During the year, we have focussed on embedding the Trust CARE 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 in 2015/16 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. During 2016/17 we have embedded the CARE behaviours across the Trust with a particular focus on:

- Embedding behaviours in core HR process and practices (i.e. appraisal and recruitment process) and existing training provision
- Bringing the behaviours to life for employees within BHT (including creating an online presence on Swan Live with toolkits, creating pocket guides)

6.6. National staff survey 2016

The 14th annual staff survey was conducted between October and December 2016. All staff within the trust were invited to participate in the paper survey, 2997 surveys were returned representing a 53% response rate compared with 52% in 2015. The national average response rate for combined acute and community trusts was 42%.

The Staff Survey comprises 32 key findings which are summary scores for groups of questions which, when taken together, give more information about each area covering 9 themes such as appraisal and support for development, working patterns, managers, errors and incidents and patient care and experience.

The trust recorded 12 statistically significant improvements and no deteriorations when compared with our 2015 staff survey results. Two of the key findings recorded statistically significant improvements for the second year in a row; KF31 Staff confidence and security in reporting unsafe clinical practice and KF1 Staff recommendation of the organisation as a place to work or receive treatment – both of these areas were priorities for the trust.

We made improvements in our rankings and are now ranked average and have 4 more key findings ranked as better than average than in 2015.

No. of key findings (32)	Worse than average	Average	Better than average
2016	7	18	7
2015	11	18	3

These results are very encouraging and demonstrate a commitment and focus on delivering our strategic people priorities. It demonstrates that our approach to driving improvements by identifying 5 or 6 key areas of focus as organisational priorities, and supporting the divisions to deliver improvements at a local level is having a positive impact.

The trust's overall staff engagement score was up slightly on 2015 from 3.76 to 3.78 on a scale of 1-5 but we fell just short of the national average of 3.80 – however, a number of departments within the organisation recorded engagement scores above the national average. Our trajectory is improving at pace faster than national average.

6.7. 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.

6.8. Communications and provision of information to employees

During 2016/17, the Chief Executive has continued to promote and embed the BHT way, which underpins the relationship with our staff. A regular forum headed up by the Chief Executive and Board colleagues is in place for 500 leaders across the Trust. This forum is used to develop and shape strategy. Other 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.

In March 2017, these leaders were invited to the Trust's first leadership conference. The aim was to further inform and engage leaders of the Trust's strategy and plans going forward. The half day conference also gave leaders the opportunity to network with colleagues and discuss ways to enable change.

6.9. Whistleblowing and raising concerns

Raising concerns was again a priority for the organisation in 2016/17 and we were pleased with the progress we made again this year. Raising concerns about unsafe clinical practice was a statistically significant improvement in our staff survey results for the second year in a row and demonstrates the focus the organisation has given to this important piece of work. As it was an organisational priority, all of the divisions put plans in place to address this issue. Trust wide actions included:

- setting up a page on our intranet dedicated to raising concerns
- a monthly item in the staff bulletin throughout the year.
- a workshop in August 2016, attended by a range of staff including senior managers the October lessons learnt session covering raising concerns

We have continued with our speak out safely and listening service telephone lines, we have re-written our raising concerns policy and procedure which is currently being ratified and we have appointed a full time Freedom to Speak Up Guardian who takes up post in May 2017.

6.10. 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 13th 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.

6.11. Occupational health, Staff Wellbeing and Healthier Lifestyles Services

We have had an active year in the Staff Wellbeing and Healthier lifestyles team, as is reflected in our accompanying CQUIN action plan. Our staff survey results show a 5% increase in staff reporting the organisation takes positive action on wellbeing, this is reflective of not only the work that has been done, but also the proactive stance BHT takes on staff wellbeing, which is well supported by the Executive team, as part of a holistic whole system approach.

Staff Survey results in relation to wellbeing CQUIN

Question	2016	2015
9a. % saying their organisation definitely takes positive action on health and well-being	38%	33%
9b. % saying they have experienced musculoskeletal problems (MSK) in the last 12 months as a result of work activities	24%	25%
9c. % saying they have felt unwell in the last 12 months as a result of work related stress	32%	35%

6.11.1. Psychological Health Interventions

Fast-track Counselling Service

There were 753 referrals to the staff counselling service in 2016/17. We delivered 1326 appointments and feedback from staff using the counselling service resulted in 100% satisfaction rate. This service helps prevent people going off work and helps staff who are unwell return to work.

Other Staff Wellbeing Activity for Psychological Wellbeing

Alongside the counselling service we have also run other interventions to complement psychological wellbeing support, as appropriate for different levels of need and working in collaboration with our Resilience Programme and Sickness absence case management approach

Team Resilience/ managing change initiatives

A total of 429 staff have benefitted from team resilience training this year

We offer 2 modules. The first, called Understanding Stress, Building Resilience (USBR) lasts for up to 90 minutes and provides both an introduction to what stress is (and is not) and hints and tips on ways to build personal resilience. It also provides a consistent language which fosters better discussion, improves confidence in talking about issues and problems and understanding.

Once USBR has been completed we offer a second module. This introduces a concept called If/Then Planning as a way of improving both team and individual resilience in response to future stressful events. Typically this also takes about 90 minutes to deliver. In both cases participation discussion is encouraged.

These are designed to fit readily into existing team meetings or audit half days. Over the last year we have also adapted our approach to resilience to the facilitation of parts of, or whole, team away days and other staff events. We are also invited to undertake further bespoke work with teams in aspects of future planning.

At a corporate level we are increasingly asked to contribute our expertise to the successful implementation of change. We attend the opening of formal consultations and are available, both in follow up group meetings and/or one-to-one drop in sessions, to support affected staff at regular intervals throughout the consultation process. We do

not get involved in the technicalities of proposed changes. We do support staff to make the best of their own contribution. We help them handle personal stress as effectively as possible.

Team Resilience		Good OR Very Good
Rating feedback following training		8 out of 10

Training with psychological Self-care/ Stress management component for managers

Band 6 & 7 - Coaching to Promote Positive Behaviours

We have now had a total of 274 Band 6/7 managers complete the Coaching to promote positive manager behaviour course.

A 2 day course, of which day one run by Education and learning dept. introduces the coaching way of managing staff and day 2 run by the Staff wellbeing service and covers mental health training, how to look after your psychological wellbeing and that of your staff and promotes specific management competencies that support good working relationships and reduce the risk of stress.

Band 5 Emerging Leaders

This is a new one day course for Band 5 staff, targeting those with line management responsibilities and has been developed on the back of the success of the Band 6/7 course as this allows for a continuity of messages across the Trust to support staff both personally and in the management of their own staff. It introduces some of the key concepts used in the two day Band 6/7 programme, adjusted as appropriate for duration and also the banding of attendees. ELD deliver the morning session and HLS the afternoon.

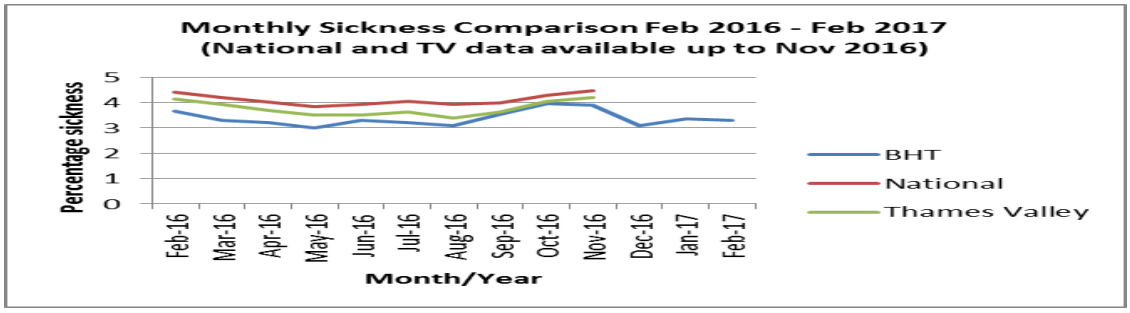
Introducing Mindfulness

In response to the national CQUIN to support staff health & wellbeing, the Healthier Lifestyles Department arranged a full day of Mindfulness training. We have created a staff webpage about Mindfulness including links to an audio practice and where to find a registered teacher. The link is in our Healthy Lifestyles section and can also be accessed via the Library's own webpage.

6.11.2. Sickness Absence Case Management Interventions

We have dedicated sickness absence case managers within the wellbeing team that support both the staff member and managers in the proactive management of sickness. In collaboration with HR and Occupational Health input, this has contributed to BHT consistently reporting sickness below both the national and local trends.
They are proactive in making referrals/ signposting to appropriate wellbeing interventions.

2016/17 - Trust Sickness Absence										
Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
3.1%	3.0%	3.2%	3.1%	3.1%	3.5%	3.9%	3.9%	3.1%	3.3%	3.3%



6.11.3. Retention focus

In a recent new initiative, exit Interviews are currently being prioritised by the case managers. As a result a new process is being implemented to identify leavers at the earliest moment, with the intention of increasing retention of staff and understanding themes which we can address.

6.11.4. Physical Health

Referrals to fast-track Physio Service

We have a fast track physio service in place that is triaged through our Occupational Health and Wellbeing Service and provided by our in house physiotherapy team. 239 staff have been referred in 16/17.

We also provide information and reduced cost activities and interventions to support physical health through building relationships with local gyms and collaboration with Adult Learning Bucks, who provide onsite taster sessions. We have established links with our local university that provides a gym along with sports therapy and massage services for our staff at a reduced rate.

Healthier Lifestyles Service

The Trust Healthier Lifestyles Service is available to patients, visitors and staff, it offers advice. Support and where appropriate onward specialist referral in regard to the main lifestyle issues, namely, smoking cessation, alcohol reduction, weight management and physical activity. It also encompasses the 5 ways to wellbeing activity, a national initiative to support general wellbeing.

We offer bespoke services for staff including wellbeing days, events, talks (e.g. managing the menopause, men's health) an on-site smoking cessation clinic, on-site NHS Health Checks and a twelve week weight loss challenge.

Staff Referrals (NB reduction in activity due to reduced resources as member of staff on maternity leave)

	Q1 (Apr, May, Jun)	Q2 (Jul, Aug, Sep)	Q3 (Oct, Nov, Dec)	Q4 (Jan, Feb, Mar)	Cumulative Total
The number of referrals made to the Healthier Lifestyles Team	83	28	20	22	153
Sources of above referrals	80 self 3 formal	28 self 0 formal	20 self 0 formal	13 self 11 Formal	141 self 14 formal

Primary Reason for Referral

	Q1 (Apr, May, Jun)	Q2 (Jul, Aug, Sep)	Q3 (Oct, Nov, Dec)	Q4 (Jan, Feb, Mar)	Cumulative Total
Smoking	1	1	0	0	2
Alcohol	0	0	0	0	0
Physical Activity	1	2	0	1	4
Weight	86	27	20	9	142
TOTAL	88	30	20	10	148

N.B.The data above only reflects staff referrals which is 18% of the total activity in the HLS service

Training / Events (numbers attended)

12 Week Weight Loss Challenge	**Q1 & Q2 (Apr to Sep)**	**Q3 (Oct, Nov, Dec)**	**Q4 (Jan, Feb, Mar)**	**Cumulative Total**
Number of staff signed up	66	17	46	129

Of the 129 staff who have signed up to the 12 week weight loss challenge programme, there were positive results, with 34% losing 5% of their bodyweight.
Teams are encouraged to meet on a weekly basis for an informal 'weigh in' and presented with a certificate if they attend all 12 weeks.

	Q1 (Apr, May, Jun)	Q2 (Jul, Aug, Sep)	Q3 (Oct, Nov, Dec)	Q4 (Jan, Feb, Mar)	Cumulative Total
Induction training on Brief Intervention and Self care	92	101	107	100	400
NHS Health Checks	25	15	32	23	95
Self-Care Course	15	13	8	3	39

All new Nurse and HCA starters to the Trust have an introduction to basic Healthier Lifestyles Brief Intervention messages and Make Every Contact Count. Evaluation of this training has been good.

Nurse Induction	Evaluation
Excellent	75 out of 157
Good	69 out of 157
Other	11 out of 157

HCA Induction	Evaluation
Excellent	53 out of 124
Good	50 out of 124
Other	15 out of 124

Self-Care	Evaluation
Excellent	23 out of 39
Good	15 out of 39
Average	1 out of 39

HLS will be rolling out the MECC presentation and Lifestyle skills to staff groups such as Pre-op assessment and outpatients with a view to enabling all staff to be able to have Brief conversation with patients about lifestyle issues and making changes, alongside thinking about making positive changes for themselves and becoming a role model/ advocate to others.

A MECC e learning package is available on NLMS, and we are liaising with ELD with a view to making this mandatory, again working towards meeting the CQUIN for training (indicator 9b)

Healthier Lifestyles Service End of year Dashboard 2016/17

Patient Referrals

	Q1 (Apr, May, Jun)	Q2 (Jul, Aug, Sep)	Q3 (Oct, Nov, Dec)	Q4 (Jan, Feb, Mar)	Cumulative Total
The number of referrals (Patients)	223	178	192	173	766
Sources of above referrals (Patients)	184 ECOF 39 Other	166 ECOF 12 Other	177 ECOF 15 Other	170 ECOF 11 Other	697 ECOF 77 OTHER

HLS has developed a digital referral system on Evolve, for clinicians (eCOF) to refer outpatients to Healthier Lifestyles Services as an outcome of their Outpatient appointment.

Following referral, patients are then triaged and signposted to relevant services either within BHT or in the wider community. To our knowledge, BHT is the first to offer such a service.
Lifestyle assessment data capture and feedback forms are being developed in conjunction with the Evolve Team, and will work towards fulfilling the CQUIN requirement for enabling digital data and audit of patient lifestyle status. (indicator 9a)

6.11.5. STP – Workforce Wellbeing within the Prevention work stream.

The BHT Head of Staff Wellbeing and Healthier Lifestyles Services represent BHT on the prevention work stream of the BOB STP. (including the obesity task and finish group) They are also the SRO for Workforce Wellbeing for BOB, working across the footprint with NHS providers, CCG's, Country Councils, Oxfordshire Academic Health Science Network, other key providers and stakeholders and local businesses e.g. Johnson and Johnson and Vodaphone.
The intention is to build upon the success and learning from this year's CQUIN to inform implementation of next 2 year Health and Wellbeing CQUIn, alongside STP priorities

7. How we have been engaging and involving our patients and carers 16/17

Our aim is to deliver patient centred change which further strengthens our quality of care and we remain committed to keep the patient perspective at the heart of what we do.

We have continued to regularly engage or involve our patients and carers on a variety of different subjects and in different ways. The following provides a range of examples which we hope demonstrate meaningful engagement and involvement as part of our improvement processes. Of these, our more major pieces of work are linked to our transformational projects as explained below. Some of our significant patient engagement and involvement activity has centred on our transformation work this year with large projects such as:

- Community Hubs and moving care closer to home.
- Musculokeletal services.
- Hearing the voice of younger people.

7.1. Community Hubs and moving care closer to home.

As a significant programme of transformation, we undertook early countywide engagement sessions throughout April and May of last year, called 'Your community, your care'. With just under 200 people attending 6 sessions and just under 300 people making contact, there was a positive level of interest. We also invited an extensive list of stakeholders and partners to send representation to the sessions including GPs.

At these sessions we asked local people across the communities what they thought a community hub might look like, which services they felt they didn't need to come to a hospital site for and their priorities. Reports for each of these sessions were fed back and verified by participants. Along with the final overview paper for our Trust Board, these are available on our website.

Themes from feedback from participants have fed into the decision making processes and are reflected in the actions below, shaped by what we heard. The result is genuine patient centred change in the launch of our new community hubs at Marlow and Thame Hospitals from April 2017, bringing community health services together. Some examples of what will be delivered in our first two pilot hubs shaped from what we heard include,

- local access to a range of prevention services
- primary care services and hospital services such as outpatient appointments
- the introduction of new services e.g. wound care or diagnostic testing
- the introduction of a voluntary sector presence We are pleased to be currently working with Prevention Matters, Carers Bucks and the Citizen Advice Bureau to offer a range of advice, support and signposting services in the first step of creating a single point of access to health and care services for the public.
- Carers Bucks will help carers access additional support such as benefits, advice, practical and emotional learning, and emergency planning.
- Prevention Matters will support people to regain confidence and independence by finding suitable social activities and community services in their area.
- Citizen Advice Bureau will offer a range of help support and advice on a wide range of topics helping to provide person centred advice.

7.2. Musculokeletal services.

We invited more than 300 recent service users, patients and their carers to attend an engagement event early this year. With 20 people attending all of whom had recent experience of the service either as a patient or a carer, we sought feedback on a range

of possible improvement ideas created jointly, working in collaboration with clinicians, our CCG colleagues and our partner providers. These ideas were in response to previous feedback from patients and a need to create a more integrated service and seamless experience. Our aim was to seek feedback from service users on some suggested solutions to increase speed of access for patients, improve information, see a senior clinical professional earlier in the process and have appropriate treatment or advice options earlier.

Largely, the ideas were well thought of with strong support from participants for better integration of services and a faster more direct route to seeing a senior clinician early on in the process. The idea of a care navigator and a single point of access were also well supported as was the concept, if achievable later, of moving to a self-referral system.

The introduction of a green card system was well supported by those who have need of intermittent treatment i.e. those with a chronic condition and who need fast access to treatment when suffering an acute flare up. E.g. inflammatory joint conditions.

There were some concerns about information giving and patients suggested more thinking about web and portal based access for information and website development would be helpful.

One person fed back following our event….:-

"I would like to thank you for the service you provide and that you are keen to keep patients in loop with changes. I hope the discussion was useful. If there are more events like this I would be open to come. I highly value the NHS and the people that make it run, even under increasing pressure."

7.3. Hearing the voice of younger people.

There has been a strong focus this year on strengthening how we hear the voice of the younger person directly, i.e. not the parent. Progress in this area has resulted in learning from direct engagement with more than 270 young people, providing feedback on our school nursing service. This was a really positive response.

We wanted to learn about how aware young people in primary schools are about the school nursing role and what support they can provide, how they can be contacted, how easy are they to contact and we wanted to identify any gaps in knowledge and understanding about this.

Our learning is that this sample of young people valued the school nurse as someone safe they could speak to and knew they could help with "staying safe".

Those that had contacted their school nurse found them to be helpful (92% of responders to this question).

The majority of the sample knew that there is a school nurse but only half of the sample knew how to contact them.

These findings have influenced actions to prioritise workstreams already mobilised to help address this and the service lead is planning to repeat this exercise next year. Undertaking this type of engagement will also have helped to raise awareness within this sample of children and young people.

Similar work was undertaken with young people who have seen our community physiotherapists and occupational therapists but only achieved a total of 27 responses. The low level of response needs to be taken into account when interpreting results. However, results are positive and show that our Physio and OT services, like our school nurses are highly valued by this patient group with just over 80% knowing who their therapist is and around 90% confirming their input as helpful.

As part of an increased focus on how we hear the young person's voice we have also designed a mobile and clinic token system which will be implemented across our community children's and young people services. Our paediatric services in our acute and community setting have examples of implementing "15 steps" part of a national tool. Work and focus continues on hearing the voice of younger people.

7.4. Other key pieces of engagement and involvement work.

In addition to these larger pieces of work, a range of ongoing engagement and involvement activity has continued over the year, often initiated by our innovative and committed staff or teams who want to make their services even better, basing improvements on patient feedback.

Our lead Gastroenterologist consultant took action based on feedback following a visit to our patient experience group (PEG) which resulted in the creation of two very helpful short information films for patients about to have a procedure. The consultant was keen to ask for views on how we could improve pre-operative advice for gastroscopies and colonoscopies with a view to reducing anxiety about these procedures for patients in future and providing information patients can reference and review at their own pace and in their own time as frequently as they wish. These high quality films have been very well received and welcomed by patients and the PEG, one of whom took an active and participative role in the making of the film. PEG has received a presentation of the films and feedback on how their suggestions shaped the format and the content. This is a great example of patients as change agents and meaningful involvement.

The films demonstrate the environment and what the procedure would involve. The films can be viewed at home and will also be helpful for people who find visual information more helpful, who may need reinforcement of information given in clinic and those with a learning disability. This is an excellent example of patient feedback resulting in patients being involved as change agents in the development process, based on their personal experiences. This is about patients communicating to patients, offering reassurance based on their lived experiences. The films will have captions for those who are hard of hearing and we hope translations will be available too.

Other examples includes recruiting and training patients who want to undertake patient led assessments of our care environment (PLACE) which is part of a national programme, patient views and feedback at PLACE assessments not only benchmarks us nationally against other Trusts but also helps to shape improvements to the environment and facilities locally and helps us to prioritise estates work. We have also involved patients in a service evaluation for support to lymphoma patients, we have taken part in the patient leaders programme and raised awareness of our interpretation and translation services with more than 200 people/patients and carers as part of a pilot project and we have sought the views of patients and visitors as well as staff about social and café facilities in the NSIC – our spinal centre.

7.5. Engagement with other stakeholders

This year we have been working in collaboration with Fedbucks, our primary care partners, to initiate an annual programme of GP and Consultant engagement sessions to help facilitate clinical conversations between healthcare professionals in the interests of patient care.

PEG- Patient Experience Group continues in strength and continues to add real value as shown in the above. Patient representatives of a range of local groups provide invaluable review of all our new patient information leaflets and a range of other input. They help to shape those policies and strategies brought to them by our leads and clinicians. Two recent examples include our new Trust wide food and drink strategy and our chaperone policy. PEG continues to provide an important two way dialogue with various patient groups.

We continue to meet and work with Healthwatch in a variety of ways and continue to have regular and helpful meetings between the Chief Executives and Chairs of both organisations.

8. 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

9. 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.

10. 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.

Throughout 2016/17, we have continued our work to embed equality and diversity as core to everything we do, central to the successful delivery of quality for patients and staff. Key activities from 2016-17 are:

Membership of the NHS Employers Partners programme; this year long programme has enabled us to share best practice and attending events with leaders in the field. We have attended five workshops, which have covered the Workforce Race Equality Scheme, the Workforce Disability Scheme, the forthcoming Sexual Orientation recording requirements and the Gender Pay Gap. Representatives from the Trust also attended NHS Employers annual diversity conference in September 2016.

The Trust's first one day equality conference "Personal, Fair and Diverse services"; this conference took place in June 2016 and was chaired by the Trust Chair, with NHS Employers head of equality, diversity and human rights as guest speaker, and a local public health specialist. Evaluation was very positive. Linked to this, we ran our first staff equality Personal Fair and Diverse awards which highlighted some excellent examples of personalised care. These examples also highlighted the positive impact on the experience of patients resulting from taking difference into account.

We have also continued to prioritise our compliance with our legal duties and responsibilities.

The Public Sector Equality Duty (PSED),
A duty placed on all NHS Trusts which provides a legal framework to protect 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. In accordance with the duty, we publish our equality information annually on our public website. We continue to develop our publication which spans thirteen different sections.

Progress against the Trust Equality Objectives and EDS 2
Highlights for 2016-17 include:

- Increase use of British Sign Language (BSL) interpreters across the Trust.
  Increase achieved. Initiatives which have helped to raise awareness such as the Accessible Information Standard and raising awareness through PALS and complaints training have contributed to this very positive increase and are ongoing.

  However, a staff member initiated a pilot in November-December 2016 to raise awareness of interpretation and translation services and importantly, to test a new method to do that. We worked in partnership with Sodexho who kindly sponsored the pilot costs and enabled us to seek feedback via a short survey and poll in the main restaurant at Stoke Mandeville.
  The "coffee sleeve" project was a significant piece of work that shows great results with a demonstrable impact.

  - **260** people (both staff and patients) participated in just two half day sessions
  - **77%** of people who filled in the survey liked the idea
  - **62%** saying they would use a cup sleeve when purchasing a hot drink
  - In addition to the survey, we also ran a quick straw poll of all those people we saw buying a hot drink. We asked if people thought that promotion using coffee

sleeves was a good idea or not? We managed to ask 207 patients, visitors and staff at the same time and 181 (87%) said they would like to see the Trust using the cup sleeve to promote specific messages or services but also highlighted colourful posters in high footfall areas, a patient information leaflet and more eye catching and colourful materials would also be helpful.

Overall our figures are showing useage for interpretation and translation to have increased by 56% over the past year with just under 2,500 requests.
Most relevant to this objective, the use of BSL has also significantly increased by 148% from 65 requests in 2015/2016 to 161 in 2016/2017.

A clear breakdown of useage of these services is published under our PSED publication.

This demonstrates the need and also suggests improved patient experience and safety.

- Raising awareness of PALS and Complaints with a view to seeing improved diversity in complainants

The annual survey has been repeated and we can see already the response rate is better. However, analysis of the results is still being collated and will be published as part of our PSED.

<u>Inclusive leadership</u>
Increasing the skills and competences of our leaders is a key element of the Trust's Organisational Development Plan. During the year, a multi-professional leadership pathway was rolled out to more than 120 senior managers, including Consultants. We also rolled out a coaching programme, "Coaching to Promote Positive Behaviours Programme" to some 200 band 6 and 7 employees. Access to these programmes is reflective of the diversity of the organisation.

<u>Accessible Information Standard (AIS)</u>
Significant progress continues with an established Trust steering group, which is chaired by the Director of HR & OD, executive lead for Equality & Diversity.
Over the past year we have implemented :

- Mandatory training for AIS for all staff
- AIS awareness into our corporate induction for all new starters which includes a short film.
- It is included in our pay-day training.
- A communication need alert
- Reminders to staff to ask the question "Do you have a communication need?"
- We have cascaded information to raise awareness to over 50 different routes across the Trust and this continues to grow.
- We have completed a pilot in our Out-Patients Department at Stoke Mandeville which has been informed by staff and patient feedback and this will now be rolled out across all other OPD sites.
- Resulting from this work we have designed a Trust wide patient friendly poster to identify common communication needs by symbol to encourage patients to tell us if they have a communication need and need help whilst in our care
- Our useage of BSL and translation services has significantly increased see equality objective results above
- Poster information is up on our screens in patient waiting areas
- A two page quick reference toolkit for staff is about to be disseminated in a supported cascade

- The Trust has committed to implementing a new and improved SMS texting service for patients over the next few months.
- Interpretation and translation services – work is underway to include Makaton as part of our offer
- The Trust has committed to investing in new IT and patient administration processes that will improve accessibility, help with communication needs and significantly improve efficiency

Workforce Race Equality Standard (WRES)

A comprehensive Trust action plan is in place (and published on the Trust website), following up from the issues identified from the WRES reporting for 2015/16. Key elements of the plan are:

- the review of key Trust policies and processes including the appraisal process, the medical error policy, and the dignity & respect at work policy.
- A focus on recruitment , with values based recruitment rolled out during the latter half of the year
- Career support for existing staff

Full outcomes for 2016/17 will be reported to the Board and published on the Trust website later in the year. However, the metrics reported as part of the Trust's national NHS Staff Survey have shown some improvements, notably Key Finding 21 of the survey, the "percentage of BME staff believing that the organisation provides equal opportunities for career progression or promotion", which has increased from 70% in 2015 to 81% in 2016 (ranking the Trust as "better than average"). The Trust also ranks better than average for question 17b of the survey, where 12% of BME staff state that in the last 12 months they have personally experienced discrimination at work from managers/team leaders or other colleagues. Whilst both these results are encouraging, there are still differences in the findings for BME and white staff, which we will continue to work to address.

Looking forward to 2017/18, there are two new requirements

Public sector employers are required to report by March 2018 on the difference in mean and median pay of male and female employees expressed as a percentage of men's; there will also be a requirement to report on bonus payments made to men and women. (The gender pay gap reflects the situation that lower paid jobs are more likely to be filled by women. It is not unequal pay, which is paying women and men differently for the same job and is illegal in the UK).

Following the introduction of the Workforce Race Equality Scheme the NHS Equality and Diversity Council (EDC) announced in October 2016 that a Workforce Disability Equality Standard (WDES) will be mandated via the NHS Standard Contract in England from April 2018.

The Sexual Orientation Standard with a focus on including equality monitoring for patients is a new standard and whilst not yet mandatory is recommended as part of demonstrating compliance with the Equality Act (2010) and the EDS2.

11. Our estate and sustainability

The sustainability report is shown in Appendix 4.

12. 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 Chief Operating Officer 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 outcome of the EPRR assurance process graded BHT as 'substantial'.
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 two Major Mass Casualties exercises run by the Trust across Buckinghamshire, jointly run with Milton Keynes; a national Burns exercise; participation in a national major incident table top and a regional Trauma exercise.

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.

The Emergency Preparedness, Resilience and Response team (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, and by the Chief Operating Officer and the regional Health Resilience Partnership.

13. 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 14 of the HSCIC Information Governance Toolkit. The Trust's end of year overall submission for 2016/17 achieved a score of 85% resulting in a 'satisfactory' rating. During 2016/17, 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 2016/2017 there has been two Level 2 serious incident data breaches. Both of these were disclosures of information in error. These breaches were reported to the Information Commissioner via the IG Toolkit and both have been assessed and closed by the Information Commissioner with no further action required.

Both incidents were reported to the Caldicott Guardian and SIRO and were thereby assessed for the level of seriousness. The incidents were then considered by both 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 654 Freedom of Information requests in the period 1 April 2016 to 31 March 2017, 128 more than in the same period the previous financial year, a 25% increase.

Ten requests were referred on to other organisations as information requested was not held by the Trust, and a further five requests were partially answered with advice to refer elsewhere. Five were withdrawn by the requestor and four requests were closed because no response from the requestor was received after four months following a request for clarification. Full exemptions were applied to 50 requests where no information was provided to the requestor and there were 300 other requests where only part of the information was made available due to partial exemption. 78% were responded to within 20 working days. This was an improvement from 62%.

14. Counter Fraud

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

15. 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.

15.1. Directors and the register of interests

The register is maintained by the Director for Governance and reported annually to the Board.

Name	Position	Interests Declared
Dipti Amin	Non-Executive Director	Medical Information and Toxicology Services (non paid Director) Trustee of Faculty of Pharmaceutical Medicine (finished in November 2016) Member of the Innovation Board of the ABPI (finished in December 2016)
Ian Anderson	Director of Human Resources	None
Neil Dardis	Chief Executive Officer	None
Rachel Devonshire	Associate Non-Executive Director	Registered director of Bucks Healthcare Projects Ltd
James Drury	Director of Finance	Registered director of Bucks Healthcare Projects Ltd
Rajiv Jaitly	Non-Executive Director	MHS Homes Ltd, Member of the Finance Risk & Audit Committee (non-executive) ; GFG Ltd, Advisory Board Member;; Jaitly LLP, Managing Partner; East Thames Group Ltd, non-executive director and member of London & Quadrant Group Risk Management and Audit Committee; Heirloom Investment Fund SPC - non-executive director; shares held directly in a number of healthcare and other companies which are not material holdings such as in GSK, Astra Zeneca, Reneuron and Legal & General Board Director of Board Apprentice Global Ltd Board Director and Council Member – Trinity College London
Graeme Johnston	Non-Executive Director	Advisory board member Patient Focussed Medicine Development a global industry not for profit in Pharmaceutical sector (£2000 incl expenses) Member scientific advisory board UCB pharma, a drug company which sells several drugs to the NHS. (£2000) Lay chair of University of Buckingham Medical School Fitness to Practise Committee (£800). UofB may endgame in training with BHT. Attendee at Aylesbury vale CCG (north locality) patient engagement group
Tina Kenny	Medical Director	Visiting Professor, Buckinghamshire New University
Hattie Llewelyn-Davies	Chair	Chair Viridian Housing Group since 2007. Directors' fees payable of £20k per annum. (The Director of NHS Improvement Financial Improvement Programme was Chief Executive of Viridian Housing until 2014.) Owner/Director of consultancy business that does not undertake work with the NHS but may advise organisations that do. Daughter a student with Bucks New University.
Mary Lovegrove	Non-Executive Director	Director of Allied Health Solutions Member of Board of Trustees-British School of Osteopathy Emeritus Professor - London South Bank University Visiting Professor – Singapore Institute of Technology Visiting Professor- Buckinghamshire New University
Neil Macdonald	Chief Operating Officer	Wife managing partner of Marlow Medical Group & chair of FedBucks (Buckinghamshire primary care federation) Registered director of Bucks Healthcare Projects Ltd
Carolyn Morrice	Chief Nurse	None
David Sines	Associate Non-Executive Director	Self-employed consultancy with Health Education England and with Department of Health and various non Buckinghamshire CCGs related to workforce planning and

Name	Position	Interests Declared
		educational development. Trustee of the Burdett Nursing Charitable Trust and Patron if the Learning Disability Choice Support in London Non-Executive Director with Central London Community Health Trust Emeritus Professor - Buckinghamshire New University
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

15.2. 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 2016	April 2016	
Professor Mary Lovegrove	May 2014		April 2016	April 2018
Mr Graeme Johnston	March 2013		March 2017	March 2019
Mr Rajiv Jaitly	June 2015		June 2017	
Ms Dipti Amin	June 2015		June 2017	
Mr David Garmon-Jones	June 2015	February 2017	June 2017	

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

In 2016/17 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 nomination and remuneration committee during 2016/17:

Ms Hattie Llewelyn-Davies (Chair)
Mr Les Broude (until April 2016)
Professor Mary Lovegrove
Mr David Garmon-Jones (until February 2017)
Mr Graeme Johnston
Mr Rajiv Jaitly
Dr Dipti Amin

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

Name and title	Date(s) of Service		2016 - 17				2015 - 16			
			(a)	(b)	(e)	(f)	(a)	(b)	(e)	(f)
			Salary (bands of £5,000)	Expense payments (taxable) to nearest £100*	All pension-related benefits (bands of £2,500)	TOTAL (a to e) (bands of £5,000)	Salary (bands of £5,000)	Expense payments (taxable) to nearest £100*	All pension-related benefits (bands of £2,500)	TOTAL (a to e) (bands of £5,000)
	Appointment	Termination	£000	£	£000	£000	£000	£	£000	£000
Chairman Mrs Hattie Llewelyn-Davies	March 2014		40 - 45			40 - 45	35 - 40			35 - 40
Non-Executive Director Mr Les Broude	May 2007	April 2016	0 - 5			0 - 5	5 - 10			5 - 10
Non-Executive Director Mr Graeme Johnston	March 2013		5 - 10			5 - 10	5 - 10			5 - 10
Non-Executive Director Professor Mary Lovegrove	May 2014		5 - 10			5 - 10	5 - 10			5 - 10
Non-Executive Director Professor David Sines	Mar-12		5 - 10			5 - 10	5 - 10			5 - 10
Non-Executive Director Mr Rajiv Jaitly	June 2015		5 - 10			5 - 10	0 - 5			0 - 5
Non-Executive Director David Garmon-Jones	June 2015	February 2016	5 - 10			5 - 10	0 - 5			0 - 5
Non-Executive Director Mr J Pulsinelli	April 2015	May 2015					0 - 5			0 - 5
Non-Executive Director Dipti Amin	June 2015		5 - 10			5 - 10	5 - 10			5 - 10
Associate Non-Executive Director Rachel Devonshire	June 2015		5 - 10			5 - 10	0 - 5			0 - 5
Chief Executive Mr Neil Dardis	April 2015		165 - 170		90.0 - 92.5	275 - 280	150 - 155		102.5 - 105	255 - 260
Director Of Finance Mr Dominic Tkaczyk	January 2016	May 2016	60 - 65			60 - 65	n/a*	n/a*	n/a*	n/a*
Interim Director of Finance Mr Wayne Preston	June 2016	September 2016	35 - 40		n/a*	35 - 40				
Director of Finance Mr James Drury	September 2016		70 - 75		n/a*	70 - 75				
Chief Nurse and Director of Patient Care Standards Mrs Carolyn Morrice	April 2015		100 - 105		30.0 - 32.5	130 - 135	95 - 100		2.5 - 5	100 - 105
Medical Director Dr Tina Kenny	April 2015		165 - 170		5.0 - 7.5	170 - 175	165 - 170		10 - 12.5	175 - 180
Director of Strategy Mr David Williams	April 2015		110 - 115		25.0 - 27.5	135 - 140	110 - 115		15 - 17.5	125 - 130
Chief Operating Officer Mr Neil Macdonald	April 2015		115 - 120		37.5 - 40.0	150 - 155	110 - 115		75 - 77.5	185 - 190
Director of HR and Organisational Development Ian Anderson	April 2015		115 - 120		n/a*	115 - 120	110 - 115	n/a*	n/a*	110 - 115

n/a - Non-Executive Directors are not entitled to pension

n/a* - Prior Year or part yaer comparitors not available

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 2017	Lump sum at age 60 related to accrued pension at 31 March 2017	Cash Equivalent Transfer Value at 31 March 2017	Cash Equivalent Transfer Value at 31 March 2017	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 £
Chief Executive Mr N Dardis	5.0 - 7.5	5 - 7.5	40 - 45	105 - 110	576	475	78	-
Chief Operating Officer Mr N MacDonald	2.5 - 5.0	0 - 2.5	20 - 25	45 - 50	575	208	350	-
Medical Director Dr C Kenny	0 - 2.5	0 - 2.5	45 - 50	145 - 150	1,084	1,012	48	-
Director of Nursing Ms C Morrice	0 - 2.5	5 - 7.5	30 - 35	95 - 100	578	526	38	-
Director of Strategy Mr D Williams	0 - 2.5	0	35 - 40	90 - 95	575	538	22	-
Director of HR and Organisational Developments Ian Anderson	n/a*	n/a*	n/a*	n/a*	n/a*	n/a*	n/a*	
Director of Finance James Drury	n/a*	n/a*	15 - 20	n/a*	n/a*	n/a*	n/a*	-
Acting Director of Finance Wayne Preston	n/a*	n/a*	35 - 40	n/a*	n/a*	n/a*	n/a*	-

* 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 where the Trust has made contributions to a pension scheme.

n/a* Prior year or current year data not available has been used where details are not available

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

Sickness Absence Data

The sickness absence data for the Trust is shown below;

Staff Sickness Absence	Total Number	Total Prior Year Number
Total Days Lost	39,938	40,750
Total Staff Years	5,067	4,971
Average working Days Lost	8	8
Number of persons retired early on ill health grounds	6	7
Total additional pensions liabilities accrued in the year (£000s)	331	161

Staff Numbers

The number of staff employed within each staff grouping is shown below;

Average Staff Numbers	Total Number	Permanently Employed Number	Other Number	Total Prior Year Number	Permanently Employed Number	Other Number
Medical and Dental	678	659	19	645	624	21
Administration and Estates	1,049	1,033	16	1,085	1,016	69
Healthcare Assistants and Other Support Staff	837	837	0	782	697	85
Nursing, Midwifery and Health Visiting Staff	2,019	1,917	102	2,087	1,805	282
Nursing, Midwifery and Health Visiting Learners	14	14		8	8	0
Scientific, Therapeutic andTechnical Staff	612	559	53	441	391	50
Social Care Staff	0	0	0	0	0	0
Healthcare Science Staff	286	285	1	422	413	9
Other	8	7	1	10	2	8
TOTAL	**5,503**	**5,311**	**192**	5,480	4,956	524
Staff engaged on capital projects (included above)	**24**	**21**	**3**	30	4	26

Banding of Senior Managers

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

Managers/Senior Managers as at 31st March 2017	
Agenda for Change Banding	**Headcount**
Band 7	50
Band 8	63
Band 9	14
Non Agenda for Change contracts	7
Total	**134**

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 2016/17 was £165,000 to £170,000 (2015/16 £165,000 to £170,000). This was 5.8 times (2015/16 5.6 times) the median remuneration of the workforce, which was £28,871 (2015/16 £29,992).

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

In 2016/17 1 employees (2015/16 2 employees) received remuneration in excess of the highest-paid director. Remuneration ranged from £165,000 to £170,000 (2015/16 £170,000 to £175,000).

Total remuneration includes salary, non-consolidated performance-related pay (none awarded in 2016/17 or 2015/16) 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 2016/17 (2015/16 nil).

There were 1% pay increases for most staff, except for those on the highest pay bands, in 2016/17. 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.

Exit Packages

The table below details Exit packages including Redundancy paid to Trust employees;

Exit package cost band (including any special payment element)	Compulsory Redundancies		Other Departures Agreed		Total Number of exit packages	Total Cost of exit packages
	*Number	*Cost £s	Number	*Cost £s		£
Less than £10,000	3	12	14	37,248	17	37,260
£25,001 - £50,000	-	-	-	-	-	-
£50,001 - £100,000	-	-	-	-	-	-
Total	**3**	**12**	**14**	**37,248**	**17**	**37,260**

Exit package cost band (including any special payment element)	Compulsory Redundancies		Other Departures Agreed		Prior Year Total Number of exit packages	Prior Year Total Cost of exit packages
	Prior Year *Number	Prior Year *Cost £s	Prior Year *Number	Prior Year *Cost £s		
Less than £10,000	1	2,472	11	37,000	12	39,472
£25,001 - £50,000	1	25,012	-	-	1	25,012
£50,001 - £100,000	1	73,536	-	-	1	73,536
Total	3	101,020	11	37,000	14	138,020

Other Exit packages - disclosures (Exclude Compulsory Redundancies)	Number of exit package agreements Number	Total Value of agreements £000s	Prior Year Number of exit package agreements Number	Prior Year Total Value of agreements £000s
Contractual payments in lieu of notice	14	37	11	37
Total	**14**	**37**	11	37

Note * this includes any non-contractual severance payment following judicial mediation and amounts relating to non-contractual payments in lieu of notice.

'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 2017, and new engagements during the period 1st April 2016 to 31st March 2017.

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	9
for between one and two years at the time of reporting	0
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 2016 and 31 March 2017	3
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	0

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	Non-Executive Director (until April 2016)
Graeme Johnston	Non-Executive Director (Chair from July 2016)
Rajiv Jaitly	Non-Executive Director (Chaired May 2016)
David Garmon-Jones	Non-Executive Director
Rachel Devonshire	Associate Non-Executive Director

Auditors

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

The scale fees for 2016/17 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.

16. 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.

16.1. 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.

The majority of the services we provide are commissioned by other NHS organisations and Local Authorities, accounting for approximately 91% of total 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 2%. This, when combined with other factors such as inflationary pressures, meant that the Trust had to plan to deliver savings in 2016/17 of £20m, to deliver a £5.2m surplus.

This surplus plan was agreed with NHS Improvement (NHSI) as part of the national financial reset exercise undertaken in June 2016, when all organisations were set a Control Total to deliver. Included in this process was access to Sustainability and Transformation Funding (STF), £9.4m was available to BHT, subject to delivery of key operational targets and financial plans. The planned deficit excluding STF was therefore £4.2m. To achieve the control total the Trust set out a number of assumptions on how delivery was to be achieved including financial assistance from system partners.

There were a number of pressures on the Trust finances in year which meant that the Trust did not deliver to its plan, and discussions with NHSI were on-going after Q2 with regard to the forecast position. NHSI reporting rules state that forecast position can only be moved at specific times of the year, and at Month 9 the Trust formally revised its forecast, with additional potential deterioration highlighted as a potential risk. Additional pressures impacted the Trust over winter and further forecast deterioration was identified during Month 10 and disclosed as a risk and NHSI informed. the Trust successfully delivered this revised forecast of £1.8m deficit.

The £7m under delivery of the in-year plan was driven through non-receipt of STF £2.5m, CIP's not achieved of £3m, and under delivery of internal savings plans £1.5m. The underlying position of the Trust, when STF is excluded, has improved from circa £12m deficit in 2015/16 to £8m deficit in 2016/17. The Trust is therefore on track to move to break-even over a three year period from 2016 to 2019 as we committed to do. The environment remains challenging but the Trust will receive assistance to deliver its trajectory through its acceptance onto the NHSI Financial Improvement Programme Wave 2 (FIP2) in April 2017. This will provide additional capacity to move forward the continued transformation of the Trust financial position.

EY, 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.

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 2017.

16.2. The efficiency programme

As outlined above, there was a 'deflator' of 2% built into the tariff that the Trust is paid for its activity for 2016/17, which together with the underlying deficit and other cost pressures meant that the Trust was required to deliver savings of £20m in year.

Efficiency savings of £17.3m were achieved, £2.7m under the levels required. The main issues driving under delivery were the planned external assistance not being received £1.5m, estates rationalisation £1m, and PFI refinancing £0.3m not being delivered. Over 70% of the savings delivered were recurrent.

Levels of savings going forward remain challenging and the plan for 2017/18 includes £17.6m expected efficiency.

16.3.Performance in year

The Trust has to deliver a surplus of approximately 1.5% of turnover in order to enable servicing of historical debt, see financing section below. As stated above the Trust did not deliver to this level, however performance is good when considering the significant in-year pressures, including:

- Failure throughout the health and social care economy to reduce demand for services to a level that the whole 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.

The Trust delivered its Agency Spend Cap, a maximum spend limit set by NHSI. The limit was £12.066m, and the Trust spent £11.844m. Overall pay expenditure reduced by approximately 1%, when social security costs are excluded, and considering the impact of a 1% pay rise, the Trust effectively delivered a 2% pay spend reduction in-year on a like for like basis. (Social security costs are excluded for comparative purposes as in-year there was a 1.8% increase to employer NI contribution)

The Trust is reporting a deficit before technical adjustments of £1.2m. The technical adjustments relate to central changes in accounting policies that impact on the reported financial performance of the Trust. These include:

- Deducting the impact of impairments to the value of land and buildings, and IFRIC reporting adjustments £0.8m;

- Receipt of £0.2m donated assets income in excess of depreciation on donated assets.

The combination of these factors, when taken in addition to the retained deficit, generates the deficit of £1.8m 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 2016/17 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.

'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 then 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. The letter stated that in future years no such written confirmation would be given.

In forming a view therefore the Trust Board has assumed "going concern" basis as a result of considering:

- The improved underlying financial position and Trust acceptance onto Finance Improvement Programme
- Two year plans, 2017/18 and 2018/19, submitted and accepted by NHSI
- Two year contracts signed with key commissioners
- Expanding clinical service base e.g. Stroke

Expense recognition
There were no staff redundancies in 2016/17.

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. A full re-valuation was undertaken with effect 1st April 2015, and as such an interim one was undertaken this year. A desk top valuation was undertaken, by the Trusts advisors Cushman and Wakefield, a firm of specialist valuers. The impact of this valuation has been included in the accounts.

The accounting treatment of the Stoke Mandeville PFI has been adjusted this year to align to the treatment of the South PFI. The lifecycle costs of the PFI have been capitalised, in line with accounting standards, and the impact upon asset values included in the accounts.

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 2016/17 to benefit from support from Scannappeal, the Trust charities and the League of Friends; to assist with the purchase of medical and other equipment. 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.

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 2016/17 financial statements.

Financing arrangements
The Trust has 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).

The Trust had a Capital Investment Loan of £9m approved in 2014/15 to support significant investments in capital projects, 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 remaining £2.5m is due to be drawn down in 2017/18. The interest rate is 1.45%.

The Trust has an Interim Revolving Working Capital Facility approved by the Department of Health for £37.6m. 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 £34.9m of this facility at the end of March 2017. During April £2m was repaid.

During the financial period, the Trust incurred £1.4m (2015/16 £0.9m) in interest on its loans.

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 2016/17 the Trust accounted for £11.6m (2015/16 £11.7m) in finance charges in relation to the PFIs.

Cash flow
The Trust had a year-end cash balance of £4m. 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 £2.3m in 2015/16.

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 £33,000 (2015/16 £36,000).

Better payment practice code
The Better Payment Practice Code (BPPC) measures the level of valid NHS and non-NHS trade creditors paid within 30 days of the due date, or within 30 days of receipt of goods or a valid invoice, whichever is later. The Trust's performance in 2016/17 is shown in Note 10.1 of the Financial Statements.

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. During 2016/17 the Trust overall paid 94

% of invoices on time, and 95.5% of its non-NHS invoice by value, improved from 89.6% in 2015/16.

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

16.4. 2017/18 and beyond
NHS England's Next Steps on the 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 as part of the BOB STP. 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. As part of this process there is a requirement to take medium term actions to support this, and the participation in FIP2 will assist this delivery.

The Trust has worked with its commissioners in agreeing contracts for activity levels in 2017/18 and 2018/19 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.

FINANCIAL ACCOUNTS 2016/17

Trust name	Buckinghamshire Healthcare NHS Trust
This year	2016-17
Last year	2015-16
This year ended	31 March 2017
Last year ended	31 March 2016
This year commencing:	1 April 2016
Last year commencing:	1 April 2015

Accounts 2016-17

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 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.

Neil Dardis
Chief Executive Date

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

Neil Dardis
Chief Executive Date

James Drury
Finance Director Date

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 2017 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 Statement of Financial Position, the Trust and Group Statement of Changes in Taxpayers' Equity, the Trust and Group Statement of Cash Flows and the related notes 1 to 40. 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 2016-17 Government Financial Reporting Manual (the 2016-17 FReM) as contained in the Department of Health Group Accounting Manual 2016-17 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 60;
- the table of pension benefits of senior managers [and related narrative notes] on page 60;
- the tables of exit packages [and related notes] on page 63;
- the analysis of staff numbers and costs [and related notes] on page 61; and
- the table of pay multiples [and related narrative notes] on page 62.

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 3, 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 2016, 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 2017.

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 2017 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.

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

Opinion on other matters

In our opinion:

Matters on which we are required to report by exception

We are required to report to you if:

• in our opinion the governance statement does not comply with the NHS Improvement's guidance; or
• we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; 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; or
• we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017.

We have nothing to report in these respects

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 2017

The maintenance and integrity of the Buckinghamshire Healthcare NHS Trust web site is the responsibility of the directors; the work carried out by the auditors does not involve consideration of these matters and, accordingly, the auditors accept no responsibility for any changes that may have occurred to the financial statements since they were initially presented on the web site. Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

Statement of Comprehensive Income for year ended 31 March 2017

	NOTE	2016-17 £000s	2015-16 £000s	Consolidated 2016-17 £000s	Consolidated 2015-16 £000s
Gross employee benefits	9.1	**(240,327)**	(236,666)	**(240,327)**	(236,666)
Other operating costs	7	**(135,757)**	(140,281)	**(136,480)**	(142,346)
Revenue from patient care activities	4	**360,502**	345,713	**360,502**	345,713
Other operating revenue	5	**31,341**	24,512	**33,249**	26,283
Operating surplus/(deficit)		**15,759**	(6,722)	**16,944**	(7,016)
Investment revenue	11	**33**	36	**302**	275
Other gains and (losses)	12	**(27)**	227	**(27)**	227
Finance costs	13	**(11,674)**	(12,642)	**(11,674)**	(12,642)
Surplus/(deficit) for the financial year		**4,091**	(19,101)	**5,545**	(19,156)
Public dividend capital dividends payable		**(4,708)**	(5,507)	**(4,708)**	(5,507)
Retained surplus/(deficit) for the year		**(617)**	(24,608)	**837**	(24,663)

Other Comprehensive Income

		2016-17 £000s	2015-16 £000s	2016-17 £000s	2015-16 £000s
Impairments and reversals taken to the revaluation reserve		**-**	-	**976**	-
Net gain/(loss) on revaluation of property, plant & equipment		**428**	1,454	**428**	1,454
Net gain/(loss) on revaluation of financial assets	40.1	**-**	-	**2,241**	(357)
Total comprehensive income for the year		**(189)**	(23,154)	**4,482**	(23,566)

Financial performance for the year

Retained surplus/(deficit) for the year	**(617)**	(24,608)
IFRIC 12 adjustment (including IFRIC 12 impairments)	**(39)**	11,674
Impairments (excluding IFRIC 12 impairments)	**(1,328)**	2,697
Adjustments in respect of donated gov't grant asset reserve elimination	**225**	(630)
Adjusted retained surplus/(deficit)	**(1,759)**	(10,867)

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 13 to 53 form part of this account.

Statement of Financial Position as at 31 March 2017

	NOTE	**31 March 2017**	31 March 2016	**Consolidated 31 March 2017**	Consolidated 31 March 2016
		£000s	£000s	**£000s**	£000s
Non-current assets:					
Property, plant and equipment	15	**261,663**	259,309	**261,663**	259,309
Intangible assets	16	**1,060**	733	**1,060**	733
Other Investments - Charitable	40			**8,353**	7,380
Trade and other receivables	20.1	**4,312**	2,005	**4,312**	2,005
Total non-current assets		**267,035**	262,047	**275,388**	269,427
Current assets:					
Inventories	19	**6,384**	5,903	**6,385**	5,905
Trade and other receivables	20.1	**27,463**	29,152	**28,480**	29,622
Other current assets	21	**146**	163	**146**	163
Cash and cash equivalents	22	**3,975**	7,531	**5,856**	8,380
Sub-total current assets		**37,968**	42,749	**40,867**	44,070
Non-current assets held for sale	23	**325**	325	**325**	325
Total current assets		**38,293**	43,074	**41,192**	44,395
Total assets		**305,328**	305,121	**316,580**	313,822
Current liabilities					
Trade and other payables	24	**(28,151)**	(30,228)	**(28,261)**	(30,242)
Other liabilities	25	**(24)**	(165)	**(24)**	(165)
Provisions	29	**(443)**	(437)	**(443)**	(437)
Borrowings	26	**(3,113)**	(2,904)	**(3,113)**	(2,904)
DH revenue support loan	26	**(1,142)**	(1,142)	**(1,142)**	(1,142)
DH capital loan	26	**(723)**	(723)	**(723)**	(723)
Total current liabilities		**(33,596)**	(35,599)	**(33,706)**	(35,613)
Net current assets/(liabilities)		**4,697**	7,475	**7,486**	8,782
Total assets less current liablilities		**271,732**	269,522	**282,874**	278,209
Non-current liabilities					
Trade and other payables	24	**(312)**	(624)	**(312)**	(624)
Other liabilities	25	**(314)**	(338)	**(314)**	(338)
Provisions	29	**(1,240)**	(1,286)	**(1,240)**	(1,286)
Borrowings	26	**(58,383)**	(61,543)	**(58,383)**	(61,543)
DH revenue support loan	26	**(37,196)**	(30,532)	**(37,196)**	(30,532)
DH capital loan	26	**(5,054)**	(5,777)	**(5,054)**	(5,777)
Total non-current liabilities		**(102,499)**	(100,100)	**(102,499)**	(100,100)
Total assets employed:		**169,233**	169,422	**180,375**	178,109
FINANCED BY:					
Public Dividend Capital		**181,951**	181,951	**181,951**	181,951
Retained earnings		**(50,984)**	(50,367)	**(50,984)**	(50,367)
Revaluation reserve		**38,266**	37,838	**38,266**	37,838
Charitable Funds Reserve	40.2			**11,142**	8,687
Total Taxpayers' Equity:		**169,233**	169,422	**180,375**	178,109

The notes on pages 13 to 53 form part of this account.

The financial statements on pages 7 to 12 were approved by the Board on 31st May 2017 and signed on its behalf by

Neil Dardis
Chief Executive **Date**

Statement of Changes in Taxpayers' Equity
For the year ending 31 March 2017

	Public Dividend capital	Retained earnings	Revaluation reserve	Other reserves	Total reserves
	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2016	**181,951**	**(50,367)**	**37,838**	**-**	**169,422**
Changes in taxpayers' equity for 2016-17					
Retained surplus/(deficit) for the year		(617)			**(617)**
Impairments and reversals			-		**0**
Net recognised revenue/(expense) for the year	**-**	**(617)**	**428**	**-**	**(189)**
Balance at 31 March 2017	**181,951**	**(50,984)**	**38,266**	**-**	**169,233**
Balance at 1 April 2015	**181,917**	**(25,806)**	**36,420**	**-**	**192,531**
Changes in taxpayers' equity for the year ended 31 March 2016					
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)	-	-
Reclassification Adjustments					
New PDC received - cash	34				34
PDC repaid in year	0				-
Other movements	0	11	-	-	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**

Statement of Changes in Taxpayers' Equity
For the year ending 31 March 2017

Consolidated

	Public Dividend capital	Retained earnings	Revaluation reserve	Charitable Funds Reserve	Other reserves	Total reserves
	£000s	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2016	**181,951**	**(50,367)**	**37,838**	**8,687**	**-**	**178,109**
Changes in taxpayers' equity for 2016-17						
Retained surplus/(deficit) for the year		(617)		1,454		**837**
Net gain / (loss) on revaluation of property, plant, equipment			428			**428**
Revaluation and impairment of Charitable fund assets				976		**976**
Charitable Funds Adjustment				25		**25**
Net recognised revenue/(expense) for the year	**-**	**(617)**	**428**	**2,455**	**-**	**2,266**
Balance at 31 March 2017	**181,951**	**(50,984)**	**38,266**	**11,142**	**-**	**180,375**
Balance at 1 April 2015	**181,917**	**(25,806)**	**36,420**	**9,113**	**-**	**201,644**
Changes in taxpayers' equity for the year ended 31 March 2016						
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)		-	-
Reclassification Adjustments						
New PDC received - cash	34					34
Other movements	-	11	-		-	11
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**

Information on reserves

1 **Public dividend capital**
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities. Additional PDC may also be issued to NHS trusts by the Department of Health. A charge, reflecting the cost of capital utilised by the NHS foundation trust, is payable to the Department of Health as the public dividend capital dividend.

2 **Income and expenditure reserve**
The balance of this reserve is the accumulated surpluses and deficits of the NHS trust.

3 **Revaluation Reserve**
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

4 **Charitable Funds Reserve**
This balance represents the ring-fenced funds held by the NHS charitable funds consolidated within these accounts. These reserves are restricted to the objects of the charity (charitable Purpose).

Statement of Cash Flows for the Year ended 31 March 2017

	NOTE	**2016-17 £000s**	2015-16 £000s	Consolidated **2016-17 £000s**	Consolidated 2015-16 £000s
Cash Flows from Operating Activities					
Operating surplus/(deficit)		**15,759**	(6,722)	**15,759**	(6,722)
Depreciation and amortisation	7	**11,366**	11,093	**11,366**	11,093
Impairments and reversals	17	**(1,722)**	14,215	**(1,722)**	14,215
Donated Assets received credited to revenue but non-cash	5	**(966)**	(1,710)	**(966)**	(1,710)
(Increase)/Decrease in Inventories	19	**(481)**	(210)	**(481)**	(210)
(Increase)/Decrease in Trade and Other Receivables		**(1,108)**	1,358	**(1,108)**	1,358
(Increase)/Decrease in Other Current Assets		**17**	-	**17**	-
Increase/(Decrease) in Trade and Other Payables		**(3,538)**	(6,885)	**(3,538)**	(6,885)
(Increase)/Decrease in Other Current Liabilities		**(165)**	117	**(165)**	117
Provisions utilised		**(362)**	(379)	**(362)**	(379)
Increase/(Decrease) in movement in non cash provisions		**317**	325	**317**	325
NHS Charitable Funds - net adjustments for working capital movements, non-cash transactions and non-operating cash flows				**2,382**	(389)
Net Cash Inflow/(Outflow) from Operating Activities		**19,117**	11,202	**21,499**	10,813
Cash Flows from Investing Activities					
Interest Received		**33**	36	**33**	36
(Payments) for Property, Plant and Equipment		**(9,136)**	(13,464)	**(9,136)**	(13,464)
(Payments) for Intangible Assets		**(642)**	-	**(642)**	-
Proceeds of disposal of assets held for sale (PPE)		**-**	25	**-**	25
Net Cash Inflow/(Outflow) from Investing Activities		**(9,745)**	(13,403)	**(9,745)**	(13,403)
Net Cash Inflow / (Outflow) before Financing		**9,372**	(2,201)	**11,754**	(2,590)
Cash Flows from Financing Activities					
Gross Temporary and Permanent PDC Received		**-**	34	**-**	34
Loans received from DH - New Capital Investment Loans		**-**	3,400	**-**	3,400
Loans received from DH - New Revenue Support Loans		**7,806**	27,100	**7,806**	27,100
Other Loans Received		**-**	-	**-**	-
Loans repaid to DH - Capital Investment Loans Repayment of Principal		**(723)**	-	**(723)**	-
Loans repaid to DH - Working Capital Loans/Revenue Support Loans		**(1,142)**	(1,142)	**(1,142)**	(1,142)
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT		**(2,976)**	(2,834)	**(2,976)**	(2,834)
Interest paid		**(11,675)**	(12,580)	**(11,675)**	(12,580)
PDC Dividend (paid)/refunded		**(4,218)**	(6,015)	**(4,218)**	(6,015)
Net Cash Inflow/(Outflow) from Financing Activities		**(12,928)**	7,963	**(12,928)**	7,963
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		**(3,556)**	5,762	**(1,174)**	5,373
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period		**7,531**	1,769	**7,531**	3,007
Cash and Cash Equivalents (and Bank Overdraft) at year end	**22**	**3,975**	7,531	**6,357**	8,380

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 2016-17 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.

Going Concern

These accounts have been prepared on the going concern basis. The Trust has submitted financial plans for 2017/2019 to NHS Improvement (NHSI). The Trusts financial positions has shown marked improvement in 2016/17 which is forecast to continue in 2017/18 with theTrust achieving a surplus. The Trusts Directors are happy that no material uncertainty exists that may cast significant doubt about the ability of the Trust to continue as a going concern has been identified.

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). 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 41 to the Accounts. This balance represents the ring-fenced funds held by the NHS charitable funds consolidated within these accounts. These reserves are restricted to the objects of the charity (charitable Purpose).

The Accounting Policies adopted by the Charity are disclosed in full in Note 41.

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 (see 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.

NOTES TO THE ACCOUNTS

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

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.

• 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.

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 41.

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 Pension Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. The schemes 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, the schemes are accounted for as though they were defined contribution schemes: the cost to the NHS body of participating in a 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 NHS 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 NHS trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and either
- the item cost at least £5,000; or
- Collectively, a number of items have a total 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.
- 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. Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date.

Revaluations of property, plant and equipment 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. Current values in existing use are determined as follows:
- Land and non-specialised buildings – market value for existing use.
- Specialised buildings – depreciated replacement cost, modern equivalent asset basis.

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 and, where capitalised in accordance with IAS 23, borrowing costs. Assets are revalued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

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.

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.

NOTES TO THE ACCOUNTS

Recognition (Continued)
Intangible assets acquired separately are initially recognised at cost. Software that is integral to the operation 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; and
- 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 current value in existing use by reference to an active market, or, where no active market exists, at the lower of amortised replacement cost (modern equivalent assets basis) and value in use where the asset is income generating. 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, assets under construction or development, and assets held for sale are not depreciated/amortised.

Otherwise, depreciation or amortisation is charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, on a straight line basis over their estimated useful lives. 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 the shorter of the lease term and the estimated useful lives. Depreciation commences in the quarter of the financial year following recognition of the asset.

At each financial year-end, the NHS trust checks whether there is any indication that its property, plant and equipment or intangible non-current assets have suffered an impairment loss. If there is indication of such an impairment, 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 at the financial year end.

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 are 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 current value in existing use, if they will be held for their service potential, or otherwise at 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 treated in the same way as for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.13 Government grants
Government grant funded assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at fair value on receipt, with a matching credit to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.14 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.

NOTES TO THE ACCOUNTS

Non-current assets held for sale (Current)
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.

1.15 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 of 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.

1.16 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 NHS 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 or, if lower, at the present value of the minimum lease payments, in accordance with the principles of IAS 17. Subsequently, the assets are measured at current value in existing use.

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 initial 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.

NOTES TO THE ACCOUNTS

PFI liability (Continued)
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 NHS 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 accrual 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 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.

Other assets contributed by the NHS trust to the operator
Assets contributed (e.g. cash payments, surplus property) by the NHS trust to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the NHS trust, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

1.17 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.

1.18 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.

1.19 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 rates.

Early retirement provisions are discounted using HM Treasury's pension discount rate of positive 0.24% (2015-16: positive 1.37%) in real terms. All other provisions are subject to three separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:
• A short term rate of negative 2.70% (2015-16: negative 1.55%) for expected cash flows up to and including 5 years

• A medium term rate of negative 1.95% (2015-16: negative 1.00%) for expected cash flows over 5 years up to and including 10 years
• A long term rate of negative 0.80% (2015-16: negative 0.80%) for expected cash flows over 10 years.

All percentages are in real terms.

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 NHS 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)

1.20 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 35.

1.21 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.

1.22 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 trust 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.

1.23 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.

1.24 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.

Financial assets at fair value through profit and loss

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in calculating the NHS trust's surplus or deficit for the year. The net gain or loss incorporates any interest earned on the financial asset.

Held to maturity investments

Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and where there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Available for sale financial assets

Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to surplus/deficit on de-recognition.

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.

NOTES TO THE ACCOUNTS

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

Loans and receivables (Continued)
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 that occurred after the initial recognition of the asset and that have an impact on the estimated future cash flows of the asset.

1.25 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 historic cost. Otherwise, financial liabilities are initially recognised at fair value.

1.26 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.

1.27 Foreign currencies
The NHS trust's functional 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.

1.28 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 44 to the accounts.

1.29 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.

1.30 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 the NHS trust not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.31 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.

NOTES TO THE ACCOUNTS

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

1.32 Associates

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.

1.33 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 2016-17. 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 from Contracts with Customers - 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 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.

1.34 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

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 £340,439k (2015/16 £330,559k).

The balance to total income is other operating income of £51,404k (3015/16 £39,666k).

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 exceed £1 million or are otherwise material.

4. Revenue from patient care activities

	2016-17 £000s	2015-16 £000s
NHS England	**72,064**	70,681
Clinical Commissioning Groups	**268,375**	259,878
Foundation Trusts	**2,273**	1,223
NHS Other (including Public Health England and NHS Property Services Ltd)	**-**	1,057
Non-NHS:		
Local Authorities	**12,674**	9,452
Private patients	**2,326**	2,094
Overseas patients (non-reciprocal)	**399**	293
Injury costs recovery	**2,313**	929
Other Non-NHS patient care income	**78**	106
Total Revenue from patient care activities	**360,502**	345,713

Injury costs recovery income is subject to a provision for the impairment of receivables for 2016-17 of 22.94% (2015-16 21.99%) to reflect expected rates of collection

5. Other operating revenue

	2016-17 £000s	2015-16 £000s
Education, training and research	**12,044**	12,030
Charitable and other contributions to revenue expenditure -non- NHS	**725**	863
Receipt of charitable donations for capital acquisitions	**966**	1,710
Non-patient care services to other bodies	**2,527**	2,942
Sustainability & Transformation Fund Income	**6,972**	-
Income generation (Other fees and charges)	**4,150**	3,885
Other revenue	**3,957**	3,082
Total Other Operating Revenue	**31,341**	24,512
Total operating revenue	**391,843**	370,225

6. Overseas Visitors Disclosure

	2016-17 £000s	2015-16 £000s
Income recognised during 2016-17 (invoiced amounts and accruals)	**399**	**293**
Cash payments received in-year (re receivables at 31 March 2016)	**62**	**7**
Cash payments received in-year (iro invoices issued 2016-17)	**141**	**70**
Amounts written off in-year (irrespective of year of recognition)	**80**	**30**

7. Operating expenses

	2016-17 £000s	2015-16 £000s
Purchase of healthcare from non-NHS bodies	**1,058**	986
Trust Chair and Non-executive Directors	**84**	84
Supplies and services - clinical	**69,305**	63,372
Supplies and services - general	**827**	1,052
Consultancy services	**952**	372
Establishment	**4,533**	4,478
Transport	**2,530**	2,681
Service charges - ON-SOFP PFIs and other service concession arrangements	**19,926**	17710
Business rates paid to local authorities	**2,041**	1124
Premises	**12,467**	13,177
Hospitality	**28**	28
Insurance	**227**	269
Legal Fees	**174**	326
Impairments and Reversals of Receivables	**1,009**	34
Depreciation	**11,051**	10,734
Amortisation	**315**	359
Impairments and reversals of property, plant and equipment	**(1,722)**	14,215
Internal Audit Fees	**199**	151
Audit fees	**105**	115
Other auditor's remuneration	**32**	-
Clinical negligence	**7,048**	5,996
Research and development (excluding staff costs)	**-**	7
Education and Training	**1,783**	1,623
Change in Discount Rate	**89**	(6)
Other	**1,696**	1,394
Total Operating expenses (excluding employee benefits)	**135,757**	140,281
Employee Benefits		
Employee benefits excluding Board members	**239,241**	235,500
Board members	**1,086**	1,166
Total Employee Benefits	**240,327**	236,666
Total Operating Expenses	**376,084**	376,947

*Services from NHS bodies does not include expenditure which falls into a category below

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

	Land £000s	Buildings £000s	Other £000s	2016-17 Total £000s	2015-16 £000s
Payments recognised as an expense					
Minimum lease payments				**79**	290
Contingent rents				**0**	0
Total				**79**	290
Payable:					
No later than one year		0	79	**79**	109
Between one and five years	0	0	23	**23**	229
After five years	0	0	0	**0**	0
Total	**0**	**0**	**102**	**102**	338
Total future sublease payments expected to be received:				0	0

9. Employee benefits

9.1. Employee benefits

	2016-17 Total £000s		2015-16 Total £000s
Employee Benefits - Gross Expenditure			
Salaries and wages	**200,267**		201,945
Social security costs	**18,787**	*	14,265
Employer Contributions to NHS BSA - Pensions Division	**22,480**		21,816
Other pension costs	**3**		-
Termination benefits	**-**		30
Total employee benefits	**241,537**		238,056
Employee costs capitalised	**1,210**		1,390
Gross Employee Benefits excluding capitalised costs	**240,327**		236,666

* With the introduction of the New State Pension from April 2016, eligibility for the contracted-out National Insurance contributions rebate of 3.4% for employers (and 1.4% for employees) ceased on 06 April 2016. For employers, the rebate was previously received for monthly earnings between £486 and £3337 where the employee was a member of a Defined Benefit Pension Scheme (such as the NHS Pension Scheme). For someone earning £3337 or more per month, this would cost the employer £96.94 extra per month.

9.2. Retirements due to ill-health

	2016-17 Number	2015-16 Number
Number of persons retired early on ill health grounds	**6**	7
	£000s	£000s
Total additional pensions liabilities accrued in the year	**331**	161

9.3. 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 2017, is based on valuation data as 31 March 2016, updated to 31 March 2017 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.

The next actuarial valuation is to be carried out as at 31 March 2016. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

10. Better Payment Practice Code

10.1. Measure of compliance

	2016-17 Number	2016-17 £000s	2015-16 Number	2015-16 £000s
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**78,014**	**224,315**	77,836	228,710
Total Non-NHS Trade Invoices Paid Within Target	**71,745**	**214,282**	61,986	204,990
Percentage of Non-NHS Trade Invoices Paid Within Target	**91.96%**	**95.53%**	79.64%	89.63%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**2,922**	**12,929**	2,162	**11,405**
Total NHS Trade Invoices Paid Within Target	**1,684**	**7,787**	1,121	**5,060**
Percentage of NHS Trade Invoices Paid Within Target	**57.63%**	**60.23%**	51.85%	44.37%

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

	2016-17 £000s	2015-16 £000s
Amounts included in finance costs from claims made under this legislation	**1**	9
Total	**1**	9

11. Investment Revenue

	2016-17 £000s	2015-16 £000s
Interest revenue		
Bank interest	**33**	36
Total investment revenue	**33**	36

12. Other Gains and Losses

	2016-17 £000s	2015-16 £000s
Gain/(Loss) on disposal of assets other than by sale (PPE)	**(27)**	**202**
Gain (Loss) on disposal of assets held for sale	**-**	**25**
Total	**(27)**	227

13. Finance Costs

	2016-17 £000s	2015-16 £000s
Interest		
Interest on loans and overdrafts	**1,386**	**862**
Interest on obligations under finance leases	**44**	**41**
Interest on obligations under PFI contracts:		
- main finance cost	**8,872**	**10,316**
- contingent finance cost	**1,365**	**1,393**
Interest on late payment of commercial debt	**1**	**9**
Total interest expense	**11,668**	12,621
Provisions - unwinding of discount	**6**	**21**
Total	**11,674**	12,642

14. Audit Costs

14.1. Other auditor remuneration

	2016-17 £000s	2015-16 £000s
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust		
2. Audit-related assurance services	**17**	12
3. Taxation compliance services		
4. All taxation advisory services not falling within item 3 above		
5. Internal audit services		
6. All assurance services not falling within items 1 to 5	**15**	-
7. Corporate finance transaction services not falling within items 1 to 6 above		
8. Other non-audit services not falling within items 2 to 7 above		
Total	**32**	**12**

14.2. Limitation on auditor's liability

There is no limitation on auditor's liability for external audit work carried out for the financial years 2016/17 or 2015/16.

15.1. Property, plant and equipment

2016-17	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 2016	46,187	171,703	4,644	781	50,395	182	46,066	4,442	**324,400**
Additions of Assets Under Construction				4,030					**4,030**
Additions Purchased	-	3,299	-		1,716	-	1,287	-	**6,302**
Additions - Purchases from Cash Donations & Government Grants	-	131	-	162	605	-	52	-	**950**
Reclassifications	-	(465)	-	465	-	-	-	-	**0**
Disposals other than for sale	-	-	-	-	(58)	-	(51)	-	**(109)**
Revaluation	-	428	-	-	-	-	-	-	**428**
Impairments/reversals charged to operating expenses	-	(2,097)	15	-	-	-	-	-	**(2,082)**
At 31 March 2017	**46,187**	**172,999**	**4,659**	**5,438**	**52,658**	**182**	**47,354**	**4,442**	**333,919**
Depreciation									
At 1 April 2016	-	122	1		33,430	175	28,007	3,356	**65,091**
Disposals other than for sale	-	-	-		(46)	-	(36)	-	**(82)**
Impairments/reversals charged to operating expenses	-	(3,717)	(87)		-	-	-	-	**(3,804)**
Charged During the Year	-	3,595	86		3,277	2	3,874	217	**11,051**
At 31 March 2017	**-**	**-**	**-**	**-**	**36,661**	**177**	**31,845**	**3,573**	**72,256**
Net Book Value at 31 March 2017	**46,187**	**172,999**	**4,659**	**5,438**	**15,997**	**5**	**15,509**	**869**	**261,663**
Asset financing:									
Owned - Purchased	46,187	92,890	4,163	5,145	11,035	-	15,042	798	**175,260**
Owned - Donated	-	9,455	496	293	3,976	5	467	71	**14,763**
Held on finance lease	-	3,789	-	-	986	-	-	-	**4,775**
On-SOFP PFI contracts	-	66,865	-	-	-	-	-	-	**66,865**
Total at 31 March 2017	**46,187**	**172,999**	**4,659**	**5,438**	**15,997**	**5**	**15,509**	**869**	**261,663**

Buckinghamshire Healthcare NHS Trust - Annual Accounts 2016-17

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 2016	20,218	14,800	6	-	2,771	7	-	71	**37,873**
Movements (specify)	-	-	-	-	-	-	-	-	**-**
At 31 March 2017	**20,218**	**14,800**	**6**	**0**	**2,771**	**7**	**0**	**71**	**37,873**

Additions to Assets Under Construction in 2016-17

Buildings excl Dwellings	4,030
Balance as at YTD	**4,030**

15.2. Property, plant and equipment prior-year

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	-	3,413	-		2,927	-	6,065	-	**12,405**
Additions - Non Cash Donations (i.e. Physical Assets)	-	384	-	43	1,175	-	10	-	**1,612**
Additions Leased (including PFI/LIFT)	-	-	-		790	-	0	-	**790**
Reclassifications	-	2,882	-	(11,416)	792	(25)	7,681	86	**-**
Reclassifications as Held for Sale and Reversals	-	-	(324)	-	-	-	-	-	**(324)**
Disposals other than for sale	-	-	-	-	(1,059)	-	-	-	**(1,059)**
Revaluation	603	851	-	-	-	-	-	-	**1,454**
Impairment/reversals charged to reserves	176	(21,891)	186	-	-	-	-	-	**(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	-	3,412	81		30,479	174	24,524	3,147	**61,817**
Reclassifications as Held for Sale and Reversals	-	-	1		-	-	-	-	**1**
Disposals other than for sale	-	-	-		(1,059)	-	-	-	**(1,059)**
Impairment/reversals charged to reserves	-	-	-		-	-	-	-	**-**
Impairments/reversals charged to operating expenses	-	(7,149)	(165)		-	-	-	-	**(7,314)**
Charged During the Year	-	3,859	84		3,098	1	3,483	209	**10,734**
At 31 March 2016	**-**	**122**	**1**	**-**	**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	-	17,460	999	**174,115**
Owned - Donated	-	9,667	493	131	4,178	7	599	87	**15,162**
Held on finance lease	-	3,697	-	-	986	-	-	-	**4,683**
On-SOFP PFI contracts	-	65,349	-	-	-	-	-	-	**65,349**
Total at 31 March 2016	**46,187**	**171,581**	**4,643**	**781**	**16,965**	**7**	**18,059**	**1,086**	**259,309**

15.3. 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, Cushman & Wakefield. 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.

15.4. 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	1	89
Dwellings	44	72
Plant & Machinery	5	21
Transport Equipment	7	10
Information Technology	5	12
Furniture and Fittings	7	23

16. Intangible non-current assets

16.1. Intangible non-current assets

2016-17	Computer Licenses £000's	Total £000's
At 1 April 2016	**1,896**	**1,896**
Additions Purchased	626	**626**
Additions - Purchases from Cash Donations and Government Grants	16	**16**
At 31 March 2017	**2,538**	**2,538**
Amortisation		
At 1 April 2016	**1,163**	**1,163**
Charged During the Year	**315**	**315**
At 31 March 2017	**1,478**	**1,478**
Net Book Value at 31 March 2017	**1,060**	**1,060**
Asset Financing: Net book value at 31 March 2017 comprises:		
Purchased	946	**946**
Donated	114	**114**
Total at 31 March 2017	**1,060**	**1,060**

16.2. Intangible non-current assets prior year

2015-16	Computer Licenses £000's	Total £000's
Cost or valuation:		
At 1 April 2015	1,798	**1,798**
Additions - donated	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
Net book value at 31 March 2016 comprises:		
Purchased	946	**946**
Donated	114	**114**
Total at 31 March 2016	1,060	1,060

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.

17. Analysis of impairments and reversals recognised in 2016-17

	2016-17 Total £000s
Property, Plant and Equipment impairments and reversals taken to SoCI	
Changes in market price	**(1,722)**
Total charged to Annually Managed Expenditure	**(1,722)**
Total Impairments of Property, Plant and Equipment changed to SoCI	**(1,722)**
Total Impairments charged to SoCI - AME	**(1,722)**
Overall Total Impairments	**(1,722)**

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. There was an upwards increase in the valuation of the Trust assets due to market conditions which has been reflected against prior impairments.

17. Analysis of impairments and reversals recognised in 2016-17

	Property Plant and Equipment	Intangible Assets	Financial Assets	Non-Current Assets Held for Sale	Total £000s
Impairments and reversals taken to SoCI					
Changes in market price	**(1,722)**	-	-	-	**(1,722)**
Total charged to Annually Managed Expenditure	**(1,722)**	**-**	**-**	**-**	**(1,722)**
Total Impairments of Property, Plant and Equipment changed	**(1,722)**	-	-	-	**(1,722)**

NHS bodies are required to ensure that assets are carried at a valuation. The Trust incurs capital expenditure on improving or maintaining the Trust assets, including buildings. This expenditure, although necessary, may not enhance the overall value of the asset. In order to ensure that the Trust assets are carried at the correct valuation the Trust employs a chartered valuer to perform a valuation on an annual basis. The total of this valuations is compared to the opening carrying value of the asset plus toal amount spent in year 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. There was a small upwards increase in the valuation of the Trust assets which has been reflected against prior impairments.

18. Commitments

18.1. Capital commitments

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

	31 March 2017 £000s	31 March 2016 £000s
Property, plant and equipment	**3,904**	2,822
Intangible assets	**460**	-
Total	**4,364**	2,822

19. Inventories

	Drugs	Consumables	Loan Equipment	Other	Total	Of which held at NRV
	£000s	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2016	**2,959**	**2,889**	**-**	**-**	**5,903**	-
Additions	39,872	25,372	-	-	**65,309**	-
Inventories recognised as an expense in the period	(39,437)	(25,319)	-	-	**(64,828)**	-
Balance at 31 March 2017	**3,394**	**2,942**	**-**	**-**	**6,384**	**-**

20.1. Trade and other receivables

	Current		Non-current	
	31 March 2017	31 March 2016	**31 March 2017**	31 March 2016
	£000s	£000s	**£000s**	£000s
NHS receivables - revenue	**13,227**	13,360	**-**	-
NHS prepayments and accrued income	**1,657**	230	**-**	-
Non-NHS receivables - revenue	**3,093**	4,705	**-**	-
Non-NHS prepayments and accrued income	**7,015**	8,886	**3,271**	-
PDC Dividend prepaid to DH	**194**	684	**-**	-
Provision for the impairment of receivables	**(704)**	(446)	**(751)**	-
VAT	**2,489**	1,394	**-**	-
Operating lease receivables	**-**	-	**-**	-
Other receivables	**492**	339	**1,792**	2,005
Total	**27,463**	29,152	**4,312**	2,005
Total current and non current	**31,775**	31,157		

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.

20.2. Receivables past their due date but not impaired

	31 March 2017	31 March 2016
	£000s	£000s
By up to three months	**1,998**	4,832
By three to six months	**538**	1,744
By more than six months	**1,514**	1,567
Total	**4,050**	8,143

20.3. Provision for impairment of receivables

	2016-17	2015-16
	£000s	£000s
Balance at 1 April 2016	**(446)**	(446)
Amount written off during the year	**-**	34
(Increase)/decrease in receivables impaired	**(1,009)**	(34)
Balance at 31 March 2017	**(1,455)**	(446)

21. Other current assets

	31 March 2017	31 March 2016
	£000s	£000s
Other Assets	**146**	163
Total	**146**	163

22. Cash and Cash Equivalents

	31 March 2017 £000s	31 March 2016 £000s
Opening balance	**7,531**	1,769
Net change in year	**(3,556)**	5,762
Closing balance	**3,975**	7,531
Made up of		
Cash with Government Banking Service	**3,898**	7,425
Cash in hand	**77**	106
Cash and cash equivalents as in statement of financial position	**3,975**	7,531
Bank overdraft - Government Banking Service	**-**	-
Cash and cash equivalents as in statement of cash flows	**3,975**	7,531
Third Party Assets - Monies on deposit	**-**	3

23. Non-current assets held for sale

	Dwellings	Total
	£000s	£000s
Balance at 1 April 2016	325	**325**
Balance at 31 March 2017	**325**	**325**
Balance at 1 April 2015		
Plus assets classified as held for sale in the year	325	**325**
Balance at 31 March 2016	**325**	**325**

The Trust holds a residential flat which is being actively marketed for sale in 2017-18. This property is shown at its current market valuation above.

24. Trade and other payables

	Current		Non-current	
	31 March 2017 £000s	31 March 2016 £000s	**31 March 2017 £000s**	31 March 2016 £000s
NHS payables - revenue	**40**	2,600	**-**	-
NHS accruals and deferred income	**2,696**	1,090	**-**	-
Non-NHS payables - revenue	**6,155**	10,476	**-**	-
Non-NHS payables - capital	**3,284**	2,135	**-**	-
Non-NHS accruals and deferred income	**7,408**	6,003	**-**	-
Social security costs	**2,532**	2,057		
Accrued Interest on DH Loans	**4**	6		
VAT	**312**	312	**312**	624
Tax	**2,123**	2,172		
Other	**3,597**	3,377	**-**	-
Total	**28,151**	30,228	**312**	624
Total payables (current and non-current)	**28,463**	**30,852**		
Included above:				
outstanding Pension Contributions at the year end	**3,154**	3,045		

25. Other liabilities

	Current		Non-current	
	31 March 2017 £000s	31 March 2016 £000s	**31 March 2017 £000s**	31 March 2016 £000s
PFI Deferred Creditor	**24**	23	**314**	338
Other Private Patients deposits against future treatment	**-**	142	**-**	-
Total	**24**	165	**314**	338
Total other liabilities (current and non-current)	**338**	**503**		

26. Borrowings

	Current		Non-current	
	31 March 2017 £000s	31 March 2016 £000s	**31 March 2017 £000s**	31 March 2016 £000s
Loans from Department of Health	**1,865**	1,865	**42,250**	36,309
PFI liabilities - main liability	**2,325**	2,088	**56,118**	58,444
Finance lease liabilities	**788**	816	**2,265**	3,099
Total	**4,978**	**4,769**	**100,633**	**97,852**
Total other liabilities (current and non-current)	**105,611**	**102,621**		

Borrowings / Loans - repayment of principal falling due in:

	31 March 2017		
	DH £000s	**Other £000s**	**Total**
0-1 Years	1,865	3,113	**4,978**
1 - 2 Years	1,865	2,858	**4,723**
2 - 5 Years	39,668	11,847	**51,515**
Over 5 Years	717	43,678	**44,395**
TOTAL	**44,115**	**61,496**	**105,611**

27. Deferred income

	Current		Non-current	
	31 March 2017 £000s	31 March 2016 £000s	**31 March 2017 £000s**	31 March 2016 £000s
Opening balance at 1 April 2016	**1,285**	1,676	**-**	-
Deferred revenue addition	**326**	-	**-**	-
Transfer of deferred revenue	**-**	(391)	**-**	-
Current deferred Income at 31 March 2017	**1,611**	1,285	**-**	-
Total deferred income (current and non-current)	**1,611**	1,285		

28. 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 2017 £000s	31 March 2016 £000s	**31 March 2017 £000s**	31 March 2016 £000s
Within one year	**680**	708	**568**	592
Between one and five years	**1,918**	2,595	**1,745**	2,360
Less future finance charges	**(285)**	(351)	**-**	-
Minimum Lease Payments / Present value of minimum lease payments	**2,313**	2,952	**2,313**	2,952
Included in:				
Current borrowings			**568**	592
Non-current borrowings			**1,745**	2,360
			2,313	2,952

Amounts payable under finance leases (Other)	**Minimum lease payments**		**Present value of minimum**	
	31 March 2017 £000s	31 March 2016 £000s	**31 March 2017 £000s**	31 March 2016 £000s
Within one year	**268**	268	**220**	224
Between one and five years	**592**	733	**161**	636
After five years	**-**	124	**359**	103
Less future finance charges	**(120)**	(162)		
Minimum Lease Payments / Present value of minimum lease payments	**740**	963	**740**	963
Included in:				
Current borrowings			**220**	224
Non-current borrowings			**520**	739
			740	963

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.

29. Provisions

		Comprising:		
	Total	**Early Departure Costs**	**Legal Claims**	**Other**
	£000s	**£000s**	**£000s**	**£000s**
Balance at 1 April 2016	**1,723**	179	1,356	188
Arising during the year	**246**	-	61	185
Utilised during the year	**(362)**	(33)	(150)	(179)
Reversed unused	**(19)**	(10)	0	(9)
Unwinding of discount	**6**	2	4	-
Change in discount rate	**89**	4	85	-
Balance at 31 March 2017	**1,683**	**142**	**1,356**	**185**
Expected Timing of Cash Flows:				
No Later than One Year	**443**	33	225	185
Later than One Year and not later than Five Years	**524**	88	436	-
Later than Five Years	**716**	21	695	-

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

As at 31 March 2017	98,072
As at 31 March 2016	90,083

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.

30. Contingencies

	31 March 2017 £000s	31 March 2016 £000s
Contingent liabilities		
NHS Litigation Authority legal claims	**(69)**	(55)
Employment Tribunal and other employee related litigation	**-**	(23)
Net value of contingent liabilities	**(69)**	(78)

31. Analysis of charitable fund reserves

	31 March 2017 £000s	31 March 2016 £000s
Restricted / Endowment Funds	7,496	5,770
Non-Restricted Funds	3,646	2,916
	11,142	8,686

Non-restricted funds are accumulated income funds that are expendable furtherance of the charity's objects. Unrestricted funds may be earmarked or designated for specific future purposes which reduces the amount that is readily available to the charity.

Restricted funds may be accumulated income funds which are expendable only in furtherance of the specified conditions of the donor and the objects of the charity. They may also be capital funds (e.g. endowments) where the assets are required to be invested, or retained for use rather than expended.

32. PFI and LIFT - additional inform

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. Both the Trusts PFI are accounted for as on SORP PFI's. The Trust does not have any off SOFP PFI's.

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 £66,685k for both sites). It also includes a liability for the payment that is required to be made to the PFI partners (totalling £58,443k).

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 and OFF SOFP PFI

	2016-17 £000s	2015-16 £000s
Service element of on SOFP PFI charged to operating expenses in year	**19,926**	17,710
Total	**19,926**	17,710

Payments committed to in respect of off SOFP PFI and the service element of on SOFP PFI		
No Later than One Year	**19,926**	19,214
Later than One Year, No Later than Five Years	**79,704**	76,858
Later than Five Years	**239,934**	236,503
Total	**339,564**	332,575

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

	2016-17	2015-16
	£000s	£000s
No Later than One Year	**12,140**	11,914
Later than One Year, No Later than Five Years	**48,014**	47,282
Later than Five Years	**202,741**	207,949
Subtotal	**262,895**	267,145
Less: Interest Element	**(204,452)**	(206,613)
Total	**58,443**	60,532

Present Value Imputed "finance lease" obligations for on SOFP PFI co	**2016-17**	2015-16
Analysed by when PFI payments are due	**£000s**	£000s
No Later than One Year	**2,325**	2,088
Later than One Year, No Later than Five Years	**9,504**	9,193
Later than Five Years	**46,614**	49,251
Total	**58,443**	60,532

Number of on SOFP PFI Contracts		
Total Number of on PFI contracts	**2**	2

33. Impact of IFRS treatment - current year

The information below is required by the Department of Heath for budget reconciliation purposes	**2016-17 Income £000s**	**2016-17 Expenditure £000s**	2015-16 Income £000s	2015-16 Expenditure £000s
Revenue costs of IFRS: Arrangements reported on SoFP under IFRIC12 (e.g PFI / LIFT)				
Depreciation charges		**1,011**		1,302
Interest Expense		**8,873**		10,316
Impairment charge - AME		**(394)**		11,518
Other Expenditure		**21,291**		19,103
Impact on PDC dividend payable		**232**		59
Total IFRS Expenditure (IFRIC12)	**-**	**31,013**	**-**	**42,298**
Revenue consequences of PFI / LIFT schemes under UK GAAP / ESA95 (net of any sublease revenue)		**31,052**		30,624
Net IFRS change (IFRIC12)		**(39)**		**11,674**
Capital Consequences of IFRS : LIFT/PFI and other items under IFRIC12				
Capital expenditure 2015-16		1,037		0
UK GAAP capital expenditure 2015-16 (Reversionary Interest)		1,285		517

	2016-17 Income/ Expenditure IFRIC 12 YTD £000s	**2016-17 Income/ Expenditure ESA 10 YTD £000s**	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	**1,011**		1,302	
Interest Expense	**8,873**		10,316	
Impairment charge - AME	**(394)**		11,518	
Other Expenditure				
Service Charge	**19,926**	**31,052**	17,710	30,624
Contingent Rent	**1,365**		1,393	
Lifecycle	**-**		-	
Impact on PDC Dividend Payable	**232**		59	
Total Revenue Cost under IFRIC12 vs ESA10	**31,013**	**31,052**	**42,298**	**30,624**
Revenue Receivable from subleasing	**-**	**-**	**-**	**-**
Net Revenue Cost/(income) under IFRIC12 vs ESA10	**31,013**	**31,052**	**42,298**	**30,624**

34. Financial Instruments

34.1. 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 (CCG's) and the way those CCG's 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. The Trust's 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.

The Trust may also borrow from government for revenue financing subject to approval by NHS Improvement. Interest rates are confirmed by the Department of Health (the lender) at the point borrowing is undertaken.

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 [organisation] has low exposure to credit risk. The maximum exposures as at 31 March 2017 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 CCG'ss, 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.

34.2. Financial Assets

	At 'fair value through profit and loss'	Loans and receivables	Available for sale	Total
	£000s	£000s	£000s	£000s
Embedded derivatives	0			**0**
Receivables - NHS		14,913		**14,913**
Receivables - non-NHS		7,040		**7,040**
Cash at bank and in hand		3,975		**3,975**
Total at 31 March 2017	**0**	**25,928**	**0**	**25,928**
Embedded derivatives	0			0
Receivables - NHS		12,768		12,768
Receivables - non-NHS		9,635		9,635
Cash at bank and in hand		7,531		7,531
Total at 31 March 2016	0	29,934	0	29,934

34.3. Financial Liabilities

	At 'fair value through profit and loss'	Other	Total
	£000s	£000s	£000s
Embedded derivatives	0		**0**
NHS payables		4,610	**4,610**
Non-NHS payables		16,780	**16,780**
Other borrowings		44,115	**44,115**
PFI & finance lease obligations		61,496	**61,496**
Total at 31 March 2017	**0**	**127,001**	**127,001**
Embedded derivatives	0		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
Total at 31 March 2016	0	126,279	126,279

35. Events after the end of the reporting period

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

36. 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
NHS England South Central
NHS England Wessex
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.

One of the Trusts Directors is also a Director of Scanappeal which is a charity linked to the Trust.

37. Losses and special payments

The total number of losses cases in 2016-17 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	556,541	171
Special payments	21,616	39
Total losses and special payments and gifts	578,157	210

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

38. 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.

38.1. 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	2016-17 £000s
Turnover	252,488	275,643	280,557	294,906	345,367	340,397	350,921	359,449	369,844	370,225	**391,843**
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)	**(617)**
Adjustment for:											
Timing/non-cash impacting distortions:											
Adjustments for impairments	-	-	-	28,236	(2,407)	(2,751)	7,226	(5,670)	14,702	14,215	**(1,722)**
Adjustments for impact of policy change re donated/government grants assets						734	(341)	37	(1,137)	(630)	**225**
Consolidated Budgetary Guidance - adjustment for dual accounting under IFRIC12*				0	779	527	616	724	114	156	**355**
Break-even in-year position	**43**	**1,729**	**(2,750)**	**146**	**1,026**	**2,848**	**299**	**320**	**(7,446)**	**(10,867)**	**(1,759)**
Break-even cumulative position	**(2,934)**	**(1,205)**	**(3,955)**	**(3,809)**	**(2,783)**	**65**	**364**	**684**	**(6,762)**	**(17,629)**	**(19,388)**

* Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, NHS [organisation]'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 %	2016-17 %
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	**-0.45**
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	**-4.95**

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 Breakeven recovery is 2018-19

38.2. 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%.

38.3. External financing

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

	2016-17 £000s	2015-16 £000s
External financing limit (EFL)	8,849	23,007
Cash flow financing	6,521	20,796
Finance leases taken out in the year	-	790
External financing requirement	**6,521**	21,586
Under/(over) spend against EFL	**2,328**	1,421

38.4. Capital resource limit

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

	2016-17 £000s	2015-16 £000s
Gross capital expenditure	11,897	15,415
Less: donations towards the acquisition of non-current assets	(966)	(1,710)
Charge against the capital resource limit	**10,931**	13,705
Capital resource limit	11,078	16,546
(Over)/underspend against the capital resource limit	**147**	2,841

39. 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 2017 £000s	31 March 2016 £000s
Third party assets held by the Trust	**1**	3

40 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 so has been consolidated.

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 considered 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 dividends.
   •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.

40.1 Group Statement of Comprehensive Income

	2016-17				2015-16			
	Trust Only	Charity Only	Inter - Company**	**Consolidated**	Trust Only	Charity Only	Inter - Company**	**Consolidated**
	£'000	£'000	£'000	**£'000**	£'000	£'000	£'000	**£'000**
Gross employee benefits	(240,327)	-	-	**(240,327)**	(236,666)	-	-	**(236,666)**
Other operating costs	(135,757)	(1,394)	671	**(136,480)**	(140,281)	(1,274)	791	**(142,346)**
Revenue from patient care activities	360,502	0	-	**360,502**	345,713	-	-	**345,713**
Other Operating revenue	31,341	2,579	(671)	**33,249**	24,512	980	(791)	**26,283**
Operating surplus/(deficit)	15,759	1,185	0	**16,944**	(6,722)	(294)	-	**(7,016)**
Investment revenue	33	269	-	**302**	36	239	-	**275**
Other gains and (losses)	(27)	-	-	**(27)**	227	-	-	**227**
Finance costs	(11,674)	-	-	**(11,674)**	(12,642)	-	-	**(12,642)**
Surplus/(deficit) for the financial year	4,091	1,454	-	**5,545**	(19,101)	(55)	-	**(19,156)**
Public dividend capital dividends payable	(4,708)	-	-	**(4,708)**	(5,507)	-	-	**(5,507)**
Retained surplus/(deficit) for the year	(617)	1,454	-	**837**	(24,608)	(55)	-	**(24,663)**

Other Comprehensive Income	2016-17				2015-16			
	Trust Only	Charity Only	Inter - Company	**Consolidated**	Trust Only	Charity Only	Inter - Company	**Consolidated**
	£'000	£'000	£'000	**£'000**	£'000	£'000	£'000	**£'000**
Impairments and Reversals	0	-	-	**-**	-	-	-	**-**
Net gain/(loss) on revaluation of property, plant & equipment	428	-	-	**428**	1,454	-	-	**1,454**
Net gain/(loss) on revaluation of financial assets	0	976	-	**976**	-	(357)	-	**(357)**
Total Comprehensive Income for the year*	(189)	2,430	-	**2,241**	(23,154)	(412)	-	**(23,566)**

*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.

In addition to the associated charity the Trust also has created a wholly owned subsidiery for the purpose of managing its outpatient pharmacy prescribing. The company, Buckinghamshire Healthcare Projects ltd was incorporated in 2016/17 but will not start trading until 2017/18. The company will be consolidated in the 2017/18 accounts.

40.2 Group Statement of Financial Position

	2016-17				2015-16			
	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	261,663	-		261,663	259,309	-	-	259,309
Intangible assets	1,060	-		1,060	733	-	-	733
Other Investments - Charitable	0	8,353		8,353	0	7,380	-	7,380
Trade and other receivables	4,312	0		4,312	2,005	0	-	2,005
Total non-current assets	267,035	8,353	-	275,388	262,047	7,380	-	269,427
Current assets:								
Inventories	6,384	1	-	6,385	5,903	2	-	5,905
Trade and other receivables	27,463	1,200	(183)	28,480	29,152	676	206	29,622
Other current assets	146	-	-	146	163	-	-	163
Cash and cash equivalents	3,975	1,881	-	5,856	7,531	849	-	8,380
Total current assets	37,968	3,082	(183)	40,867	42,749	1,527	206	44,070
Non-current assets held for sale	325	-	-	325	325	-	-	325
Total current assets	38,293	3,082	(183)	41,192	43,074	1,527	206	44,395
Total assets	305,328	11,435	(183)	316,580	305,121	8,907	206	313,822
Current liabilities								
Trade and other payables	(28,151)	(293)	183	(28,261)	(30,228)	(220)	(206)	(30,242)
Other liabilities	(24)	-	-	(24)	(165)	-	-	(165)
Provisions	(443)	-	-	(443)	(437)	-	-	(437)
Borrowings	(3,113)	-	-	(3,113)	(2,904)	-	-	(2,904)
Working capital loan from Department	(1,142)	-	-	(1,142)	(1,142)	-	-	(1,142)
Capital loan from Department	(723)	-	-	(723)	(723)	-	-	(723)
Total current liabilities	(33,596)	(293)	183	(33,706)	(35,599)	(220)	(206)	(35,613)
Net current assets/(liabilities)	4,697	2,789	-	7,486	7,475	1,307	-	8,782
Non-current assets plus/less net current assets/liabilities	271,732	11,142	-	282,874	269,522	8,687	-	278,209
Non-current liabilities								
Trade and other payables	(312)	-	-	(312)	(624)	-	-	(624)
Provisions	(1,240)	-	-	(1,240)	(1,286)	-	-	(1,286)
Borrowings	(58,383)	-	-	(58,383)	(61,543)	-	-	(61,543)
Working capital loan from Department	(37,196)	-	-	(37,196)	(30,532)	-	-	(30,532)
Capital loan from Department	(5,054)	-	-	(5,054)	(5,777)	-	-	(5,777)
Total non-current liabilities	(102,499)	-	-	(102,499)	(100,100)	-	-	(100,100)
Total Assets Employed:	169,233	11,142	-	180,375	169,422	8,687	-	178,109
FINANCED BY:								
TAXPAYERS' EQUITY								
Public Dividend Capital	181,951		-	181,951	181,951		-	181,951
Retained earnings	(50,984)		-	(50,984)	(50,367)		-	(50,367)
Revaluation reserve	38,266		-	38,266	37,838		-	37,838
Charitable Funds Reserve	-	11,142	-	11,142	-	8,687	-	8,687
Total Taxpayers' Equity:	169,233	11,142	-	180,375	169,422	8,687	-	178,109

*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.

ANNUAL GOVERNANCE STATEMENT

Annual Governance Statement 2016/17

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 LLP) and Internal Auditors (Risk Assurance Services LLP), counter fraud (Risk Assurance Services LLP) and an internal Clinical Audit function.

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' focused inspection of medical, surgical and end of life care services at Stoke Mandeville and Wycombe Hospitals, and focused inspection of Buckingham Hospital in September 2016 as published in February 2017.
- External scrutiny 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.
- Monitoring from other regulators such as the Health and Safety Executive.
- 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.
- NHS Improvement 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, Strategic Workforce Committee, Audit Committee, Charitable Funds Committee, Nominations and Remuneration 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'.

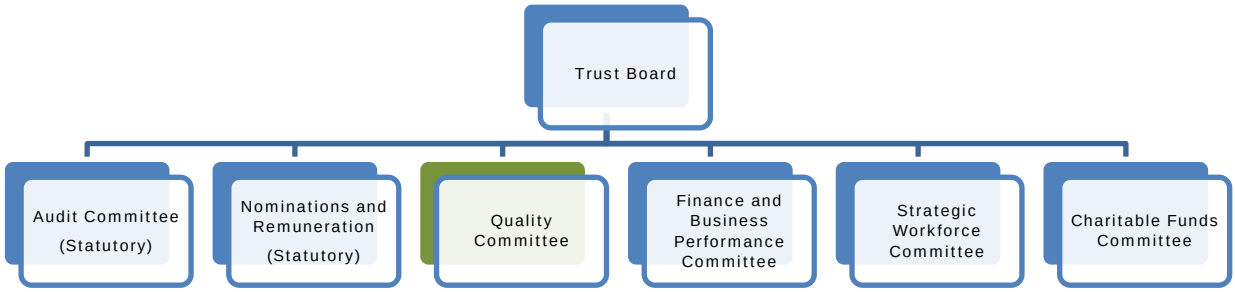
3. THE GOVERNANCE FRAMEWORK OF THE ORGANISATION

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 Reservation and Delegation of Powers for the regulation and development of its proceedings and business with integral Standing Financial Instructions.

The Trust Board comprises a Chair appointed by NHS Improvement (NHSI), five Non-Executive Directors appointed by NHSI 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 two associate Non-Executive Directors (non-voting) and two non-voting Executive Directors. There is currently a vacancy (since 1 March 2017) in one Non-Executive director post which NHSI are working with the Trust to fill.

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'.

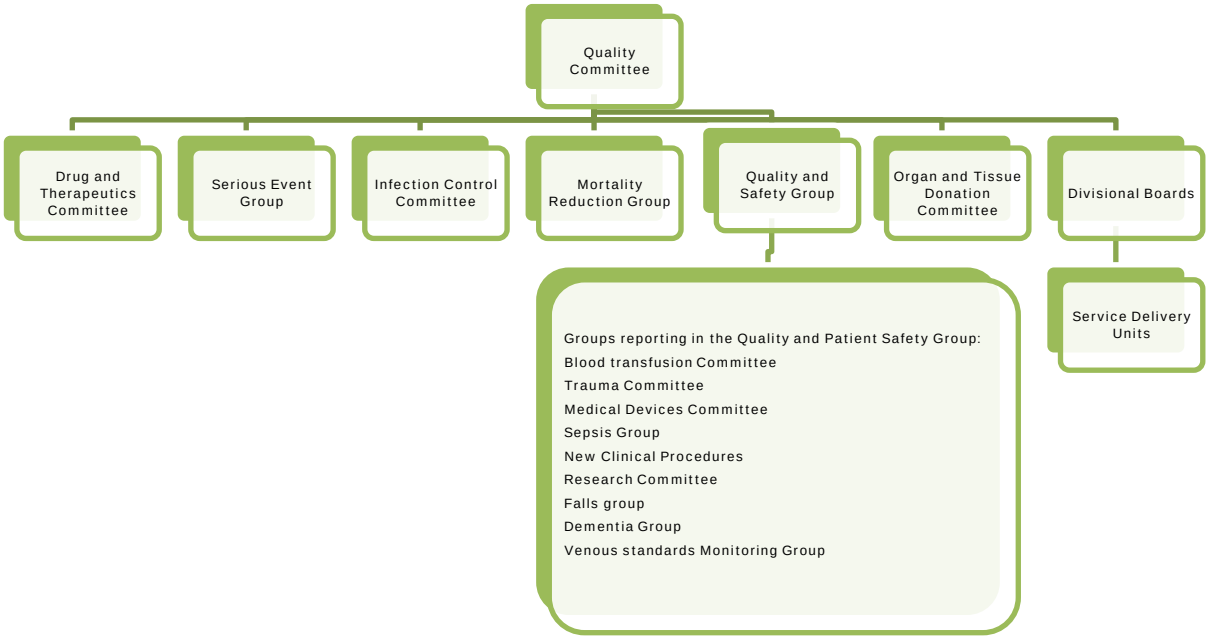
Figure 1 Board of Directors Committee Structure



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

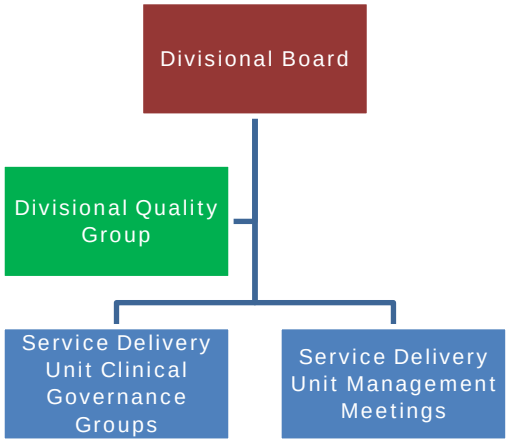


Also important to the governance process are the Executive Management Committee and its sub-committees as shown in Figure 3 below. The Executive Management Committee is the key decision making and risk committee. It is chaired by the Chief Executive Officer and attended by the Executive Team, Director for Governance and Director of Communications. 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

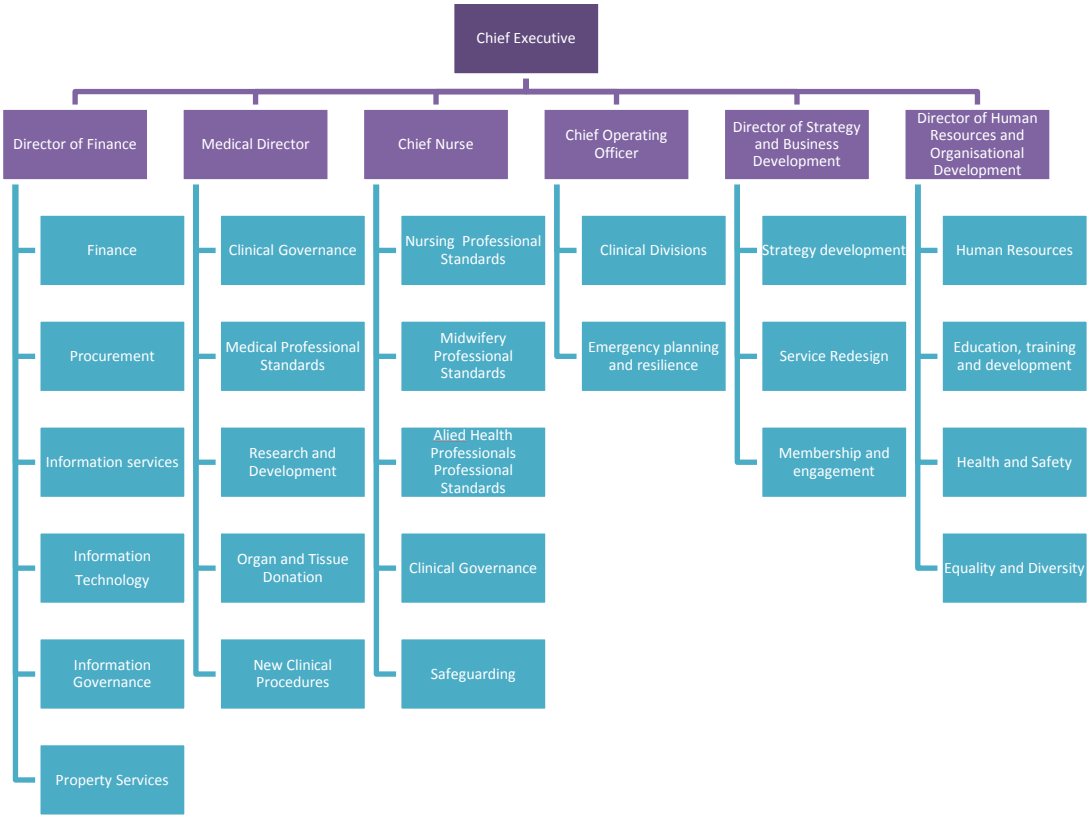
The clinical services are delivered through five clinical divisions each led by a Consultant Doctor, Divisional Director and Associate Chief Nurse. The five Divisions are the Division of Surgery and Critical Care, the Division of Women and Children, the Division of Specialist Services, the Division of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

Figure 5 Executive portfolios



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

3.1 Description of Board and Committees

3.1.1 Trust Board

The Trust Board 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 committees work together to deliver an integrated approach to governance. The Board Assurance Framework and the Integrated Performance Report each indicate which Committee scrutinises which element of assurance. Each of the committees has a Non-Executive chair and membership. There is a significant common membership across the four committees. Every Committee 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.

The Audit Committee is invested with sufficient authority to act with independence.

The Audit Committee members comprised the panel advising the Trust Board on the appointment of External Auditors. This was exercised in year with the outcome of the appointment of Grant Thornton UK LLP for 17/18.

Mr Rajiv Jaitly chaired the Audit Committee from April to June 2016. A re-organisation of Board Committee membership took place in June 2016 and as a result Mr Graeme Johnston took over as Chair of the Audit Committee in July 2016.

One of the Non-Executive Directors, Mr David Garmon-Jones left the Trust in February 2017 which has left one NED vacancy on the Committee.

Meeting Date	Number of members attending
12th May 2016	3
26th May 2017 (Extraordinary)	2
14th July 2016	4

Meeting Date	Number of members attending
15th September 2016	3
17th November 2016	4
12th January 2017	3
8th March 2017	3

The meetings that each member was eligible to attend, together with actual attendances, are shown below. The Board attendance record is presented at each Board meeting held in public.

Member	Number of meetings eligible to attend	Number of meetings attended
Graeme Johnston	7	7
Rajiv Jaitly	7	7
Rachel Devonshire	5	5
David Garmon-Jones	6	4

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 January 2017.

The Audit Committee has received the Board Assurance Framework in full four times in the year in July, September, November 2016 and March 2017. The Committee is satisfied that it covers the full range of risks to achieving the objectives of the Trust. The Audit Committee has received assurance from the Quality Committee, Finance and Business Performance Committee and the Strategic Workforce Committee in relation to their more detailed review of individual risks. 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. The Committee has acknowledged in the year the progress with the development of the Board Assurance Framework and the significant assurance rating provided by Internal Audit.

Review of the highest risks on the corporate risk register has allowed the Committee to assure itself the system of operational 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, Strategic Workforce 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 2016/17 at the March meeting, and in April the members of the Committee were provided with an opportunity to comment on its contents. The Accountable Officer presented the final draft of the Annual Governance Statement for 16/17 to the Audit Committee on the 11 May 2017. 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 recommended the Board's approval of the AGS.

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. Internal auditors 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 2016/17. 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 2016/17 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 2016/17 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 Accountable Officer meets with External Audit at least twice a year. This enables him to raise issues with them as necessary, brief them on any strategic developments and hear from them if they have any concerns.

The Trust has been through a procurement process to appoint its own external auditor for the 2017/18 financial statements and the Board have ratified the appointment of Grant Thornton following a recommendation from the appointment panel.

During the year, members carried out a self-assessment replying to questions based on criteria set out in the NHS Audit Handbook 2014.

The Committee is due to have 6 standard meetings in 2017/18 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 2017/18.

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

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 will provide assurance as to the actions taken to address the risk.

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 16/17 particularly on progress against actions within the Quality Improvement Plan to deliver the Quality Improvement Strategy. The Committee has seen significant progress with the actions in the plan and has noted improvement in indicators relating to mortality, pressure ulcers and early recognition of the deteriorating patient. The Committee has challenged level of compliance with statutory training, and in particular Level 3 Safeguarding training and has been monitoring a plan to improve compliance. The Committee receives the integrated performance Floodlight report and quality related exception reports.

The Quality Committee has received assurance with regard to the design and delivery of the Clinical Audit programme and has challenged the organisation to have a more focused, risk based approach to the programme and to provide greater assurance on closing the loop on identified actions.

A structured programme of clinical service review deep dives has been followed through the year providing assurance from ward to Board.

The Committee welcomes a colleague from the Clinical Commissioning Group to the meeting to provide a level of external scrutiny and challenge.

3.1.4 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 underpin assurance and seek out 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 statutory and 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 2016/17 through the following measures:

- Control mechanisms within the Medway application.
- A programme of clinical audit, including engagement with required national audits.
- External reviews initiated by the Trust.
- Results from National Staff Survey showing improvement in an open, learning culture.
- 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.

Serious Incident Framework and Process

The Patient Safety Team is responsible for the Trust wide Serious Incident (SI) management process. As part of the management of SIs the trust hold monthly Executive led internal Serious Incident approval panels (SE Group). To complement this, there is a quarterly Serious Incidents approval panel specifically for fall. This was set up specifically as part of a range of innovative approaches the trust is taking to actively prevent and reduce harm from falls.

The SE Group has two main functions i) to internally approve SI reports for submission to the Clinical Commissioning Group (CCG) and ii) to disseminate learning from SIs.

Assurance for the management of SIs is through regular panel meetings with Aylesbury Vale CCG and Chiltern CCG to facilitate timely sign off of SI's and this forum enables discussion on the quality of reports and investigations. It also provides assurance that the Trust is tracking completion of action plans, with sustainability of improvements evidenced.

The number and types of serious incidents is tracked closely. There is a focus on high quality investigations and analysis to enable rich learning to arise from the incidents with the aim of developing preventative strategies to ensure the incidents do not reoccur in other areas.

Learning from Serious Events is also widely shared at Academic Half Days.

3.1.5 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 capital or revenue business case above the value of £1m.

The Committee has focused in 16/17 on consistency of delivery and transparency of information in relation to managing the risks in relation to the financial plan.

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 Committee has sought and received assurance in relation to business continuity processes.

3.1.6 Strategic Workforce Committee

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.

The Committee receives assurance around Health and Safety processes and compliance. The Committee has asked for systematic approach to the way in which it receives this assurance and this will further develop in 17/18.

The Committee receives the integrated performance Floodlight Report and reviews exception reports relating to workforce.

A particular focus in 16/17 has been the embedding of the organisational values and behaviours.

The Committee has recently invited a representative from Health Education Thames Valley to become a member in order to strengthen strategic discussions around workforce development.

3.1.7 Nominations and Remuneration Committee

The Nominations and Remuneration Committee monitors and takes decisions on:

- The formal, rigorous and transparent procedures in place for the appointment of Executive Directors to the Board.
- Executive salaries.
- The talent management of senior leaders in the organisation.
- The ratification of Clinical Excellence Awards in line with recommendations from a NED chaired Clinical Excellence Award panel.
- Restructuring and redundancy as required.

3.1.8 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 some changes in 16/17. Changes are set out below.

Directors who have left the Board

Name	Post	Leaving date
Mr Les Broude	Non-Executive Director	April 2016
Mr Dominic Tkaczyk	Interim Director of Finance	May 2016
Mr Wayne Preston	Interim Director of Finance	August 2016
Mr David Garmon-Jones	Non-Executive Director	February 2017

Directors who have joined the Board

Name	Post	Date
Mr James Drury	Director of Finance	Commencement September 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. The work has included testing of best practice, talent management and leadership development.

Each Board member has received an appraisal and has a personal development plan in place.

The Board has developed its risk appetite statement in October 2016 and ratified this in January 2017.

3.3 Board Performance

The Board reviewed its own performance in December 2016 with the support of an external facilitator. The purpose of the review was to carry out a robust evaluation of the Board's collective performance effectiveness and to identify individual contributions and how to channel them to enhance Board synergy.

Throughout the workshop the Board engaged in reflective learning, constructive challenge and peer feedback. Key Achievements included:

- Significant progress in achieving financial sustainability by 2018
- Positioning BHT as lead provider for Healthcare across the system
- Redesign of Services from a patient perspective
- Driving up the pace of delivery by speeding up decision-making and planning process and empowering Divisions to move things forward (without letting go of the Board's scrutiny role)

During 2016 the Board worked hard to keep strategic goals clear and concise. The communication of these goals has played a key part in giving clarity of focus and direction at all levels across BHT. Alongside these achievements the Board continues to strengthen its reputation as a strong, effective leadership team both internally and externally.

The Board saw a need to further tackle system issues which have the potential to contribute to patient harm, to work on sharpness in the framing of each subject under discussion, and to work on improving Board synergy to playing more to individual strengths.

Underpinning all this has been a focus on relationships with partner organisations, and on learning from the best in other organisations.

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 draws on best practice as relevant to an NHS Trust from the UK Corporate Governance Code and the Foundation Trust Code of Governance to shape its governance processes.

3.6 Statutory functions

Many of the statutory functions of the Board are set out in the Standing Orders Reservation and Delegation of Powers 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.

The Compliance with Legislation policy has been reviewed and updated in 2016. Each relevant statute has an Executive lead who provides assurance of compliance. This policy includes an Assurance Map illustrating the various sources of assurance of compliance.

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.

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 and Committee 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 6: Risk Communication Process for Board Assurance Framework

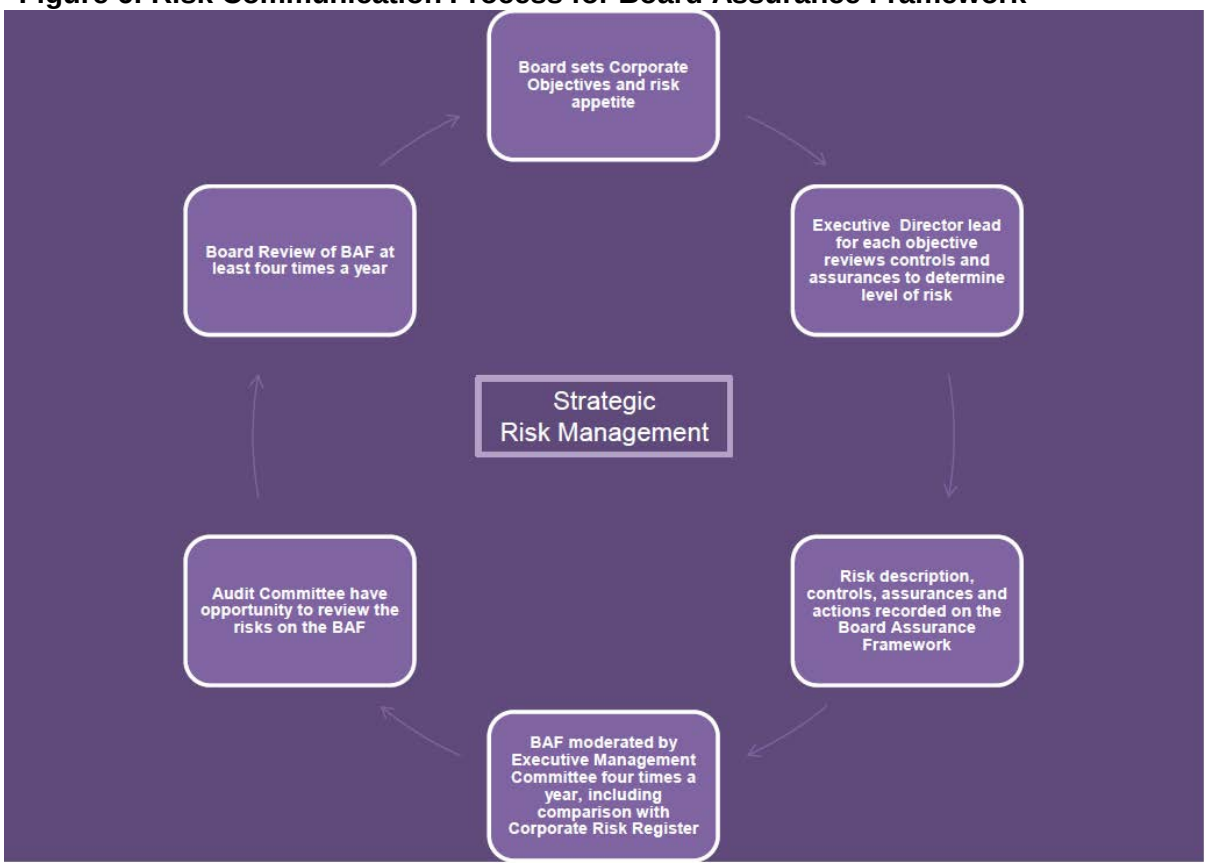
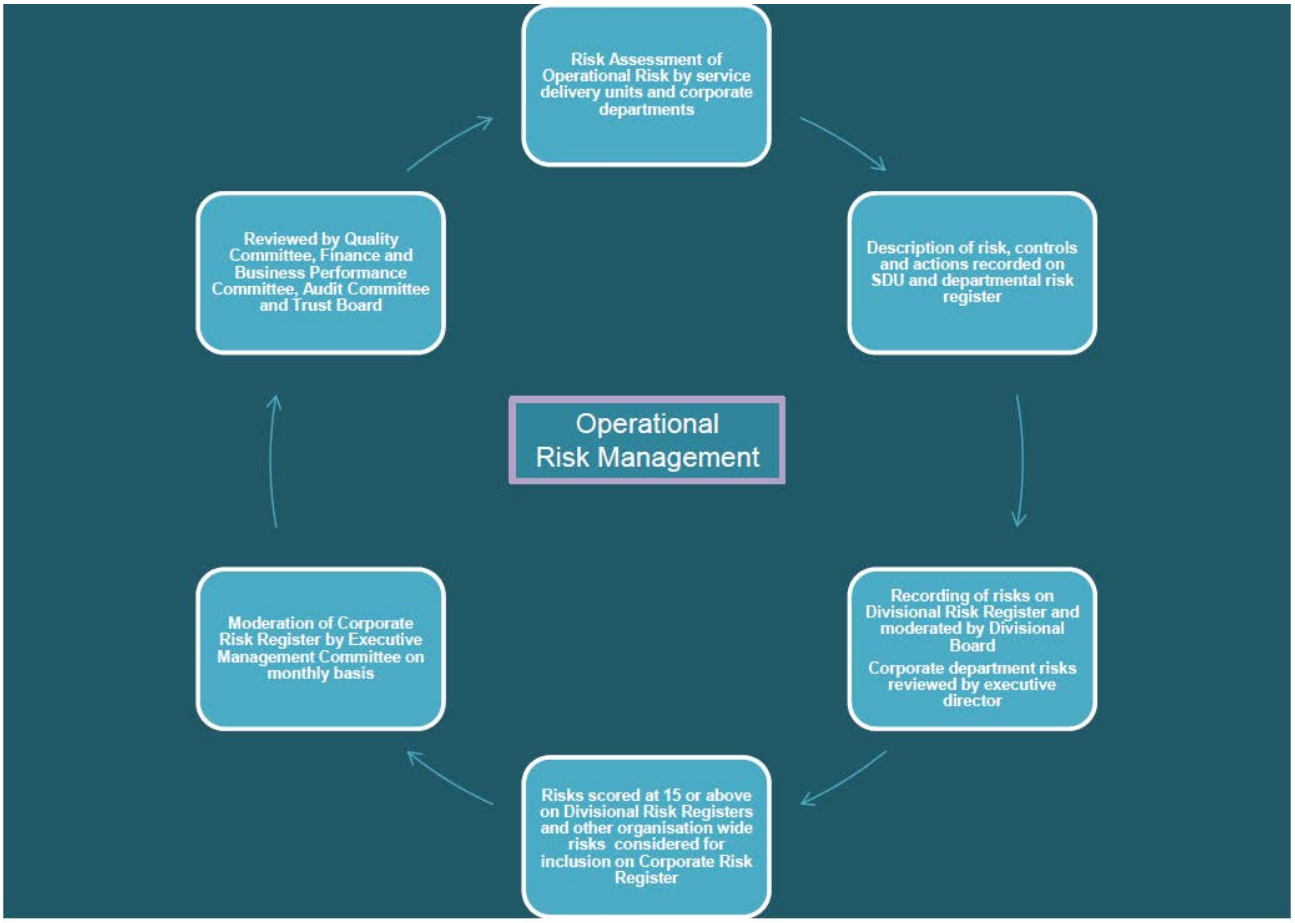


Figure 7: Risk Communication Process for Corporate Risk Register



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.
- Procurement Adviser.
- Workforce Best Practice Advisers.

4.2 Risks Identified in 2016/17

A range of risks were identified in 2016/17 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 substantive 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.

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 for the Trust to recover from its deficit position.

- The risk around the cash position has also been monitored and managed through the year.

4.2.5 Information risk

During 2016/2017 there have been two Level 2 serious incident data breaches. Both of these were disclosures of information in error. These breaches were reported to the ICO via the IG Toolkit and both have been assessed and closed by the ICO with no further action required.

Both incidents were reported to the Caldicott Guardian and SIRO and were thereby assessed for the level of seriousness. The incidents were then considered by both 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.

4.2.6 Deficiencies resulting in realised risk

In summary, the deficiencies resulting in realised risk in 2016/17 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 17/18 (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).
- Issues relating to compliance with the 18 week admitted pathway for elective treatment.
- The Trust received some requirement notices following the Care Quality Commission inspection in September 2016, report published in February 2017. The Trust worked through the year on a comprehensive Quality Improvement Plan. This is considered in more detail in section 6.1

4.3 Future Risks

Many of the risks described in 16/17 will continue to be risks in 17/18, 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.
- 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
- Commission external reviews when appropriate
- 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 14 of the HSCIC Information Governance Toolkit. The Trust's end of year overall submission for 2016/17 achieved a score of 85% resulting in a 'satisfactory' rating. During 2016/17, internal Auditors 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

The review for 16/17 should be considered in the context of the strategy and vision approved by the Trust Board in 2016. The key pillars of this strategy relate to Quality, People and Money and set the foundations for a sustainable future. Considerable effort has been put into engaging leaders within the organisation in a way that builds shared ownership of the vision and strategy, and there have been a variety of mechanisms whereby every member of staff has the opportunity to engage with the key messages.

The following 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' Focused Inspection of Surgical, Medical and End of Life Care Services at Stoke Mandeville and Wycombe Hospitals, and Focused Inspection of the inpatient ward at Buckingham Hospital.

The inspectors recognised the continued progress that the Trust has made since its last inspection in 2015, demonstrating improvements in the culture and quality of care it provides in the majority of areas inspected, though with some areas in need of improvement.

The CQC inspection report stated: "In all areas, patients and relatives were positive about the caring attitude of staff, their kindness and compassion" and "Staff worked effectively within their team and with other teams to provide co-ordinated care to patients, which focused on their needs."

Each of the four services retained their overall 'requires improvement' rating, though many individual elements were rated as good. In particular all services were rated as 'good' for caring. Out of a total of 35 service domain ratings, the Trust received 21 good, 14 requires improvement and 0 inadequate ratings.

Significant improvements in the majority of areas inspected were highlighted, including:

- The Excellence Reporting initiative – reporting and learning from excellent care to ensure that 'success breeds success' - has been highlighted as an area of outstanding practice.
- Safeguarding knowledge of staff is good and people understand the actions required to protect the safety of patients in vulnerable situations.
- Multidisciplinary working is embedded across all wards: "Staff worked effectively within their team and with other teams to provide co-ordinated care to patients, which focused on their needs."
- Services are responsive to the needs of local people: "working in partnership with local commissioners to plan and deliver services to meet the needs of local people." The development of our stroke unit at Wycombe Hospital being a good example of this.
- Our use of the National Early Warning Score to identify when a patient's condition is deteriorating.
- Our values and vision for the Trust are understood by staff. We have "an open and transparent culture" and that "the leadership of the Trust and within the division were visible and supportive."

The report also identified areas for further development. This included improvements in the management of medicines, environmental improvements, consistency in record keeping, governance processes, learning from incidents, and training.

The report identified compliance actions (requirement notices) against six of the Care Quality Commission regulations. These included reference to end of life care plans, documentation of checks on anaesthetic machines and resuscitation equipment, storage and management of medicines, pharmacist vacancies, and capacity assessments.

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.

Specific clinical reviews by relevant experts

During the year the Trust has sought assurance on specific clinical issues by using independent external reviews. These reviews have included a review of still births by the Royal College of Obstetricians and Gynaecologists, a review of operating theatres by Professor Jane Reid, and a review of the pharmacy service through NHS Improvement. Findings from these reviews have been presented to the Quality Committee along with actions to address any identified learning. The Quality Committee continues to monitor the completion of action plans.

6.2 Internal Audit

The Head of Internal Audit has provided the following opinion for 16/17:

Head of internal audit opinion 2016/2017

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 16/17 the Internal Audit programme issued 18 reports of which one is an advisory report. The assurance ratings are below:

Substantial Assurance: (3)

- Divisional Risk Management
- Board Assurance Framework
- Payroll (DRAFT)

Reasonable Assurance: (10)

- Nursing Revalidation
- Financial Forecasting and CIPs
- Appraisals
- Application of Agency Cap
- Accounts Receivable
- Creditors
- Follow Up - PPM
- E Rostering
- Recruitment
- Infection Control

Partial Assurance: (4)

- Clinical Audit
- Sis and Complaints
- Data Quality – A & E
- Asset Management

Advisory: (1)

- PFI – Catering

All partial and no assurance 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.

All recommendations were considered by the relevant executive director and management leads and actions put in place to address. High priority actions included the following:

- Improved communication within the Accident and Emergency department with speciality doctors reporting to the coordinator before leaving the department.
- Agreement of internal professional standards within the Accident and Emergency department.
- Strengthen documentation processes within the Accident and Emergency department.
- Ensuring that all cost improvement plans have completed quality impact assessments.
- Standard procedures for catering tasks at ward level by Sodexo.
- Strengthening asset review throughout the year.
- Use of standardised supplier amendment form.
- More performance data around management of Serious Incidents in Divisional Quality Reports.

The Accountable Officer meets with Internal Audit at least once a year. This enables him to raise issues with them as necessary, brief them on any strategic developments and hear from them if they have any concerns.

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 operational performance report demonstrated compliance over the year for all indicators with the following exceptions:

- The 4 hour emergency access target which achieved 90.5% against a standard of 95%
- MRSA bacteraemia, 1 recorded cases against a zero standard
- Clostridium difficile infection rate – 44 recorded cases against a standard of 32
- Admitted patients finishing their pathway – achieved 89.89% by 31st March (full year position)

All cover access standards are assured of accuracy and risk through a rolling programme of both internal and external audit assurance (managed by the audit committee) which advises of risk to the quality and accuracy of the data.

6.4 National Staff Survey

In 2016 we sampled all of our staff and the results represent the views of 53% of the workforce, some 2997 staff members.

In 2016 we significantly improved on 12 Key Findings, showed no statistical change on 18 Key Findings and deteriorated on no Key Findings.

Improvements:

Errors and incidents

- KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents
- KF31. Staff confidence and security in reporting unsafe clinical practice

Health and wellbeing

- KF17. % feeling unwell due to work related stress in the last 12 months
- KF19. Organisation and management interest in, and action on, health and wellbeing
- Working patterns
- KF16. % working extra hours

Job satisfaction

- KF1. Staff recommendation of the organisation as a place to work or receive treatment

Errors and incidents

- KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents
- KF31. Staff confidence and security in reporting unsafe clinical practice

Health and wellbeing

- KF17. % feeling unwell due to work related stress in the last 12 months
- KF19. Organisation and management interest in, and action on, health and wellbeing

Working patterns

- KF16. % working extra hours

Job satisfaction

- KF1. Staff recommendation of the organisation as a place to work or receive treatment

In 2016 the Trust focused on a few key areas of priority and set goals against these as follows:

- Encourage more staff to engage with the survey (increase response rate from 52% to 65%)
- Improve staff engagement score (from 3.76 to 3.90)
- Ensure staff feel secure raising concerns about unsafe clinical practice (score to increase from 3.55 to 3.70)
- Improve scores on equalities questions for BME staff
- On equal opportunities for progression (from 70% to 80%)
- On personal experience of discrimination from managers/colleagues (from 13% to 7%)
- Improve quality of appraisals (from 3.03 to 3.20)
- Improve fairness and effectiveness of safety reporting (from 3.61 to 3.65)

Although the Trust did not achieve every target improvement in the staff survey there was improvement in every area identified as a priority, and some of the improvements were significant.

6.5 Clinical Audit

A wide range of clinical audits have been undertaken in 2016/17 and these 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 Serious Incidents and Never Events

One area where there has been evidence of sustainable change in relation to Serious Incidents is with the most serious Category of Pressure Ulcers Category 3 & 4. Significant and effective improvement work has been undertaken– with only 6 reported in 2016/17 – the last of which was in August 2016.

The most high volume types of serious incidents relate to:

Type	Comment
Falls	BHT is working with the regional Academic Health Science Network to develop a holistic approach to prevention of Falls using data to inform practice.
Diagnostic incidents	There is continued Trust wide focus on the importance of using the National Early Warning Score (NEWS) for escalation and response to patients who have changing care needs within a short period of time. There is an expectation that all clinical staff ensure that the SBAR (Situation, Background, Assessment, Recommendation approach to communication is used for escalation of a patient's needs.
Maternity incidents	Maternity services have focused on the findings from the Royal College of Obstetricians and Gynaecologists (RCOG) to improve services and recently developed a governance structure which links more strongly with other service development units within the Division to facilitate sustainable learning from serious incidents.

The Trust declared three Never Events in Quarter 1, one Never Event in Quarter 2 and no Never Events in Quarters 3 and 4. These are summarised below:

- Wrong route administration of medication. No long term physical harm to patient.
- Incorrect lens implanted into patient's eye. No long term physical harm to patient.
- Misidentification of patient led to an unintended invasive procedure. No long term physical harm to patient reported.
- Wrong finger surgery. Patient had a return to theatre for the planned procedure and has scarring as a surgical scar for the unintended incident.

Each has been separately investigated and actions taken to minimise the risk of recurrence.

6.7 Public Sector Equality Duty

Information for the forthcoming Public Sector Equality Duty (PSED) publication for 2016/17 is currently being collected and analysed ready for publication in May 2017. Work has focused on career progression and promotion and retention particularly in reference to BME (Black and Minority Ethnic) staff in bands 7 and above. Areas relating to these areas given additional focus over the past year and resulting in the following actions include:

- The review of key Trust processes including the appraisal process e.g. a new online appraisal process is currently being launched.
- The review of key linked policies, e.g. medical error policy, and the dignity & respect at work policy.
- A focus on recruitment , with values based recruitment rolled out during the latter half of the year

- Career support for all existing staff – but also to support in particular BME staff of band 7 and above.

The most recent staff survey results have shown some positive improvements in this area with the "percentage of BME staff believing that the organisation provides equal opportunities for career progression or promotion", showing an increase from 70% in 2015, to 81% in 2016 (ranking the Trust as "better than average").

The Trust now also ranks better than average for BME staff reporting they have personally experienced discrimination over the past 12 months from managers/team leaders or other colleagues decreasing to 12% in 2016. Whilst both these results are encouraging, there is still work to do and we will continue to address and monitor.

Work has been progressed and is ongoing against the equality objectives which are published and progress will be updated in May when publishing the PSED.

With regard to the Accessible Information Standard (AIS), good progress has been made with an established Trust steering group, which is led by the Director of Human Resources who is also the Executive lead for Equality & Diversity. AIS awareness training for all staff is now part of our statutory training, pay-day training and is referenced at corporate inductions. We have recorded near 50 different cascade routes for AIS information across the Trust. We have run a pilot project for our Out-Patients Department at Stoke Mandeville Hospital which is now rolling out across other OPD areas in a staged implementation. Staff in the pilot area have informed the development of a process and posters and we have developed a two sided toolkit for staff for quick reference. The Trust is progressing with the implementation of new systems such as SMS texting and Hybrid mail the latter will follow in a staged implementation after texting. This remains a risk on the corporate risk register until this is fully implemented.

We have developed a Trust poster which is fully implemented in the pilot areas and radiology on all sites which is a sub-pilot area. We have the poster implemented on the pilot area patient screens to be rolled out further once poster and toolkit are rolled out. We have also had regular items to keep awareness raised via team brief, staff bulletin and we have information and a resource page on our intranet

Annual equality and diversity report is submitted to the Strategic Workforce Committee.

Three representatives from the Trust have recently completed the NHS Employers Diversity and Inclusion Programme and received a final award on behalf of the Trust. This is a programme designed to support development and sharing of good practice in implementing national and local equality and diversity initiatives across the Country.

6.8 Our Financial Performance

The Trust faced another challenging year financially ending with a £1.8m deficit compared to its planned surplus of £5.2m.

Within this out-turn a Cost Improvement Plan (CIP) of £17.3m was achieved.

The Finance and Business Performance Committee has continued to focus through the year on monitoring the delivery of the three year action plan towards an underlying break-even position. The action plan includes the following key elements:

- The engagement of a Transformation Director to develop the process and plans to deliver the Financial Transformation Programme.

- Budget setting is more formal, with an agreement of a realistic but challenging starting position. For the 2017/18 financial year divisional lead and corporate leads who hold budgets will meet, agree and sign off budgets with the Chief Executive, Chief Operating Officer and Director of Finance.
- Budget review and monitoring has been aligned to the NHSI Reporting Framework, from October 2016, establishing Control Totals, with movements allowable at set points in the financial year.
- Budgetary reporting is moving to a more balanced format that facilitates income and expenditure reporting, and allocates the costs of activity to the budget holders who are responsible for the spend.
- 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.
- Contract Management has been strengthened especially with regard to PFI contracts.
- The Trust has developed a Procurement Transformation Plan and is discussing future benefits and opportunities as part of the Strategic Transformation Plan footprint.
- iSLR will go live in Q1 of 2017/18, 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.
- The Business Case governance processes have been redesigned to better enable assurance of Value for Money assessment, and evidence contribution to the Trust Financial Improvement Programme.

The organisation is engaged in a significant transformation programme and volunteered to be involved in the NHSI FIP2 work stream, engaging a partner to assist delivery. The Trust continues to build upon the work from Lord Carter, as one of the original cohort organisations. The Trust participates in other benchmarking exercises, through the Benchmarking Network, and NHSI. It is anticipated that it will take a further two years to achieve an underlying break-even / surplus position.

In February 2017 the Trust identified a potential fraud in the procurement department that is in the process of being investigated by the Local Counter Fraud Specialist team.

6.9 2017/18 and beyond

NHS England's Next Steps on the 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 as part of the BOB STP (Buckinghamshire, Oxfordshire and West Berkshire Strategic Transformation Partnership.

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. As part of this process there is a requirement to take medium term actions to support this, and the participation in FIP2 will assist this delivery.

The Trust has worked with its commissioners in agreeing contracts for activity levels in 2017/18 and 2018/19 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.

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:

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 2016/17

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 of key terms and acronyms

Key Term	Acronym	Definition
A		
Academic Health Science Network	**AHSN**	AHSNs are system integrators and organisations which link different parts of the health ecosystem to ensure that a range of aspects to improve health outcomes are considered using proven methodology and improvement in science to lead large scale, sustainable transformational change across traditional boundaries.
Accident and Emergency	**A&E**	A hospital department concerned with the provision of immediate treatment to people who are seriously injured in an accident or who are suddenly taken seriously ill.
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.
Acute hospital services		Medical and surgical interventions provided in hospitals.
Agenda for Change		Agenda for Change is the pay system for the majority of NHS staff.
Annual Governance Statement	**AGS**	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.
B		
Better Payment Practice Code	**BPPC**	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.
Board Assurance Framework	**BAF**	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.
Break-even duty		A financial target. In its simplest form it requires the Trust to match income and expenditure.
Buckinghamshire, Oxfordshire and West Berkshire	**BOB**	One of the 44 Strategic Transformation Partnerships
C		
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

Key Term	Acronym	Definition
		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 Group	**CCG**	NHS organisation 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. diff**	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.
	CP-IS	National Child Protection Information Sharing.
Commissioning	**CQUIN**	These payment targets are aimed at driving up

Key Term	Acronym	Definition
for Quality and Innovation		quality in certain areas. They have been developed to support implementation of *High Quality Care for All*.
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.
Cost Improvement Programme	**CIP**	An annual 'savings' plan
Current assets		Debtors, stocks, cash or similar whose value is, or can be converted into, cash within the next twelve months.
D		
Deprivation of Liberty Safeguards	**DoLS**	In certain cases, the restrictions placed upon an individual who lacks capacity to consent to the arrangements of their care may amount to "deprivation of liberty". This must be judged on a case-by-case basis. Where it appears a deprivation of liberty might occur, the provider of care (usually a hospital or a care home) has to apply to their local authority, who will then arrange an assessment of the individual's care and treatment to decide if the deprivation of liberty is in the best interests of the individual concerned. If it is, the local authority will grant a legal authorisation. If it is not, the care and treatment package must be changed – otherwise, an unlawful deprivation of liberty will occur. This system is known as the Deprivation of Liberty Safeguards.
Disability equality scheme	**DES**	The Disability Discrimination Act amended in 2005 gives the Trust 'general' and 'specific' duties to promote disability equality.
Door To Needle Time	**DTNT**	Length of time to administer antibiotics.
E		
Education, Learning and Development	**ELD**	
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.
Electronic Referral System	**ERS**	Electronic referrals between clinicians
Emergency Inpatient Activity		Emergency activity is where admission is unpredictable and at short notice because of clinical need.
Emergency Preparedness, Resilience and Response	**EPRR**	The NHS needs to plan for, and respond to, a wide range of incidents and emergencies that could affect health or patient care. These could be anything from extreme weather conditions to an outbreak of an infectious disease or a major transport accident. The Civil Contingencies Act (2004) requires NHS

Key Term	Acronym	Definition
		organisations, and providers of NHS-funded care, to show that they can deal with such incidents while maintaining services. This programme of work is referred to in the health community as emergency preparedness, resilience and response (EPRR). New arrangements for local health EPRR form some of the changes the Health and Social Care Act 2012 is making to the health system in England.
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	**EDRM**	Electronic document and records management system which has been rolled out from Autumn 2013.
Executive directors	**ED's**	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.
External Financing Limit	**EFL**	A positive EFL arises as a NHS trust is required to draw on Government funding or utilise its cash resources. A negative EFL arises where the NHS trust is required to repay Public Dividend Capital or save cash.
F		
	FFP3	Filtering efficiency level for protective equipment.
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.
Foundation Year 1 **Foundation Year 2**	**FY1 and FY2**	A grade of medical practitioner in the United Kingdom undertaking the Foundation Programme – a two-year, general postgraduate medical training programme which forms the bridge between medical school and specialist/general practice training.
Friends and Family Test	**F&FT or FFT**	The Friends and Family Test (FFT) is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. It asks people if they would recommend the services they have used and offers a range of responses. When combined with supplementary follow-up questions, the FFT provides a mechanism to highlight both good and poor patient experience. This kind of feedback is vital in transforming NHS services and supporting patient choice.
Full Time Equivalent	**FTE**	The hours worked by one employee on a full-time basis. The concept is used to convert the hours

Key Term	Acronym	Definition
		worked by several part-time employees into the hours worked by full-time employees.
G		
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.
Gross Domestic Product	**GDP**	A measure of the value of national economic activity.
H		
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.
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 England Thames Valley	**HEE-TV**	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.
Healthier Lifestyles Service	**HLS**	The healthier lifestyles service is here to support staff to live life well. Trained staff provide free, confidential advice, information and help with: • Physical activity • Smoking • Alcohol • General emotional wellbeing • Healthy eating • Weight management
Healthy Child Programme	**HCP**	The 'Healthy Child Programme' is the main universal health service for improving the health and wellbeing of children, through: • health and development reviews • health promotion • parenting support • screening and immunisation programmes
Health and Safety Executive	**HSE**	National independent watchdog for work-related health, safety and illness. It acts in the public interest to reduce work-related death and serious injury

Key Term	Acronym	Definition
		across Great Britain's workplaces.
Hospital Standardised Mortality Ratio	**HSMR**	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.
I		
Information Technology	**IT or ICT**	Information and communications technology.
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.
Integrated Urgent Care	**IUC**	System in Buckinghamshire working with partners across Thames Valley in redesigning NHS 111 and primary care out of hours services.
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.
K		
Key Performance Indicators	**KPI's**	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.
L		
Learning Disability	**LD**	Significant reduced ability to understand new or complex information, to **learn** new skills (impaired intelligence), with a reduced ability to cope independently (impaired social functioning), which started before adulthood"
Library Quality Assurance Framework	**LQAF**	The NHS Library Quality Assurance Framework England provides a quality assurance tool for health library/knowledge services, establishing an infrastructure through which to deliver the outcomes defined in the Framework.
Limited Liability Partnership	**LLP**	A partnership in which some or all partners (depending on the jurisdiction) have limited liabilities. It therefore exhibits elements of partnerships and corporations. In an LLP, one partner is not responsible or liable for another partner's misconduct or negligence.
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.
Long Term Financial Model	**LTFM**	Long term financial planning.

Key Term	Acronym	Definition
Looked After Child	**LAC**	A child is looked after by a local authority if a court has granted a care order to place a child in care, or a council's children's services department has cared for the child for more than 24 hours
M		
Making Every Contact Count	**MECC**	Making every contact count (MECC) is an approach to behaviour change that utilises the millions of day to day interactions that organisations and people have with other people to encourage changes in behaviour that have a positive effect on the health and wellbeing of individuals, communities and populations.
Mental Capacity Act	**MCA**	The Mental Capacity Act (MCA) is designed to protect and empower individuals who may lack the mental capacity to make their own decisions about their care and treatment. It is a law that applies to individuals aged 16 and over. Examples of people who may lack capacity include those with: • dementia • a severe learning disability • a brain injury • a mental health condition • a stroke • unconsciousness caused by an anaesthetic or sudden accident
Meticillin Resistant Staphylococcus Aureus	**MRSA**	This is a strain of a common bacterium which is resistant to an antibiotic called methicillin.
Multi-Agency Safeguarding Hub	**MASH**	The Buckinghamshire Multi-Agency Safeguarding Hub (MASH) co-locates key partners in order to improve the initial response to safeguarding concerns in relation to children and vulnerable adults. Bringing together key partners and forging stronger links with other agencies enables information to be shared quickly and effectively and better informed decisions to be made by social care. This approach will assist in identifying risk at an earlier stage and result in appropriate early intervention in order to safeguard vulnerable children and adults.
N		
National Learning Management System	**NLMS**	The NLMS is a free-to-use elearning system available to all NHS staff.
NHS Improvement	**NHSI**	NHS Improvement. NHS Improvement is responsible for overseeing foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care.
NHS Litigation Authority	**NHSLA**	The NHS Litigation Authority (NHSLA) manages negligence and other claims against the NHS in England on behalf of its member organisations.

Key Term	Acronym	Definition
		Name has changed to **NHS Resolution** from April 2017.
NHS Professionals	**NHSP**	Provider of managed flexible worker services to the NHS.
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 Director	**NED**	Member of a company's board of directors who is not part of the executive team. A non-executive director typically does not engage in the day-to-day management of the organization, but is involved in policy making and planning exercises.
O		
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'.
P		
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**	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.
Patient Experience Group	**PEG**	Patient and public involvement group at the Trust.
Patient-Led Assessments of the Care Environment	**PLACE**	System for assessing the quality of the patient environment
Primary care		Family health services provided by family doctors, dentists, pharmacists, optometrists, and ophthalmic medical practitioners.
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
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,

Key Term	Acronym	Definition
		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 in the workplace and in delivering public services.
Q		
Quality Accounts	**QA**	From 2009/10 onwards all NHS trusts have to publish quality accounts to give information about the quality of the services being delivered.
R		
Revenue		Expenditure other than capital. For example, staff salaries and drug budgets. Also known as current expenditure.
Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013	**RIDDOR**	Puts duties on employers, the self-employed and people in control of work premises (the Responsible Person) to report certain serious workplace accidents, occupational diseases and specified dangerous occurrences (near misses).
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.
S		
Secondary care		Care provided in hospitals.
Service Delivery Unit	**SDU**	Clinical service related to a specific speciality. Each clinical Division comprises a number of SDU's.
Senior Information Risk Owner	**SIRO**	Senior Information Risk Owner (SIRO) required by the Information Governance Toolkit (IGT) was one of several NHS Information Governance (IG) measures identified to strengthen information assurance controls for NHS information assets.
Strategic Transformation Partnership	**STP**	Five year plans for the future of health and care services in local areas. NHS organisations have come together with local authorities and other partners to develop the plans in 44 areas of the country. STPs represent a very significant change to the planning of health and care services in England.

Key Term	Acronym	Definition
Swan Unit		The Swan Unit was set up in July 2015 in response to CSE concerns within the authority. it is a multi agency team including professionals from Thames Valley Police, Children's Social Care, Buckinghamshire Healthcare NHS Trust, R U Safe? and virtual representation from CAMHS. The Unit has 5 specific functions in relation to children at risk of sexual exploitation: 1) The assessment of risk 2) Chairing strategy meetings 3) Advice to partner professionals on CSE 4) Direct work with children vulnerable to CSE 5) Co-ordination of information and intelligence about victims and perpetrators of CSE
T		
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.
U		
	USBR	Understanding Stress, Building Resilience
V		
Visual Analogue Scale	**VAS**	A measurement instrument that tries to measure a characteristic or attitude that is believed to range across a continuum of values and cannot easily be directly measured. For example, the amount of pain that a patient feels ranges across a continuum from none to an extreme amount of pain.
W		
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.
Workforce Race Equality Standard	**WRES**	A requirement for NHS commissioners and NHS provider organisations. ... By using the EDS2 and the WRES, NHS organisations can also be helped to deliver on the Public Sector Equality Duty.

Appendix 4 – Sustainability report

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 environmental impact.

Policies

In order to embed sustainability within our business it is important to explain where in our process and procedures sustainability features.

Area	Is sustainability considered?
Travel	Yes
Procurement (environmental)	Yes
Procurement (social impact)	Yes
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.

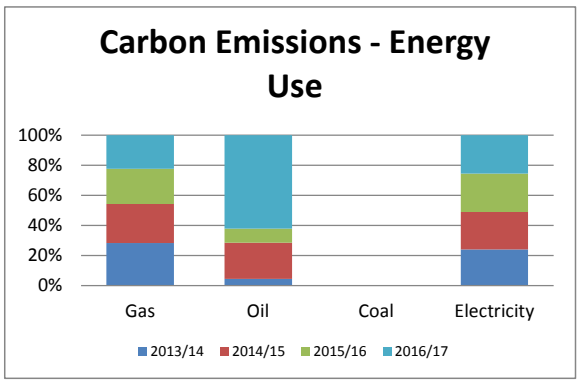
Context Info		2012/13	2013/14	2014/15	2015/16	2016/17
Floor Space (m2)		138983	138477	138983	138477	138477
Number of Staff		5800	5925	5800	5925	6146

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 2019. It is our aim to meet this target by reducing our carbon emissions 10% by 2019 using 2007 as the baseline year. Here's how we have done:

Energy

Buckinghamshire Healthcare NHs Trust has spent £3,548,625.30 on energy in 2016/17 which is 17% decrease on energy spend from last year. This is largely due to a reduction in unit price and net consumption.

Resource		2013/14	2014/2015	2015/16	2016/17
Gas	Use (kWh)	61108989	56646548	50401458	48140097
	tCO_2e	12963	11884	10692	10212
Oil	Use (kWh)	56262	309983	120209	77814
	tCO_2e	18	99	38	25
Coal	Use (kWh)		0	0	0
	tCO_2e		0	0	0
Electricity	Use (kWh)	26155176	25741523	22848738	22789462
	tCO_2e	12015	12476	12793	12760
Total Energy CO_2e		24997	24459	23523	23228
Total Energy Spend	£	4,356,889.00	£ 3,878,725.00	£ 4,233,877.80	£ 3,548,625.30



Performance

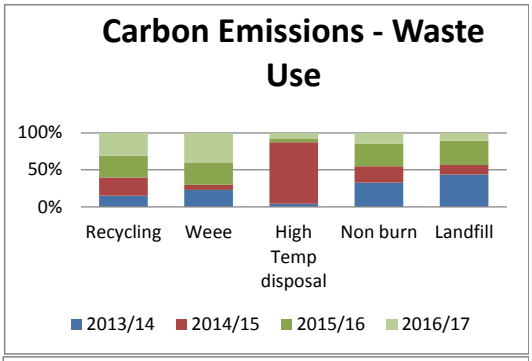
The CHP is end of life and relatively inefficient in comparison to newer CHP available today. During 16/17 the trust has suffered unreliability with the CHP resulting in the plant only operating for 31% of its target run time during 16/17. This is now resolved following repair work and is expected to provide improved output during 17/18.

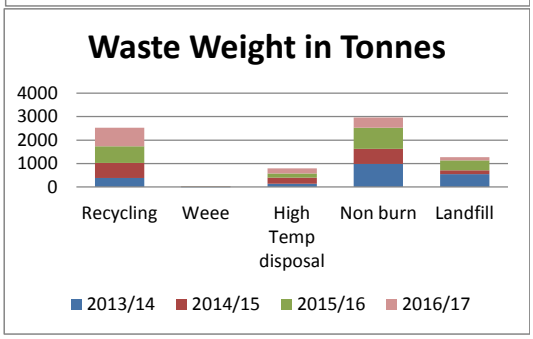
Commentary

We are currently looking at using the options to finance new infrastrucure that will assist in reducing our emissions footprint and energy cost. We have currently started a programme across the Trust replacing external street lighting with updated LED units. In addition we are upgrading our generators and transformers to the triad scheme (run the generators when the main grid is at capacity).

Waste

Waste		2013/14	2014/15	2015/16	2016/17
Recycling	(tonnes)	389	632	719	790
	tCO_2e	8.17	13.27	15.09	16.59
Re-use	(tonnes)	0	0	0	0
	tCO_2e	0	0	0	0
Compost	(tonnes)	0	0	0	0
	tCO_2e	0	0	0	0
WEEE	(tonnes)	5	1.5	6.6	8.5
	tCO_2e	0.1	0.03	0.13	0.18
High Temp recovery	(tonnes)	0	0	0	0
	tCO_2e	0	0	0	0
High Temp disposal	(tonnes)	145	252	174	230
	tCO_2e	3.04	55.44	3.65	4.83
Non-burn disposal	(tonnes)	980	649	897	438
	tCO_2e	20.58	13.64	18.83	9.2
Landfill	(tonnes)	554	165	422	131
	tCO_2e	135.41	40.33	103.14	32.02
Total Waste (tonnes)		2073	1700	2219	1598
Total Waste tCO_2e		167.3	122.71	140.84	62.82





Performance

Waste has decreased due to the Trust introducing a new "Offensive Waste" stream known as tiger bags. This has enabled the trust to make significant reductions in our Non-Burn and land fill categories with a reduction year on year. The Trust has also introduced waste champions and continues to strive for further waste reduction

Water

Water		2013/14	2014/15	2015/16	2016/17
Mains	m^3	169092	157232	135221	128674
	tCO_2e	178	143	142	135
Water & Sewage Spend		£ 331,794	£ 286,552	£ 282,435	£ 286,064

Performance

The water consumption across the trust remains constant due in part to our water management regimes, infection control requirement, and programmed flushing in line with Trust policy. In order to safeguard the integrity of supply and water quality the trust has installed a secondary metered water supply at Stoke Mandeville Hospital.

Commentary

Programmed water testing is reported into the Infection control and water quality group to meet audit and assurance requirements. Water meter readings are collected by trust and partner staff on a monthly basis and all invoice are monitored for accuracy and consumption trends by the Energy and Sustainability Officer.

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.

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 co	225,158
Freight transport	69,570
Food and catering	426,124
Construction	693,999
Business services	867,541
Capital spend	7,563,129
Water and sanitatio	142
Waste products and	141
Travel	283495
Imported Heat/Stea	0
Electricity	12760.047
Coal	0
Oil	256.42783
Gas	10212.44